

Amendment No. 2 to SB2184

Crowe
Signature of Sponsor

AMEND Senate Bill No. 2184

House Bill No. 2177*

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 71, Chapter 5, is amended by adding a new part 11 to read as follows:

71-5-1101. As used in this part:

(1) "Alternative payment system" means a payment methodology used by a healthcare payor that includes a risk-sharing or gain-sharing component for a physician who participates in a plan, program, or network offered by the healthcare payor;

(2) "Healthcare payor" means the state or any health insurance company, health maintenance organization, or managed care organization contracted with by the state to provide, arrange, or pay for medical assistance provided under this chapter in the TennCare program;

(3) "Gain-sharing payment" means an increase in a payment or additional payment made by a healthcare payor to a physician, or a group practice of which the physician is a member, as a result of patient care costs that fall below cost thresholds set by the healthcare payor;

(4) "Risk-sharing payment" means a reduction in a payment to a physician, or group of which a physician is a member, or refund of a payment already made to the physician, or a recoupment applied against payments for future services provided by that physician, as a result of patient care costs that exceed cost thresholds set by the healthcare payor; and

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(5) "TennCare" means the medical assistance program operated under this chapter.

71-5-1102. For a healthcare payor using an alternative payment system, during a period when penalties are not to be imposed, a physician who could be subject to a risk-sharing penalty shall receive on request within ten (10) business days from the payor an itemized claim-level break down of the episodes of care covered by the most recent reporting period that fall above the penalty threshold.

71-5-1103. For a healthcare payor using an alternative payment system, a physician against whom the payor assesses a penalty for cost of care or quality of care that is not acceptable shall receive on request within ten (10) business days from the payor an itemized claim-level break down of the episodes of care covered by the reporting period for which the penalty is imposed that fall above the penalty threshold.

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it.