

**STATE OF TENNESSEE  
BUREAU OF TENNCARE**



**2010**

**QUALITY ASSESSMENT AND PERFORMANCE  
IMPROVEMENT STRATEGY**

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## I. Introduction

### I.A Overview

#### Driver for implementation of managed care

The purpose of the TennCare program is to demonstrate that a state Medicaid program can implement a managed care approach incorporating waivers of some federal Medicaid requirements and through this approach can be successful in (a) providing more services than Medicaid provided and (b) covering more people than Medicaid covered, all while assuring quality of care and spending no more money than would have been spent under Medicaid.

#### History of managed care program

On January 1, 1994, Tennessee began a new health care reform program called TennCare. This was the original TennCare waiver named TennCare I. This program, designed as a managed care model, essentially replaced the Medicaid program in Tennessee. At the start of TennCare I, Tennessee moved almost all of its Medicaid program into a managed care model. The original TennCare design was extraordinarily ambitious. It involved extending coverage to large numbers of uninsured and uninsurable people. Almost all benefits were delivered by Managed Care Organizations (MCO) of varying size, operating at full risk. The TennCare program was implemented as a five-year demonstration program and received several extensions after the original expiration date of December 30, 1999. TennCare II, the new demonstration that started on July 1, 2002, revised the structure of the original program in several important ways. The program was divided into "TennCare Medicaid" and TennCare Standard." TennCare Medicaid is for Medicaid eligibles, while TennCare Standard is for the demonstration population. At the time that TennCare II began, several MCOs were either leaving the program or at risk of leaving the program, due to their inability to maintain financial viability. A Stabilization Plan was introduced under TennCare II whereby the MCOs were temporarily removed from risk. Pharmacy benefits and dental benefits were carved out of the MCO scope of services, and new single benefit managers were selected for those services. Enrollment of demonstration eligibles was sharply curtailed, with new enrollment being open only to uninsurable persons with incomes below poverty and "Medicaid rollovers," meaning persons losing Medicaid eligibility who met the criteria for the demonstration population. In 2004, in the face of projections from an outside consultant that TennCare was growing at a rate that would soon make it impossible for the state to both support TennCare and meet its obligations in other critical areas, Governor Phil Bredesen proposed a TennCare Reform package to accomplish goals such as "right sizing" program enrollment and reducing the dramatic growth in pharmacy spending. With CMS approval, the state began implementing these modifications in 2005. On October 5, 2007, the waiver for the TennCare II extension was approved for three additional years. The TennCare II extension made additional revisions in the program, one of which was to require that demonstration children who have incomes under 200 percent of poverty be classified as Title XXI children. The extension also mandated a new cap on supplemental payments to hospitals.

In July 2009, CMS approved an amendment to the TennCare waiver that will allow MCOs to coordinate all of the care a TennCare member needs, which will now include medical, behavioral and long-term

care. The Long-Term Care Community Choices Act of 2008 (CHOICES) will utilize the existing Medicaid MCOs to provide eligible individuals with nursing facility services or home and community based services. The CHOICES program will be implemented in stages over time in different geographic areas of the state. Implementation of CHOICES for the Middle Grand Region MCOs is planned for March 2010 with the East and West Grand Region MCOs to follow in 6-12 months.

### **MCO contracting and turnover experience**

Traditionally, MCOs have been "at risk." However, because of instability among some of the MCOs participating in TennCare, the "at risk" concept was replaced in July 2002 with an "administrative services only" arrangement. The state added its own MCO, TennCare Select, to serve as a backup if other plans failed or there was inadequate MCO capacity in any area of the state. TennCare Select is administered by BlueCross/BlueShield of Tennessee. Maintaining MCO participation in Middle Tennessee has been troublesome over the years. During the 2006-2007 state fiscal year, one of the major TennCare priorities was recruiting well-run, well-capitalized MCOs to Middle Tennessee. In addition, to bringing in new MCOs, the Bureau wanted to establish a new service-delivery model - an integrated medical and behavioral health model. Another crucial factor in the implementation was structuring the MCOs' contracts to return the organizations to full financial risk. To meet these goals, the state conducted its first RFP process for TennCare MCOs. The Bureau secured contracts with two successful bidders. The two new MCOs "went live" on schedule on April 1, 2007. TennCare placed the managed care contracts for the East and West grand regions of the state up for competitive bid in January 2008. In April 2008, the state awarded the regional contracts to two companies in each region. The MCO contractors accepted full financial risk to participate in the program and the new contracts also established an integrated medical and behavioral health care system for members. The plans began serving West region members on November 1, 2008 and began serving members in the East region January 1, 2009. In September 2009, behavioral health services for TennCare Select enrollees were transferred to BlueCross BlueShield of Tennessee (BCBST). TennCare Select operates statewide and serves enrollees such as foster children, children receiving SSI benefits and nursing facility or IDF-MR residents under age 21. It also serves as the back-up MCO should there be capacity problems with any of the other MCOs.

Currently, TennCare services are offered through several managed care entities. Each enrollee has a MCO for his/her primary care, medical/surgical services, and mental health and substance abuse treatment services, and a Pharmacy Benefits Manager (PBM) for his/her pharmacy services. Children under the age of 21 are eligible for dental services, which are provided by a Dental Benefits Manager (DBM).

### **Population description/changes**

All Medicaid and demonstration eligibles are enrolled in TennCare, including those who are dually eligible for TennCare and Medicare. There are approximately 1.2 million persons enrolled in TennCare. There are two (2) kinds of TennCare, TennCare Medicaid and TennCare Standard.

**TennCare Medicaid** is for Tennesseans who are eligible for a Medicaid program. Some of the groups TennCare Medicaid covers are:

- Children under age 21
- Women who are pregnant
- Single parents or caretakers of a minor child
- Two-parent families with a minor child living at home when one of the parents:
  - Has lost their job or had their work hours cut, or
  - Has a health or mental health problem expected to last 30 days
- Women who need treatment for breast or cervical cancer
- People who receive an Supplemental Security Income (SSI) check
- People who have received both an SSI check and a Social Security check in the same month at least once since April, 1977 AND who still get a Social Security check
- People who:
  - Lives in a nursing home and has income below \$2,022 per month, or
  - Receives other long-term care services that TennCare pays for

**TennCare Standard** is only available for children under age 19 who are already enrolled in TennCare Medicaid and:

- Who lack access to group health insurance through their parents' employer, or
- Their time of eligibility is ending and they don't qualify anymore for TennCare Medicaid.

There are two ways they can qualify and be able to keep their healthcare benefits:

- To qualify as uninsured:
  - The child's eligibility through TennCare Medicaid is ending,
  - The child must be under the age of 19,
  - The child must lack access to group health insurance through their own job or a parent's job, and
  - The family income is below 200 percent of poverty.

If the family's income is above 200 percent of poverty, the child may qualify for TennCare Standard as Medically Eligible.

- To qualify as "medically eligible":
  - The child must be under the age of 19,
  - Have a health condition which makes the child "uninsurable", (or unable to access private health insurance because of their health condition.) and
  - The child must lack access to group health insurance through their job or a parent's job

TennCare Standard Spend Down is only available to adults who have Standard Spend Down now.

- Aged (65 or older), or
- Blind or

- Disabled, or
- The caretaker of a minor child
  - In a two-parent family with a minor child, one of the parents must:
    - have lost a job or had work hours cut,
    - or have health or mental health problems expected to last 30 days.

### **Long-Term Care Community Choices Act of 2008 (CHOICES)**

In July 2009, CMS approved an amendment to the TennCare waiver that will allow MCOs to coordinate all of the care a TennCare member needs, which will now include medical, behavioral and long-term care. Implementation of CHOICES for the Middle Grand Region MCOs is planned for March 2010 with the East and West Grand Region MCOs to follow in 6-12 months. Initial implementation will include two CHOICES groups:

- CHOICES Group 1 is for individuals receiving services in a Nursing Facility. These individuals are enrolled in TennCare Medicaid.
- CHOICES Group 2 is for individuals who meet the NF LOC and are receiving HCBS as an alternative to NF care. Those in CHOICES 2 may be enrolled in either TennCare Medicaid, if they are SSI-eligible, or TennCare Standard, if they are not SSI-eligible. The non-SSI group in CHOICES 2 is called the CHOICES 217-Like HCBS Group. The CHOICES 217-Like HCBS Group is composed of individuals age 65 and older or adults age 21 and older with physical disabilities who:
  - Meet the NF level of care requirement;
  - Are receiving HCBS; and
  - Who would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236, and 435.726, and Section 1924 of the Social Security Act, if the HCBS were provided under a Section 1915(c) waiver. With the statewide implementation of CHOICES, the Bureau will no longer provide HCBS under a Section 1915(c) waiver.

TENNCARE intends to add CHOICES Group 3 on January 1, 2011.

- CHOICES 3 is for individuals age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who qualify for TennCare as SSI recipients, who do not meet the nursing facility level of care, but who, in the absence of HCBS, are “at-risk” for nursing facility care, as defined by the State.

### **Strategy evaluation and revision**

Annually, in November, TennCare plans to review the Quality Strategy and provide an update to CMS by January 31 of each year.

### **Process to get public input on strategy**

The Quality Strategy will be available on TennCare’s Web site. When the Quality Strategy is updated, TennCare will notify enrollees, providers, and advocacy groups that an updated Quality Strategy is

posted on TennCare's Web site or is alternately available in print. TennCare staff will be available to make presentations as requested. Comments on the Strategy will be encouraged.

## I.B Strategy Goals and Objectives

### Medical and Behavioral Health

The table below discusses the Quality Strategy goals and objectives established by the State for medical and behavioral health.

Goal	Objective	Additional Information
1. Assure appropriate access to care for enrollees.	<p>1.1 By 2013, the statewide weighted HEDIS rate for adults' access to preventive/ambulatory health services will increase to 75% for enrollees 20-44 years old and the rate for enrollees 45-64 years old will be maintained at 79% or above.</p> <p>1.2 By 2013, the statewide weighted HEDIS rate for children and adolescents' access to primary care practitioners will increase to 89% for enrollees 7-11 years old and 85% for enrollees 12-19 years old.</p> <p>1.3 By 2013, 97% of TennCare heads of household and 98% or greater of TennCare children will go to a doctor or clinic when they are first seeking care rather than a hospital (emergency room).</p>	<p><u>Data source:</u> <i>A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs).</i></p> <p><u>Data source:</u> <i>A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs).</i></p> <p><u>Data source:</u> <i>The Impact of TennCare: A Survey of Recipients.</i></p>
2. Provide quality care to enrollees.	<p>2.1 By 2013, the statewide weighted HEDIS rate for adolescent well-care visits will increase to 41%.</p> <p>2.2 By 2013, the statewide weighted HEDIS rate for timeliness of prenatal care will be maintained at 82% or above.</p> <p>2.3 By 2013, the statewide weighted HEDIS rate for breast cancer screening will increase to 48%.</p>	<p><u>Data source:</u> <i>A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs).</i></p> <p><u>Data source:</u> <i>A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs).</i></p> <p><u>Data source:</u> <i>A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs).</i></p>

Goal	Objective	Additional Information
	<p>2.4 By 2013, the statewide weighted HEDIS rate for cervical cancer screening will increase to 65%.</p> <p>2.5 By 2013, providers of EPSDT screening services will document the delivery of 95% of the required seven components of an EPSDT screen.</p>	<p><u>Data source:</u> <i>A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs).</i></p> <p><u>Data source:</u> EPSDT Medical Record Review.</p>
3. Assure enrollees' satisfaction with services.	<p>3.1 By 2013, 95% of TennCare enrollees will be satisfied with TennCare.</p> <p>3.2 By 2013, the statewide average for adult CAHPS getting needed care-always or usually will increase to 82%.</p> <p>3.3 By 2013, the statewide average for child CAHPS getting care quickly-always or usually will increase to 81%.</p>	<p><u>Data source:</u> <i>The Impact of TennCare: A Survey of Recipients.</i></p> <p><u>Data source:</u> <i>A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs).</i></p> <p><u>Data source:</u> <i>A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs).</i></p>
4. Improve health care for program enrollees.	<p>4.1 By 2013, the statewide weighted HEDIS rate for HbA1c testing will be maintained at 73% or above.</p> <p>4.2 By 2013, the statewide weighted HEDIS rate for controlling high blood pressure will increase to 55%.</p> <p>4.3 By 2013, the statewide weighted HEDIS rate for follow-up after hospitalization for mental illness will be maintained at 51% for follow-up within 7 days of discharge and 72% for follow-up within 30 days of discharge.</p> <p>4.4 By the end of each demonstration year, the state will</p>	<p><u>Data source:</u> <i>A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs).</i></p> <p><u>Data source:</u> <i>A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs).</i></p> <p><u>Data source:</u> <i>A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs).</i></p> <p><u>Data source:</u> CMS-416.</p>

Goal	Objective	Additional Information
	<p>achieve a total statewide EPSDT screening rate of at least 80%.</p> <p>4.5 By 2013, the statewide weighted HEDIS rate for antidepressant medication management will be maintained at 63% for acute phase and 48% for continuation phase.</p> <p>4.6 By 2013, the statewide weighted HEDIS rate for follow-up care for children prescribed ADHD medication will be maintained at 36% for initiation and 46% for continuation and maintenance.</p>	<p><u>Data source:</u> <i>A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs).</i></p> <p><u>Data source:</u> <i>A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs).</i></p>

### Long-Term Care

In July 2009, CMS approved an amendment to the TennCare waiver that will allow TennCare to integrate nursing facility services and HCBS for the elderly and adults with physical disabilities into the existing managed care program. MCOs will coordinate all of the care a TennCare member needs, which will now include medical, behavioral and long-term care. Implementation of CHOICES for the Middle Grand Region MCOs is planned for March 2010 with the East and West Grand Region MCOs to follow several months thereafter. The table below discusses the long-term care sub-assurances and performance measures established by the State to identify levels of compliance/noncompliance with federal assurances pertaining to Section 1915(c) waiver programs, including level of care, service plan, qualified providers, health and welfare, administrative authority, and participant rights; to ensure prompt remediation of individual findings, and to promote system improvements in the managed long-term care delivery system.

Assurance	Sub-Assurance	Performance Measure	Additional Information
Level of Care	1. CHOICES Group 2 members have a level of care determination indicating the need for institutional services prior to enrollment in CHOICES and receipt	1. Number and percent of CHOICES Group 2 members who had an approved CHOICES PAE (i.e., nursing facility level of care eligibility determination) prior to	<p><u>Data Source:</u> MMIS report</p> <p><u>Sampling Approach:</u> 100% of all CHOICES Group 2 members</p>

Assurance	Sub-Assurance	Performance Measure	Additional Information
	of Medicaid-reimbursed HCBS.	enrollment in CHOICES and receipt of Medicaid-reimbursed HCBS.	<p>enrolled</p> <p><u>Frequency:</u> Quarterly</p> <p><u>Remediation:</u> TennCare is responsible for quarterly reports and review/analysis of data, as well as remediation of individual findings.</p>
Service Plan	2. CHOICES members are offered choice between institutional (NF) services and HCBS.	2. Number and percent of CHOICES Group 2 member records reviewed with an appropriately completed and signed freedom of choice form that specifies choice was offered between institutional services and HCBS.	<p><u>Data Source:</u> Member record review</p> <p><u>Sampling Approach:</u> Stratified, with strata comprised of CHOICES Group 2 members enrolled in each of the MCOs per region serving the CHOICES Group 2 population. For the first auditing year, the sample size will consist of sixty (60) records per stratum with a ten percent (10%) oversample to determine subsequent error for future audits. For following years, sample size will be based on the first auditing year's sampling error in order to achieve a ninety-five percent (95%) confidence interval.</p> <p><u>Frequency:</u> Semi-Annually, in May and</p>

Assurance	Sub-Assurance	Performance Measure	Additional Information
			<p>November</p> <p><u>Remediation:</u> TennCare is responsible for semi-annual member record review and review/analysis of data. MCOs will be responsible for remediation of individual findings with review/validation by TennCare.</p>
Service Plan	3. Plans of Care are reviewed/ updated at least annually.	3. Number and percent of CHOICES Group 2 member records reviewed whose plans of care were reviewed and updated prior to the member's annual review date.	<p><u>Data Source:</u> Member record review</p> <p><u>Sampling Approach:</u> Stratified, with strata comprised of CHOICES Group 2 members enrolled in each of the MCOs per region serving the CHOICES Group 2 population. Sample size will be based on the first auditing year's sampling error in order to achieve a ninety-five percent (95%) confidence interval. Any records used previously in a semi-annual audit will be excluded.</p> <p><u>Frequency:</u> Annually, in November, following the first full year of CHOICES implementation</p> <p><u>Remediation:</u> TennCare is responsible for annual member record review</p>

Assurance	Sub-Assurance	Performance Measure	Additional Information
			and review/ analysis of data. MCOs will be responsible for remediation of individual findings with review/ validation by TennCare.
Qualified Providers	4. CHOICES HCBS providers meet minimum provider qualifications established by the State prior to enrollment in CHOICES and delivery of HCBS.	4. Number and percent of CHOICES HCBS providers reviewed for whom the MCO provides documentation that the provider meets minimum qualifications established by the State and was credentialed by the MCO in accordance with NCQA guidelines prior to enrollment in CHOICES and delivery of HCBS.	<p><u>Data Source:</u> Provider record review</p> <p><u>Sampling Approach:</u> Stratified, with strata comprised of HCBS providers contracted with each of the MCOs serving the CHOICES Group 2 population; sample size – 25 records per stratum. Sample size may be adjusted in subsequent years based on individual findings.</p> <p><u>Frequency:</u> Annually, in November</p> <p><u>Remediation:</u> TennCare is responsible for annual provider record review and review/analysis of data. MCOs will be responsible for remediation of individual findings with review/validation by TennCare.</p>

Assurance	Sub-Assurance	Performance Measure	Additional Information
Health and Welfare	5. CHOICES Group 2 members (or their family member/authorized representative, as applicable) receive education/information at least annually about how to identify and report instances of abuse, neglect and exploitation.	5. Number and percent of CHOICES Group 2 member records reviewed which document that the member (or their family member/authorized representative, as applicable) received education/information at least annually about how to identify and report instances of abuse, neglect and exploitation.	<p><u>Data Source:</u> Member record review</p> <p><u>Sampling Approach:</u> Stratified, with strata comprised of CHOICES Group 2 members enrolled in each of the MCOs per region serving the CHOICES Group 2 population. Sample size will be based on the first auditing year's sampling error in order to achieve a ninety-five (95%) confidence interval. Any records used previously in a semi-annual audit will be excluded.</p> <p><u>Frequency:</u> Annually, in November</p> <p><u>Remediation:</u> TennCare is responsible for annual member record review and review/analysis of data. MCOs will be responsible for remediation of individual findings with review/validation by TennCare.</p>

Assurance	Sub-Assurance	Performance Measure	Additional Information
Health and Welfare	6. Critical incidents are reported within timeframes specified in the Contractor Risk Agreement.	6. Number and percent of critical incident records reviewed in which the incident was reported within timeframes specified in the Contractor Risk Agreement.	<p><u>Data Source:</u> Sample record review</p> <p><u>Sampling Approach:</u> Stratified, with strata comprised of reported incidents for CHOICES Group 2 members enrolled in each of the MCOs per region serving the CHOICES Group 2 population. For the first auditing year, the sample size will consist of sixty (60) records per stratum with a ten percent (10%) oversample to determine subsequent error for future audits. For following years, sample size will be based on the first auditing year's sampling error in order to achieve a ninety-five percent (95%) confidence interval.</p> <p><u>Frequency:</u> Semi-Annually, in May and November</p> <p><u>Remediation:</u> TennCare is responsible for semi-annual record review and review/ analysis of data. MCOs will be responsible for remediation of individual findings with review/ validation by TennCare.</p>

Assurance	Sub-Assurance	Performance Measure	Additional Information
Administrative Authority	<p>7. The State ensures that MCO provider agreements meet uniform requirements set forth in the Contractor Risk Agreement.</p> <p>Data Source: TDCI report of provider agreement template approval</p> <p>Sampling Approach: 100% of all MCO provider agreement templates</p> <p>Frequency: Annual</p> <p>TDCI is responsible for quarterly reports and for remediation of individual findings. TennCare is responsible for review/ analysis of data, as well as review/ validation of remediation activities.</p>	<p>7. Number and percent of MCO provider agreements reviewed which meet uniform requirements set forth in the Contractor Risk Agreement.</p>	<p><u>Data Source:</u> TDCI report of provider agreement template approval</p> <p><u>Sampling Approach:</u> 100% of all MCO provider agreement templates</p> <p><u>Frequency:</u> Annually</p> <p><u>Remediation:</u> TDCI is responsible for quarterly reports. TDCI and MCOs are responsible for remediation of individual findings. TennCare is responsible for review/ analysis of data, as well as review/ validation of remediation activities.</p>

Assurance	Sub-Assurance	Performance Measure	Additional Information
Participant Rights	8. CHOICES members are informed of and afforded the right to request a Fair Hearing when services are denied, reduced, suspended or terminated.	8. Number and percent of CHOICES Group 2 member records reviewed in which HCBS were denied, reduced, suspended or terminated as evidenced in the Plan of Care and, consequently, the member was informed of and afforded the right to request a Fair Hearing when services were denied, reduced, suspended or terminated as determined by the presence of a Grievance consent decree notice.	<p><u>Data Source:</u> Member record review</p> <p><u>Sampling Approach:</u> Stratified, with strata comprised of reported incidents for CHOICES Group 2 members enrolled in each of the MCOs per region serving the CHOICES Group 2 population. Sample size will be a subset of the sample used in Sub-Assurance 2.</p> <p><u>Frequency:</u> Semi-Annually, in May and November</p> <p><u>Remediation:</u> TennCare is responsible for semi-annual record review and review/ analysis of data. MCOs will be responsible for remediation of individual findings with review/ validation by TennCare.</p>

## II. Assessment

### II.A Quality and Appropriateness of Care

#### Identification of race, ethnicity, and primary language spoken of each enrollee and transmission to managed care plans

Eligibility for TennCare and other Medicaid programs is determined by the Department of Human Services (DHS). All 95 counties in Tennessee have a DHS office. Applicants complete the Application for Family Assistance Programs and Benefits and indicate that they are applying for TennCare/Medicaid. The application includes questions about race and ethnicity and instructs the applicant that response to these questions is voluntary. The application also includes questions about need for an interpreter and for what language interpretation is needed. The contracts with the MCOs contain eligibility and enrollment data exchange requirements in section 2.23.5. The requirements state that the MCOs must receive, process and update enrollment files sent daily by TENNCARE and the MCOs must update eligibility/enrollment databases within twenty-four hours of receipt of enrollment files.

TennCare uses information about language and need for an interpreter to identify those Limited English Proficiency (LEP) groups constituting five percent (5%) of the TennCare population or one-thousand (1,000) enrollees, whichever is less. In section 2.17.2.5, the contract with the MCOs requires that all vital documents be translated and available to the LEP groups identified by TennCare within ninety calendar days of notification from TennCare.

The contracts with the MCOs also require the MCO to develop written policies and procedures for the provision of language interpreter and translation services to members in section 2.18.2.

The contracts require that member materials such as the member handbook and the quarterly member newsletter contain statements on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free in sections 2.17.4.5.23 and 2.17.5.3.2.

#### Use of EQRO Technical Report to evaluate quality and appropriateness of care

The EQRO Technical Report summarizes the manner in which data from mandated external quality review activities were aggregated and analyzed, and conclusions drawn, as to the quality and timeliness of, and access to, care furnished to TennCare-enrolled recipients by its contracted MCOs, behavioral health organizations (BHOs), and dental benefits manager (DBM). The three federally mandated activities – performed by the external quality review organization (EQRO) for TennCare – are: validation of performance measures (PMVs); validation of performance improvement projects (PIPs); and monitoring compliance with federal and state standards. The EQRO monitors compliance with federal and state standards through Annual Quality Surveys (AQS) and Annual Provider Network Adequacy and Benefit Delivery Reviews also known as Annual Network Adequacy (ANA). The 2010 AQS and ANA will not include CHOICES since implementation is planned for 2010. Beginning in 2011, the AQS and the ANA will include CHOICES.

Independent external quality reviews and activities are a primary means of assessing the quality, timeliness and accessibility of services provided by TennCare MCCs. QSource's annual technical report

compiles the results of these reviews and activities, making it a streamlined source of unbiased, actionable data. TennCare can use this data to measure progress toward stated goals and objectives and to determine if new or restated goals are necessary.

Where applicable, the data in the annual technical report are trended over time to help TennCare identify areas where targeted quality improvement interventions might be needed. Trending in the 2009 Technical Report is limited compared to previous reports due to the reduced number of health plans and subsequent changes in their enrollee populations. More complete trending will again be possible with the 2010 Technical Report since all MCOs will have returned to an integrated service model and will have achieved NCQA accreditation.

As mandated by 42 CFR § 438.364, technical report data make it possible to benchmark performance both statewide and nationally. In presenting part of the state's healthcare picture, the data aid TennCare as it collaborates with other state agencies to address common health issues – particularly those that are prevalent, chronic and preventable.

### Specific performance measures or performance improvement projects required by the State based on Strategy Objectives and associated performance standards

Strategy Objective	Performance Measure	Benchmark	Sanction
4.4 By the end of each demonstration year, the state will achieve a total statewide EPSDT screening ratio of at least 80%.	Attachment VII- Performance Standards 16 TENNderCare screening ratio (calculated quarterly by TennCare)	Equal to or greater than 80 percent	\$5,000 for each full percentage point ratio is below 80 percent for the most recent rolling twelve month period

This strategy objective is a statewide rate related to a performance measure calculated quarterly by TennCare. This performance measure is specified in the MCO contracts in Attachment VII-Performance Standards. The contracts specify that the MCO benchmark for the TENNderCare screening ratio is equal to or greater than 80%.

Strategy Objective	Performance Measure	Benchmark	Sanction
2.5 By 2013, providers of EPSDT screening services will document the delivery of 95% of the required seven components of an EPSDT screen.	Rate of documentation of the delivery of the required seven components of an EPSDT screen	Within one standard deviation of the statewide average	Plan of correction for results that are greater than one standard deviation below the statewide average

This strategy objective is a statewide average based on MCO results obtained from the annual EPSDT Medical Record Review conducted by TennCare. The medical record review is conducted in medical provider offices and Health Department clinics throughout the state by nursing consultants on a

stratified random sample of records. The purpose of the review is to determine the extent to which medical providers are in compliance regarding the documentation of the delivery of the seven components of the EPSDT exam. MCOs with Medical Record Review results that are greater than one standard deviation below the statewide average are required to submit a plan of correction to TennCare.

Several of the strategy objectives are either statewide weighted HEDIS rates or statewide average CAHPS rates and are based on HEDIS and CAHPS results submitted by the MCOs. The contracts require the MCOs to annually complete all HEDIS measures designated by NCQA as relevant to Medicaid. The only exclusion from the complete Medicaid HEDIS data set is dental measures. The MCOs are required to contract with an NCQA certified HEDIS auditor to validate the processes of the CONTRACTOR in accordance with NCQA requirements. The contracts also require that the MCOs submit the audited HEDIS results to TENNCARE, NCQA, and TENNCARE's EQRO annually by June 15 of each calendar year. In addition, the contracts require the MCOs to annually conduct a CAHPS survey. The MCOs are required to enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The MCO's CAHPS vendor is required to perform the CAHPS adult survey, CAHPS child survey and the CAHPS children with chronic conditions survey. The contracts also require that the MCOs submit survey results to TENNCARE, NCQA, and TENNCARE's EQRO annually by June 15 of each calendar year. There are no performance standards for HEDIS/CAHPS results, but pay-for-performance quality incentive payments are offered for MCOs who demonstrate significant improvement from the previous reporting period for specified measures.

### **Provision of clinical guidelines to managed care plans**

The state does not provide clinical practice guidelines to the MCOs, but the contracts require that each Disease Management (DM) program (Maternity Care Management, Diabetes, CHF, Asthma, CAD, COPD, Bipolar Disorder, Major Depression, Schizophrenia, and Obesity) utilize evidence-based clinical practice guidelines that have been formally adopted by the MCO's Quality Management/Quality Improvement (QM/QI) committee or other clinical committee. The contracts stipulate that the guidelines for the required DM programs include a requirement to conduct a mental health and substance abuse screening. The DM programs for bipolar disorder, major depression, and schizophrenia are also required to include the use of the evidence-based practice for co-occurring disorders.

The contracts require that the MCOs measure performance against at least two important clinical aspects of the guidelines associated with each DM program. The MCOs report results to TennCare on July 1 in the annual DM Report.

## II.B MCO Requirements and Contractual Compliance

The following section discusses requirements established by the State for the managed care plans in the following domains: access to care; structure and operations; and quality measurement and improvement. Monitoring mechanisms used by the State to provide oversight to the managed care plans and contract provisions that hold the managed care plans accountable for meeting the standards established by the state are also discussed.

### Access to Care

As stated in section [I.B](#), one of the goals of this Quality Strategy is to assure appropriate access to care for enrollees. Section I.B also lists the accompanying objectives to assess attainment of this goal. This section addresses the standards that have been established in the MCO contracts for access to care, how TennCare determines whether the MCOs are in compliance with the contract requirements, and disincentives for nonperformance.

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
<p><b>42 CFR 438.206</b> <b>Availability of Services</b></p>	<p>The contracts with the MCOs address provider networks in section 2.11 including: primary care providers, specialty service providers, prenatal care providers, behavioral health services, long-term care providers, and safety net providers; credentialing and other certification; and network notice requirements.</p> <p>The contracts with the MCOs address provider agreements in section 2.12.</p> <p>The contracts with the MCOs address customer service for members in section 2.18 including: member services toll-free phone line; interpreter and translation services; cultural competency; member involvement with behavioral health services.</p>	<p>2.30.7 requires the MCOs to submit provider network reports including, but not limited to: monthly Provider Enrollment File, annual Provider Compliance with Access Requirements, quarterly PCP Assignment Report, annual Report of Essential Hospital Services, quarterly Behavioral Health Initial Appointment Timeliness Report, annual Long-Term Care Provider Network Development Plan, and quarterly Long-Term Care Provider Capacity Performance Report.</p> <p>2.30.12 requires the MCOs to submit customer service reports including, but not limited to:</p>	<p>4.20.2.1.1 – Liquidated damages can be assessed for each day that a report or deliverable is late, incorrect, or deficient.</p> <p>4.20.2.2.7 C.2 - Liquidated damages can be assessed for failure to report provider notice of termination of participation in the MCO.</p> <p>C.7 - Liquidated damages can be assessed for failure to submit a Provider Enrollment File that meets TennCare’s specifications.</p> <p>B.25 - Liquidated damages can be assessed for failure to</p>

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
	<p>Contractor Risk Agreement (CRA) Attachment III addresses general access standards and attachment IV addresses specialty network standards. Attachment V addresses access and availability for behavioral health services.</p>	<p>quarterly Member Services and Provider Services Phone Line Report; quarterly 24/7 Nurse Triage Line Report; quarterly ED Assistance Tracking Report; and quarterly Translation/Interpretation Services Report.</p>	<p>maintain provider agreements in accordance with Section 2.12 and Attachment XI of the contract.</p>
		<p>CRA Attachment VII Performance Standards requires the MCOs to meet established benchmarks for performance measures relating to these requirements. The performance measures include, but are not limited to: provider network documentation, provider participation accuracy, and distance from provider to member. The measurement frequency for these measures ranges from monthly to quarterly.</p> <p>The MCOs are required to meet established benchmarks for performance measures relating to: Telephone Response Time/Call Answer Timeliness -Member Services Line and Telephone Call Abandonment Rate (unanswered calls) – Member Services Line. The measurement frequency for these measures is quarterly.</p>	<p>CRA Attachment VII Performance Standards - Liquidated damages can be assessed if an MCO fails to meet the benchmark for the performance measures.</p>

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
		<p>CRA Attachment VIII requires the MCOs to submit documentation for review and/or approval by TennCare during readiness review and/or during operations:</p> <p>27. Policies and procedures to develop and maintain a provider network that ensure compliance with Section 2.11.1, including policies and procedures for selection and/or retention of providers.</p> <p>28. Policies and procedures for PCP selection and assignment that ensure compliance with Section 2.11.2, including policies and procedures regarding change of PCP and use of specialist as PCP.</p> <p>29. Plan to identify, develop, or enhance existing inpatient and residential treatment capacity for adults and adolescents with co-occurring mental health and substance abuse disorders to ensure compliance with Section 2.11.5.2.</p> <p>33. Provider agreement template(s) and revisions to TDCI as required in Section 2.12.</p>	
		<p>CRA Attachment VIII requires the MCOs to submit documentation for review and/or approval by</p>	

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
		<p>TennCare during readiness review and/or during operations:</p> <p>53. Member services phone line policies and procedures that ensure compliance with Section 2.18.1.</p> <p>54. Policies and procedures regarding interpreter and translation services that ensure compliance with Section 2.18.2.</p> <p>56. Description of 24/7 ED Assistance Line (see Section 2.18.4.7).</p>	
		<p>Some of these requirements are evaluated by the Provider Data Validation Quarterly Report<sup>i</sup>, an EQRO contractual activity.</p>	
		<p>Some of these requirements are evaluated as part of the Annual Network Adequacy (ANA)<sup>ii</sup>, an EQRO mandatory activity.</p>	
		<p>Some of these requirements are evaluated as part of the Annual Quality Survey (AQS)<sup>iii</sup>, an EQRO mandatory activity.</p>	<p>TennCare requires that each MCC submit a plan of correction (POC) for any element not meeting 100% compliance.</p> <p>4.20.2.2.7 B.2 – Liquidated damages can be assessed for failure to complete or comply with corrective action plans as</p>

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
		Some of these requirements are deemed met by the NCQA Accreditation Survey. For specific information, see Attachment A: State Requirements Deemed Met by NCQA Accreditation Survey- <a href="#">Availability of Services</a> .	required by TENNCARE.  4.20.2.2.7 B.4 – Liquidated damages can be assessed for failure to submit NCQA Accreditation Report within 10 days of receipt.
<b>42 CFR 438.208 Coordination and Continuity of Care</b>	The contracts with the MCOs address management, coordination, and continuity of care in 2.9. This section specifies requirements for transition of new members; transition of members receiving long-term care services at the time of CHOICES implementation; transition of care; MCO case management; care coordination (for CHOICES members); consumer direction of HCBS; coordination and collaboration for members with behavioral health needs; coordination and collaboration among behavioral health providers; coordination of pharmacy services; coordination of dental benefits; coordination with Medicare; ICF/MR services and alternatives to ICF/MR services and inter-agency coordination.  Section 2.9.5.1 specifies that the MCOs must maintain a case management program that includes a component for systematically identifying eligible members. In addition,	2.30.6 requires the MCOs to submit service coordination reports including, but not limited to: MCO Case Management Reports (annual MCO Case Management Program Description, annual MCO Case Management Services Report, quarterly MCO Case Management Update Report), monthly Status of Transitioning CHOICES Members Report, quarterly Care Coordination Report, semi-annual Nursing Facility Diversion Report, quarterly Nursing Facility to Community Transition Report, monthly HCBS Missed Visits Report, and quarterly Consumer Direction of HCBS Report.  CRA Attachment VIII requires the MCOs to submit documentation	4.20.2.1.1 – Liquidated damages can be assessed for each day that a report or deliverable is late, incorrect, or deficient.

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
	<p>section 2.9.5.2 requires the MCOs to provide case management to members who are at high risk or have unique, chronic, or complex needs. This shall include but not be limited to members with co-occurring mental illness and substance abuse and/or co-morbid physical health and behavioral health conditions.</p>	<p>for review and/or approval by TennCare during readiness review and/or during operations:</p> <ol style="list-style-type: none"> <li>11. Service coordination policies and procedures that ensure compliance with Section 2.9.1.</li> <li>12. Policies and procedures for transition of new members that ensure compliance with the requirements of Section 2.9.2.</li> <li>13. Policies and procedures for transition of member receiving long-term care services at the time of CHOICES implementation that ensure compliance with Section 2.9.3.</li> <li>14. Transition of care policies and procedures that ensure compliance with Section 2.9.4.</li> <li>15. MCO case management policies and procedures that ensure compliance with Section 2.9.5.</li> <li>16. Care coordination policies and procedures that ensure compliance with Section 2.9.6.</li> <li>17. Policies and procedures for consumer direction of HCBS that ensure compliance with Section 2.9.7.</li> <li>18. Policies and procedures for coordination of physical health, behavioral health, and long-term</li> </ol>	

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
		<p>care services that ensure compliance with Section 2.9.8.</p> <p>20. Policies and procedures for coordination among behavioral health providers that ensure compliance with Section 2.9.9.</p> <p>21. Policies and procedures for coordination of pharmacy services that ensure compliance with Section 2.9.10.</p> <p>22. Policies and procedures for coordination of dental services that ensure compliance with Section 2.9.11.</p> <p>25. Policies and procedures for inter-agency coordination that ensure compliance with Section 2.9.14.</p>	
		<p>Some of these requirements are evaluated as part of the Annual Quality Survey (AQS)<sup>iii</sup>, an EQRO mandatory activity.</p>	<p>TennCare requires that each MCC submit a plan of correction (POC) for any element not meeting 100% compliance.</p>
		<p>Some of these requirements are deemed met by the NCQA Accreditation Survey. For specific information, see Attachment A: State Requirements Deemed Met by NCQA Accreditation Survey-<a href="#">Coordination and Continuity of Care</a>.</p>	<p>4.20.2.2.7 B.4 – Liquidated damages can be assessed for failure to submit NCQA Accreditation Report within 10 days of receipt.</p>

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
<p><b>42 CFR 438.210 Coverage and Authorization of Services</b></p>	<p>The contracts with the MCOs address benefits, service requirements and limits in section 2.6. This section requires the provision and integration of medical, behavioral health, and long-term care benefits and services. This section specifies requirements for contractor covered benefits, TennCare benefits provided by TennCare, medical necessity determination, second opinions, use of cost effective alternative services, additional services and use of incentives, and cost sharing and patient liability. In addition, section 2.7 addresses specialized services such as: emergency services; behavioral health services; self-direction of health care tasks for CHOICES members; health education and outreach; preventive services; TENNderCare; advance directives; and sterilizations, hysterectomies, and abortions. Attachment I addresses behavioral health specialized service descriptions for mental health case management and psychiatric rehabilitation. Section 2.8 specifies requirements for disease management including: member identification strategies, stratification, program content, informing and education members, informing and educating providers, program evaluation (satisfaction and effectiveness), and obesity disease management.</p> <p>The contracts with the MCOs address utilization management (UM) in 2.14. This</p>	<p>2.30.4 requires the MCOs to submit specialized service reports including, but not limited to: quarterly Psychiatric Hospital/RTF Readmission Report, quarterly Mental Health Case Management Report, quarterly Behavioral Health Crisis Response Report, quarterly Adverse Occurrences Report, and quarterly TENNderCare Report.</p> <p>The Quality Oversight Division of the Bureau of TennCare conducts periodic abortion, sterilization, hysterectomy (ASH) medical record reviews.</p> <p>2.30.5 requires the MCOs to submit disease management reports, including, but not limited to: quarterly Disease Management Update Report, annual Disease Management Report, and an annual updated Disease Management Program Description.</p> <p>2.30.10 requires the MCOs to submit UM reports including, but not limited to: annual UM Program Description, Work Plan and Evaluation; quarterly Cost and Utilization Reports; monthly</p>	<p>4.20.2.1.1 – Liquidated damages can be assessed for each day that a report or deliverable is late, incorrect, or deficient.</p> <p>4.20.2.2.7 A.7 – Liquidated damages can be assessed for failure to comply with this Agreement and federal rules/law regarding Sterilizations/Abortions/Hysterectomies as outlined in Section 2.7.8.</p> <p>4.20.2.2.7 B.20 - Liquidated damages can be assessed if the MCOs impose arbitrary utilization guidelines or other quantitative coverage limits as prohibited in Section 2.6.3 and 2.14.1 of this Agreement.</p>

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
	<p>section specifies general UM requirements, prior authorization for physical health and behavioral health covered services, referrals for physical health and behavioral health, exemptions to prior authorization and/or referrals for physical health and behavioral health, authorization of long-term care services, transition of members receiving long-term care services at the time of CHOICES implementation, notice of adverse action requirements, medical history information requirements and PCP profiling.</p>	<p>CHOICES Utilization Report; quarterly Prior Authorization Report; Referral Provider Listing; and semi-annual Emergency Department Threshold Report.</p> <p>CRA Attachment VIII requires the MCOs to submit documentation for review and/or approval by TennCare during readiness review and/or during operations: 6. Policies and procedures for self-direction of health care tasks in accordance with Section 2.7.3.</p>	

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
		<p>8. TENNderCare policies and procedures that ensure compliance with the requirements of Section 2.7.6.</p> <p>9. Policies and procedures for advance directives that ensure compliance with Section 2.7.7.</p> <p>10. Disease management program policies and procedures that ensure compliance with Section 2.8.</p>	
		<p>CRA Attachment VIII requires the MCOs to submit documentation for review and/or approval by TennCare during readiness review and/or during operations:</p> <p>38. Policies and procedures for PCP profiling to ensure compliance with Section 2.14.9.</p>	
		<p>Some of these requirements are deemed met by the NCQA Accreditation Survey. For specific information, see Attachment A: State Requirements Deemed Met by NCQA Accreditation Survey- <a href="#">Coverage and Authorization of Services</a>.</p>	<p>4.20.2.2.7 B.4 – Liquidated damages can be assessed for failure to submit NCQA Accreditation Report within 10 days of receipt.</p>

## Structure and Operations

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
<b>42 CFR 438.214 Provider Selection</b>	The contracts with the MCOs address requirements for credentialing and other certification in 2.11.8. This section includes credentialing of contract providers, credentialing of non-contract providers, credentialing of behavioral health entities, credentialing of long-term care providers, compliance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA), and Weight Watchers or other weight management program.		4.20.2.2.7 B.24 – Liquidated damages can be assessed for applications that have not been approved and loaded into the MCO's system or denied within thirty (30) calendar days of receipt of a completed credentialing application and a signed provider agreement/contract if applicable.
		Attachment VIII requires the MCOs to submit documentation for review and/or approval by TennCare during readiness review and/or during operations: 30. Credentialing manual and policies and procedures that ensure compliance with Section 2.11.8	
		Some of these requirements are evaluated as part of the Annual Network Adequacy (ANA) <sup>ii</sup> , an EQRO mandatory activity.	
<b>42 CFR 438.218 Enrollee Information</b>	The contracts with the MCOs contain requirements for member materials in	2.17.1.1 requires the MCOs to submit to TennCare for review and	4.20.2.2.7 B.7 - Liquidated damages can

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
	<p>section 2.17. This section addresses: prior approval process for all member materials; written material guidelines; distribution of member materials; member handbooks; quarterly member newsletter; identification card; CHOICES member materials; provider directories; additional information available upon request.</p>	<p>prior written approval all materials that will be distributed to members. This includes but is not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, member education and outreach activities.</p>	<p>be assessed for failure to obtain approval of member materials as required by Section 2.17.  B. 8 – Liquidated damages can be assessed for failure to comply with time frames for providing Member Handbooks, I.D. cards, Provider Directories, Quarterly Member Newsletters, and CHOICES member education materials as required in Section 2.17</p>
		<p>Some of these requirements are evaluated as part of the Annual Quality Survey (AQS)<sup>iii</sup>, an EQRO mandatory activity.</p>	<p>TennCare requires that each MCC submit a plan of correction (POC) for any element not meeting 100% compliance.  4.20.2.2.7 B.2 – Liquidated damages can be assessed for failure to complete or comply with corrective action plans as required by TENNCARE.</p>
		<p>Some of these requirements are deemed met by the NCQA Accreditation Survey. For specific information, see Attachment A: State Requirements Deemed Met by NCQA Accreditation Survey-</p>	<p>4.20.2.2.7 B.4 – Liquidated damages can be assessed for failure to submit NCQA Accreditation Report within 10 days of receipt.</p>

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
		<a href="#">Enrollee Information.</a>	
<b>42 CFR 438.224 Confidentiality</b>	The contracts with the MCOs contain requirements for compliance with the Health Insurance Portability and Accountability Act (HIPAA) in section 2.27 and additional requirements for confidentiality of information in section 4.33.	2.30.20 requires the MCOs to submit a HIPAA Report annually entitled Privacy/Security Incident Report. The MCOs must provide the report more frequently if requested by TennCare.	2.27.2 - In accordance with HIPAA regulations, the MCOs are required to, at a minimum: 2.27.2.3 Agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security and all subsequent HIPAA standards, that it will be in breach of the contract and will then take all reasonable steps to cure the breach or end the violation as applicable... if for any reason the MCO cannot meet the requirements of this Section, TennCare may terminate the contract.
		CRA Attachment VIII requires the MCOs to submit documentation for review and/or approval by TennCare during readiness review and/or during operations: 87. HIPAA policies and procedures that ensure compliance with Section 2.27.	
		Some of these requirements are	4.20.2.2.7 B.4 – Liquidated

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
		deemed met by the NCQA Accreditation Survey. For specific information, see Attachment A: State Requirements Deemed Met by NCQA Accreditation Survey- <a href="#">Confidentiality</a> .	damages can be assessed for failure to submit NCQA Accreditation Report within 10 days of receipt.
<b>42 CFR 438.226 Enrollment and Disenrollment</b>	<p>The contracts with the MCOs address enrollment requirements in section 2.4. This section includes: general; authorized service area; maximum enrollment; MCO selection and assignment; effective date of enrollment; eligibility and enrollment data; enrollment period; transfers from other MCOs; enrollment of newborns; and information requirements upon enrollment.</p> <p>In addition, the contracts with the MCOs address disenrollment requirements in section 2.5. This section includes: general; acceptable reasons for disenrollment from a MCO; unacceptable reasons for disenrollment from a MCO; informing TennCare of potential ineligibility; and effective date of disenrollment from a MCO.</p>	2.30.2 requires the MCOs to submit Eligibility, Enrollment and Disenrollment Reports including, but not limited to the Monthly Enrollment/Capitation Payment Reconciliation Report and the Quarterly Member Enrollment/Capitation Payment Report.	4.20.2.1.1 – Liquidated damages can be assessed for each day that a report or deliverable is late, incorrect, or deficient.

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
<p><b>42 CFR 438.228</b>  <b>Grievance Systems - Complaints</b></p>	<p>The contracts with the MCOs address complaints and appeals in section 2.19. The MCOs are required to have internal complaint procedures for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees, or court orders governing the appeals process. In addition, 2.17.4.5.11 requires the MCOs to inform members of their right to file a complaint in the member handbook and 2.17.5.3.5 requires the MCOs to inform members of their right to file a complaint in the quarterly MCO newsletters.</p>	<p>2.30.13 requires the MCOs to submit a quarterly Member Complaints Report.</p>	<p>4.20.2.1.1 – Liquidated damages can be assessed for each day that a report or deliverable is late, incorrect, or deficient.</p> <p>4.20.2.2.7  B.16 - Liquidated damages can be assessed for failure to maintain a complaint and appeal system as required in Section 2.19.  B. 17 - Liquidated damages can be assessed for failure to comply with the timeframe for resolving complaints (see Section 2.19.2).</p>
		<p>CRA Attachment VIII requires the MCOs to submit documentation for review and/or approval by TennCare during readiness review and/or during operations:  65. Appeal and complaint policies and procedures that ensure compliance with Section 2.19.</p>	
		<p>Some of these requirements are evaluated as part of the Annual Quality Survey (AQS)<sup>iii</sup>, an EQRO mandatory activity.</p>	<p>TennCare requires that each MCC submit a plan of correction (POC) for any element not meeting 100% compliance.</p>

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
			4.20.2.2.7 B.2 – Liquidated damages can be assessed for failure to complete or comply with corrective action plans as required by TENNCARE.
<b>42 CFR 438.228 Grievance Systems - Appeals</b>	The contracts with the MCOs address appeals in section 2.19.3. Citation 2.19.3.2 requires the MCOs to direct all appeals to TennCare. In addition, 2.19.3.1 requires the MCO's appeal process to meet the requirements outlined in 2.19.3. including the requirement that the MCO have internal appeal procedures for members. In addition, 2.17.4.7.23 and -24 require the MCOs to include appeal procedures and notification of the right to file an appeal in the member handbook.	4.20.2.2.7 A.12 requires the MCOs to provide complete documentation and comply with the timelines for responding to a medical appeal.	4.20.2.2.7 A.12 – Liquidated damages can be assessed for each calendar day beyond the required time frame that the appeal is unanswered...and/or the appeal is not handled according to the provision. B.16 - Liquidated damages can be assessed for failure to maintain a complaint and appeal system as required in Section 2.19.
		CRA Attachment VIII requires the MCOs to submit documentation for review and/or approval by TennCare during readiness review and/or during operations: 65. Appeal and complaint policies and procedures that ensure compliance with Section 2.19.	
		Some of these requirements are evaluated as part of the Annual	TennCare requires that each MCC submit a plan of

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
		Quality Survey (AQS) <sup>iii</sup> , an EQRO mandatory activity.	correction (POC) for any element not meeting 100% compliance. 4.20.2.2.7 B.2 – Liquidated damages can be assessed for failure to complete or comply with corrective action plans as required by TENNCARE.
<b>42 CFR 438.230 Subcontractual Relationships and Delegation</b>	The contracts with the MCOs contain subcontract requirements in section 2.26 and addresses the requirement that the MCOs must ensure that the subcontracting relationship and subcontracting document(s) comply with federal requirements, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b). This section also addresses subcontract relationships and delegation, legal responsibility, prior approval, subcontracts for behavioral health services, subcontract for assessments and plans of care, subcontract with Fiscal Employer Agent (FEA), standards, quality of care, interpretation/translation services and limited English proficiency (LEP) provisions, children in state custody, assignability, claims processing, HIPAA requirements, compensation for UM activities, and notice of subcontractor termination.	2.26.3 requires the MCOs to obtain prior approval from TennCare for subcontracts and revisions of subcontracts.	
		Some of these requirements are deemed met by the NCQA Accreditation Survey. For specific information, see Attachment A: State Requirements Deemed Met by NCQA Accreditation Survey- <a href="#">Subcontractual Relationships and Delegation</a> .	4.20.2.2.7 B.4 – Liquidated damages can be assessed for failure to submit NCQA Accreditation Report within 10 days of receipt.

## Quality Measurement and Improvement

As stated in section I.B, three additional goals of the Quality Strategy are as follows: to provide quality care to enrollees, to assure enrollees' satisfaction with services and to improve health care for program enrollees. Section I.B also lists the accompanying objectives to assess attainment of these goals. The following section addresses the standards that have been established in the MCO contracts for quality measurement and improvement, how TennCare determines whether the MCOs are in compliance with the contract requirements, and disincentives for nonperformance.

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
<p><b>42 CFR 438.236 Practice Guidelines</b></p>	<p>In 2.8.1.2, the contracts require that the MCOs utilize evidence-based clinical practice guidelines that have been formally adopted by the MCO's QM/QI committee or other clinical committee with each Disease Management (DM) program (Maternity Care Management, Diabetes, CHF, Asthma, CAD, COPD, Bipolar Disorder, Major Depression, and Schizophrenia). The guidelines must include a requirement to conduct a mental health and substance abuse screening. The DM programs for bipolar disorder, major depression, and schizophrenia must include the use of evidence-based practice for co-occurring disorders.</p> <p>In 2.8.7.2, the contracts also require the MCOs to establish measurable benchmarks and goals for each DM program and to evaluate the programs using these benchmarks and goals. These benchmarks and goals should include: performance measured against at least two important clinical aspects of the guidelines associated with each DM program.</p>	<p>2.30.5.2 requires the MCOs to submit an annual Disease Management Report for each of the DM programs that contain information about the use, updating and dissemination of clinical practice guidelines for each DM program and includes benchmarks and goals as described in Section 2.8.7.</p>	<p>4.20.2.1.1 – Liquidated damages can be assessed for each day that a report or deliverable is late, incorrect, or deficient.</p>
		<p>Some of these requirements are evaluated as part of the Annual Quality Survey (AQS)<sup>iii</sup>, an EQRO mandatory activity.</p>	<p>TennCare requires that each MCC submit a plan of correction (POC) for any element not meeting 100% compliance.</p> <p>4.20.2.2.7 B.2 – Liquidated damages can be assessed for failure to complete or comply with corrective action plans as required by TENNCARE.</p>
		<p>Some of these requirements are</p>	<p>4.20.2.2.7 B.4 – Liquidated</p>

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
		deemed met by the NCQA Accreditation Survey. For specific information, see Attachment A: State Requirements Deemed Met by NCQA Accreditation Survey- <a href="#">Practice Guidelines</a> .	damages can be assessed for failure to submit NCQA Accreditation Report within 10 days of receipt.
<b>42 CFR 438.240</b> <b>Quality Assessment and Performance Improvement Program - 42 CFR 438.240(a) Program</b>	The contracts with the MCOs address requirements for the Quality Management/Quality Improvement (QM/QI) program in section 2.15.1 and 2.15.2. Section 2.15.1.1 requires the program to be written and to be consistent with the current NCQA Standards and Guidelines for the Accreditation of HPs. Section 2.15.1.1.1 requires the program to address physical health, behavioral health, and long-term care. Section 2.15.1.1.7 requires the MCO to evaluate the program annually and to update the program as appropriate.	2.30.11.1 requires the MCOs to annually submit the following Quality Management/Quality Improvement Reports including, but not limited to: QM/QI Program Description, Associated Work Plan, and Annual Evaluation.	4.20.2.1.1 – Liquidated damages can be assessed for each day that a report or deliverable is late, incorrect, or deficient.
		CRA Attachment VIII requires the MCOs to submit documentation for review and/or approval by TennCare during readiness review and/or during operations: 40. QM/QI policies and procedures to ensure compliance with Section 2.15.	
		Some of these requirements are evaluated as part of the Annual Quality Survey (AQS) <sup>iii</sup> , an EQRO mandatory activity.	TennCare requires that each MCC submit a plan of correction (POC) for any element not meeting 100% compliance. 4.20.2.2.7 B.2 – Liquidated damages can be assessed for

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
			failure to complete or comply with corrective action plans as required by TENNCARE.
		Some of these requirements are deemed met by the NCQA Accreditation Survey. For specific information, see Attachment A: State Requirements Deemed Met by NCQA Accreditation Survey- <a href="#">Program</a> .	4.20.2.2.7 B.4 – Liquidated damages can be assessed for failure to submit NCQA Accreditation Report within 10 days of receipt.
<b>42 CFR 438.240(c) Performance Measurement</b>	In 2.15.6.1, the contracts require the MCOs to annually complete all HEDIS measures designated by NCQA as relevant to Medicaid. The only exclusion from the complete Medicaid HEDIS data set is dental measures. The MCO is required to contract with an NCQA certified HEDIS auditor to validate the processes of the MCO in accordance with NCQA requirements.	2.15.6.1 requires the MCOs to annually submit audited HEDIS results to TennCare, NCQA, and TennCare's EQRO.	4.20.2.2.7 B.3 - Liquidated damages can be assessed for failure to submit audited HEDIS and CAHPS results annually by June 15.
		This requirement is evaluated by the Performance Measure Validation <sup>iv</sup> , an EQRO mandatory activity.	
		This requirement is also evaluated by the HEDIS/CAHPS Report: A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs) <sup>v</sup> , an EQRO contractual activity.	
	In 2.15.6.2, the contracts require the MCOs to annually conduct CAHPS surveys including the CAHPS adult survey, CAHPS child survey and the CAHPS children with chronic	2.15.6.2 requires the MCOs to annually submit survey results to TennCare, NCQA, and TennCare's EQRO.	4.20.2.2.7 B.3 - Liquidated damages can be assessed for failure to submit audited HEDIS and CAHPS results

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
	conditions survey. The MCO is required to enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys.		annually by June 15.
		This requirement is evaluated by the HEDIS/CAHPS Report: A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs) <sup>v</sup> , an EQRO contractual activity.	
<b>42 CFR 438.240(d) Performance Improvement Projects</b>	In 2.15.3, the contracts require each MCO to conduct two clinical and three nonclinical performance improvement projects (PIPs) relevant to the enrollee population. One of the two clinical PIPs must be relevant to one of the behavioral health disease management programs for bipolar disorder, major depression, or schizophrenia. Two of the three nonclinical PIPs must be in the area of long-term care.	2.30.11.2 requires the MCOs to submit an annual Report on Performance Improvement Projects to TennCare.	4.20.2.1.1 – Liquidated damages can be assessed for each day that a report or deliverable is late, incorrect, or deficient.
		This requirement is evaluated by the Performance Improvement Project Validation <sup>vi</sup> , an EQRO mandatory activity.	
<b>42 CFR 438.242 Health Information Systems</b>	The contracts with the MCOs contain information system requirements in section 2.23. The MCOs are required to have information management processes and information systems that enable them to meet TennCare and federal reporting requirements. This section includes requirements for: general provisions; data and document management; system and data integration; encounter data provision	2.30.17 requires submission of information system reports including, but not limited to: Systems Refresh Plan, Encounter Data Files, Systems Availability and Performance Report, Business Continuity and Disaster Recovery Plan.	2.23.13 addresses corrective actions, liquidated damages, and sanctions related to information systems.

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
	(encounter submission and processing); eligibility and enrollment data exchange; system and information security and access management; systems availability, performance and problem management; system user and technical support; system testing and change management; information systems documentation; reporting; and statewide data warehouse and community health record.		

<sup>i</sup> QSource conducts a quarterly provider data validation survey. The purpose of this activity is to determine the accuracy of the provider data files submitted by the TennCare Managed Care Contractors (MCCs) and to use the results as a proxy to determine the extent to which providers are available and accessible to TennCare enrollees. For this activity, MCCs include Managed Care Organizations (MCOs) and the Dental Benefits Manager (DBM). The following data elements from the provider files were identified for validation by TennCare and QSource: contract status with MCC, provider address, provider specialty/behavioral health service code, panel status (open/closed), services to children under 21, services to adults 21 and older, primary care services (MCOs/DBM), and prenatal services (MCOs). Based on contractual requirements, additional information related to the availability of routine and urgent care services is also collected.

<sup>ii</sup> The Annual Network Adequacy and Benefit Delivery Review (ANA) is conducted by Health Services Advisory Group (HSAG), a subcontractor for QSource, at the direction of the Tennessee Department of Commerce and Insurance (TDCI). The DBM and each MCO is evaluated to determine if it has an adequate provider network to ensure the effective and efficient delivery of healthcare to enrollees. The review also examines the completeness of each health plan's communication with its enrollees and providers regarding TennCare-covered services. The ANA includes: analyses of the distribution, availability, and assignment of providers to TennCare enrollees; review of credentialing/recredentialing and contracting policies and procedures; examination of each health plan's provider manual and enrollee handbook; review of a sample of credentialing/recredentialing files and provider contracts; determination of the number of appointments and access complaints; analysis of the distribution of providers and service facilities.

<sup>iii</sup> QSource conducts an Annual Quality Survey (AQS) of each Managed Care Organization (MCO) and the Dental Benefits Manager (DBM). The purpose of the AQS is to determine the extent to which each TennCare MCC is in compliance with the TennCare Contractor Risk Agreement (CRA), and the quality process (QP) standards and performance activities (PAs) derived from them. The AQS also evaluates compliance with: QP standards for the John B. Consent Decree, Grier Revised Consent Decree, Newberry Dispute Resolution, and non-discrimination; PAs derived from the John B. Consent Decree, Grier Revised Consent Decree, Newberry Dispute Resolution; 42 CFR Parts 417.106, 430,433, 434, and 438; other quality standards established by the state of Tennessee. QSource

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follows *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs), Final Protocol Version 1.0, February 11, 2003* to complete the review.

<sup>iv</sup> Performance Measure Validation for the MCOs is conducted by HSAG, subcontractor to QSource. The audit includes detailed review of a select set of two HEDIS measures required for reporting by TennCare. HSAG is an organization licensed by NCQA to perform HEDIS audit reviews. HSAG conducts an independent audit of HEDIS data from each MCO consistent with the current volume of NCQA's HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5. The auditor's examination includes procedures to obtain reasonable assurance the Final Audit Report presents fairly, in all material respects, the MCO's performance with respect to the HEDIS Technical Specifications. This activity is not required for the DBM.

<sup>v</sup> QSource compiles the annual *HEDIS/CAHPS Report: A Comparative Analysis of Audited Results from TennCare Managed Care organizations (MCOs)*. The report includes a statewide performance section in which statewide weighted rates calculated from all reporting MCOs are compared to national averages and statewide rates for the previous reporting period. An individual plan performance section is also included in the report. This section allows for cross-comparison of results across the state's MCOs. In this section, HEDIS results are color-coded according to national percentiles and CAHPS results are color-coded according to comparison with the statewide average.

<sup>vi</sup> Annually, Performance Improvement Project (PIP) Validation of one or more PIPs completed by each MCO, is conducted on behalf of QSource by HSAG in accordance with CMS's *Validating Performance Improvement Projects, a Protocol for Use in Conducting External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002*.

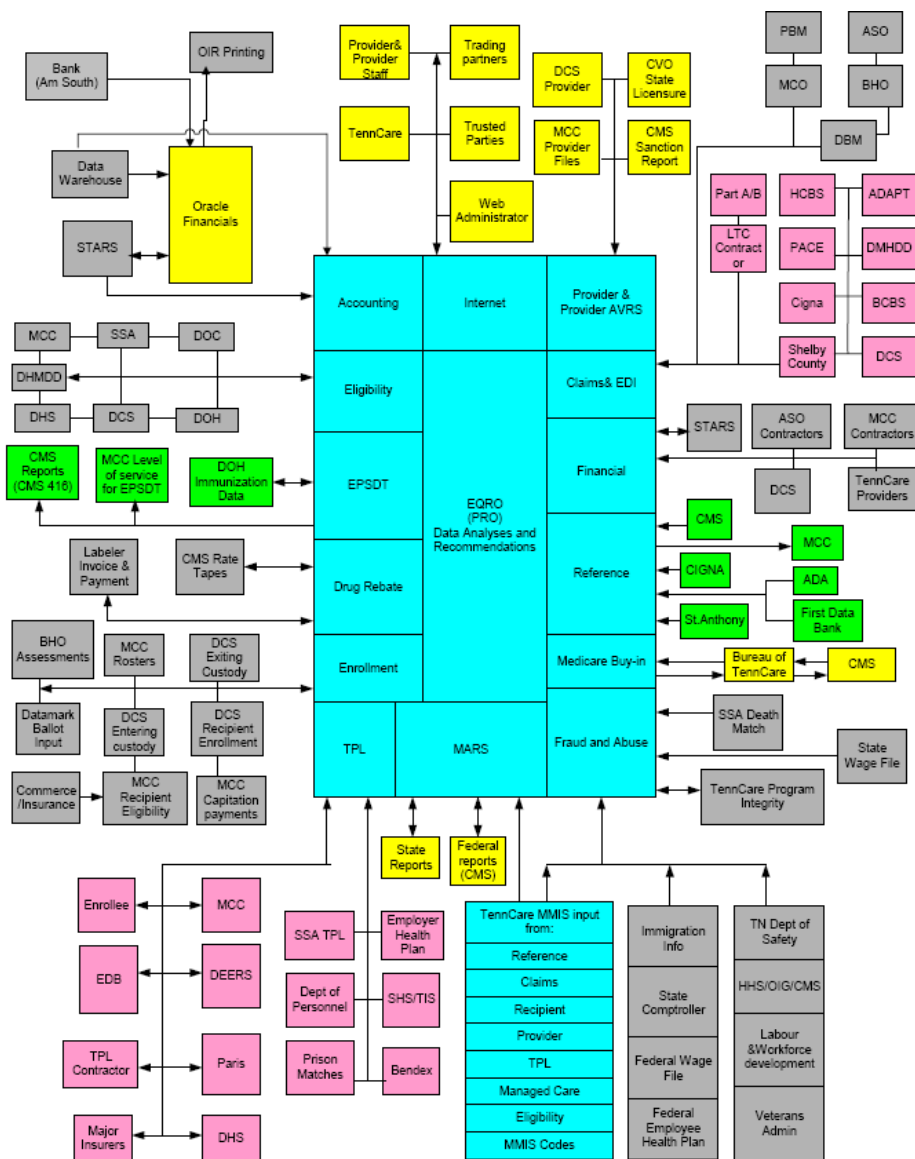
## II.C Evolution of Health Information Technology

### Information system to support initial and ongoing operation and review of the State's quality strategy objectives and progress toward performance targets

The TennCare Management Information System (TCMIS) supports the operation of TennCare and supports evaluation of progress toward targets for quality strategy objectives. One of the strategy objectives relies on data obtained from TCMIS. The strategy objective is 4.4 – By the end of each demonstration year, the state will achieve a total statewide EPSDT screening ratio of at least 80%.

#### TCMIS Interface Diagram

This diagram depicts the specific entities with which TennCare exchanges data.



Since July 1, 2009, TennCare has contracted with Electronic Data Systems (EDS) for operation and enhancement of the TennCare Management Information System (TCMIS). In September of 2009, EDS became HP Enterprise Services.

The current contract with HP Enterprise Services requires specific assessments of the TCMIS. The required assessments include Management and Administrative Reporting (MAR) review and ICD 10 design. HP Enterprise Services will review and assess the current MAR processes and provide recommendations for improving MAR as well as other TCMIS business analytics, decision support and dashboard capabilities for key business processes. HP Enterprise Services will also review the proposed changes to ICD coding in version 10, Procedural Coding System (PCS) and identify the changes needed in the TCMIS to accommodate them.

In addition to specific assessments, the current contract requires HP Enterprise Systems to perform specific enhancements to the TCMIS including:

1. **Capability Maturity Model Integration (CMMI)** – This Enhancement requires HP Enterprise Services to lead the effort in raising the TennCare capability maturity level.
2. **Technology Modernization** - This Enhancement requires HP Enterprise Services to support the Bureau's upgrade of specific hardware and software suites approaching end of life.
3. **Project Management Office (PMO)** - This Enhancement requires HP Enterprise Services to create a PMO for coordinating the multiple aspects and projects within the TCMIS.
4. **Commercial Off The Shelf (COTS) Dashboard** – This Enhancement is to establish the use of a COTS dashboard software product (such as Crystal Xcelsius), that shall be used to report performance metrics and operations indicators.
5. **COTS Documentation Software** - HP Enterprise Services shall secure and operate COTS documentation software with enhanced content management features and enhance Filenet, to be an enterprise-wide content management solution.
6. **Enhanced Testing Environment** – HP Enterprise Services shall develop multiple integrated test environments with subsequent promotion to a full system test environment and finally promoted to a regression test environment prior to a production release.
7. **Business Process Improvement** – This Enhancement requires HP Enterprise Services to develop a complete and detailed business process model of the Bureau and Contractor business processes, and that this process modeling shall include Activity Based Costing.
8. **Long-Term Care (LTC) CHOICES** - This Enhancement requires HP Enterprise Services to support the Bureau's implementation of the LTC CHOICES project.

### III. Improvement/Interventions

#### Implementation of interventions by the State specific to each strategic objective

TennCare has implemented a number of initiatives to support the goals of the TennCare Quality Strategy: assure appropriate access to care for enrollees, provide quality care to enrollees, assure enrollee satisfaction with services, and improve health care for program enrollees. These initiatives, in turn, support the attainment of the Quality Strategy objectives.

### ***NCQA Health Plan Accreditation***

Tennessee was the first state in the nation to mandate that all of its MCOs become accredited by the National Committee for Quality Assurance (NCQA). NCQA is an independent, 501(c)(3) non-profit organization that assesses and scores MCO performance in the areas of quality management and improvement, utilization management, provider credentialing and recredentialing, and members' rights and responsibilities. This process leaves only those MCOs providing the highest quality of care and service to provide for enrollees. All of TennCare's MCOs were initially accredited in 2006. In 2009, two of the original MCOs underwent the resurvey process and both MCOs maintained accreditation. In addition, a new MCO in Middle Tennessee completed the initial survey process and obtained accreditation. At the end of 2009, all TennCare MCOs are NCQA accredited. TennCare MCOs are contractually required to maintain accreditation once it is obtained.

In conjunction with accreditation, MCOs are required to annually submit a full set of audited measures from the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to NCQA. NCQA uses the results to reevaluate the organization's performance on specified HEDIS/CAHPS measures, and may change the organization's accreditation status based on the results.

### ***Integrated Operations - Medical and Behavioral Healthcare***

TennCare began integrating behavioral and medical health care delivery for Middle Tennessee members in 2007 with the implementation of two new MCOs. TennCare continued the process with the execution of new MCO contracts in West Tennessee in November 2008 and East Tennessee in January 2009. In September 2009, behavioral health services for TennCare Select enrollees were transferred to BlueCross BlueShield of Tennessee (BCBST). TennCare Select operates statewide and serves enrollees such as foster children, children receiving SSI benefits and nursing facility or ICF-MR residents under age 21. It also serves as the back-up MCO should there be capacity problems with any of the other MCOs. This transition for TennCare Select completes TennCare's phased implementation of a fully-integrated service delivery model.

### ***TENNderCare***

TennCare's Early Periodic Screening Diagnosis and Treatment (EPSDT) Program, TENNderCARE, aggressively reaches out to enrollees and informs them of the availability of services provided by the MCOs that contract with TennCare. To strengthen outreach efforts, TennCare has contracted with the Tennessee Department of Health to provide a comprehensive program to all 95 Tennessee counties. The program is designed to inform families of the benefits of preventive health services, encourage families to utilize TENNderCARE services and to assist families with the scheduling of appointments. The TENNderCARE outreach program has two core elements: (1) a child enrollee call center and (2) a community-based outreach program. Also, TennCare provides marketing materials to state agencies, public schools, and mental health centers.

### ***Statewide MCO Collaborative***

In addition, MCOs and staff from TennCare and the Department of Health participate in an Adolescent Well Care Collaborative. Conference calls are held by the group to identify innovative methods of

providing outreach to teens. The group has developed a newsletter that is mailed quarterly to enrollees between the ages of 15-20 with topics of special interest to this age group.

### ***Emergency Room Diversion Grants***

On April 15, 2008 Tennessee received \$4,472,240 in Medicaid Emergency Room Diversion Grants for three projects for a two-year period. This initiative is in place in all three Grand Regions of the state: the Volunteer State Health Plan (VSHP) Partnership, the Haywood County Clinic, and the Nashville Medical Home Connection. The intent is to develop alternative service delivery systems to prevent the use of hospital emergency departments for primary and non-urgent care.

### ***Pay-for-Performance Quality Incentive Payment***

TennCare offered the first pay-for-performance quality incentive payments to the MCOs in 2006 and has continued to offer quality incentive payments annually since then. In 2010, TennCare will offer quality incentive payments for six physical health HEDIS measures to the MCOs in the East, Middle, and West regions and to TennCare Select. In addition, TennCare will offer quality incentive payments for three behavioral health HEDIS measures to the MCOs in the East, Middle, and West regions. MCOs are eligible for incentive payment if they demonstrate significant improvement from baseline for the specified measures. Significant improvement is determined by using NCQA's minimum effect size change methodology. TennCare plans to continue the pay-for-performance quality incentive payment program in 2011 and beyond.

### ***Disease Management Programs***

In 2007, TennCare increased the number of DM programs that the MCOs in the Middle Grand Region were required to offer. The required DM programs include maternity management, congestive heart failure, asthma, diabetes, coronary artery disease, chronic obstructive pulmonary disease, bipolar disorder, major depression, schizophrenia, and obesity. These requirements have now been extended to the MCOs in the East and West Grand Regions and to TennCare Select so that currently all MCOs are required to have the specified ten DM programs.

TennCare requires the MCOs to emphasize the prevention of exacerbation and complications in their DM programs. The purpose of the DM programs is to educate members to increase their understanding of their condition(s) and the factors that impact their health status, and to empower members to be more effective in self-care and management of their health.

### ***TennCare Health Plan Meetings***

TennCare's External Quality Review Organization, QSource, conducts quarterly meetings that are attended by TennCare and its MCCs. Each meeting is organized around a specific quality improvement (QI) topic and features keynote presentations, panel discussion and breakout sessions. QSource arranges for continuing education opportunities to be offered for at least one quarterly meeting per year.

## Interventions under development

### *Integration of Long-term Care Services with Medical and Behavioral Healthcare*

In July 2009, CMS approved an amendment to the TennCare waiver that will allow MCOs to coordinate all of the care a TennCare member needs, which will now include medical, behavioral and long-term care. Implementation of the Long-Term Care Community Choices Act of 2008 (CHOICES) for the Middle Grand Region MCOs is planned for March 2010 with the East and West Grand Region MCOs to follow in 6-12 months.

The “whole-person” care coordination approach will include:

- Implementation of active transition and diversion programs for people who can be safely and effectively cared for at home or in another community setting outside the nursing home
- Installation of an electronic visit verification system to monitor home care quality.

Other components of CHOICES include:

- Consumer Choice and Options
  - Creation of consumer-directed care options, including the ability to hire non-traditional providers like family members, friends and neighbors with accountability for taxpayer funds
  - Broadening of residential care choices in the community beyond nursing facilities with new options such as companion care, family care homes and improved access to assisted care living facilities
- Simplified Process for Accessing Services
  - Streamlining the member’s eligibility process for faster service delivery and the enrollment process for new providers
  - Maintaining a single point of entry for people who are not on TennCare today and need access to long-term care services through Medicaid or other available programs
  - Use of existing Medicaid funds to serve more people in cost-effective home and community settings

## IV. Strategy Effectiveness

### Planned evaluations

TennCare plans to reevaluate the Quality Strategy objectives annually by December 31. For more detailed information, see the [TennCare Quality Strategy Review and Revision Timeline](#) on page 55. The table below summarizes TennCare's 2009 evaluation of the strategy objectives.

Quality Strategy Objectives				
Goals	Objectives	2009 HEDIS/CAHPS Result	Percentage Point Difference Between 2009 HEDIS/CAHPS Statewide Rate and 2008 National Average	Change from Statewide Rate 2008 to Statewide Rate 2009
1. Assure appropriate access to care for enrollees.	1.1 By 2013, the statewide weighted HEDIS rate for adults' access to preventive/ambulatory health services will increase to 75% for enrollees 20-44 years old and the rate for enrollees 45-64 years old will be maintained at 79% or above.	20-44 years old-74.35% 45-64 years old-79.13%	20-44 years old and 45-64 years old-within 5 percentage points	20-44 years old and 45-64 years old-Increase
	1.2 By 2013, the statewide weighted HEDIS rate for children and adolescents' access to primary care practitioners will increase to 90% for enrollees 7-11 years old and 86% for enrollees 12-19 years old.	7-11 years old-86.13% 12-19 years old-80.95%	7-11 years old-above 12-19 years old-within 5 percentage points	7-11 years old and 12-19 years old- Decrease
	1.3 By 2013, 97% of TennCare heads of household and 98% or greater of TennCare children will go to a doctor or clinic when they	Heads of household-95% Children-100%	NA-Not a HEDIS/CAHPS measure	Heads of household and children-increase

<b>Quality Strategy Objectives</b>				
<b>Goals</b>	<b>Objectives</b>	<b>2009 HEDIS/CAHPS Result</b>	<b>Percentage Point Difference Between 2009 HEDIS/CAHPS Statewide Rate and 2008 National Average</b>	<b>Change from Statewide Rate 2008 to Statewide Rate 2009</b>
	are first seeking care rather than a hospital (emergency room).			
2. Provide quality care to enrollees.	2.1 By 2013, the statewide weighted HEDIS rate for adolescent well-care visits will increase to 41%.	35.77%	>5 percentage points below	Decrease
	2.2 By 2013, the statewide weighted HEDIS rate for timeliness of prenatal care will be maintained at 82% or above.	83.79%	Above 2008 national average	Increase
	2.3 By 2013, the statewide weighted HEDIS rate for breast cancer screening will increase to 50%.	41.97%	>5 percentage points below	Increase
	2.4 By 2013, the statewide weighted HEDIS rate for cervical cancer screening will increase to 68%.	59.04%	>5 percentage points below	Slight decrease
	2.5 By 2013, providers of EPSDT screening services will document the delivery of 95% of the required seven components of an EPSDT screen.	91.8%	NA-Not a HEDIS/CAHPS measure	Increase

<b>Quality Strategy Objectives</b>				
<b>Goals</b>	<b>Objectives</b>	<b>2009 HEDIS/CAHPS Result</b>	<b>Percentage Point Difference Between 2009 HEDIS/CAHPS Statewide Rate and 2008 National Average</b>	<b>Change from Statewide Rate 2008 to Statewide Rate 2009</b>
3. Assure enrollees' satisfaction with services.	3.1 By 2013, 95% of TennCare enrollees will be satisfied with TennCare.	92%	NA-Not a HEDIS/CAHPS measure	Increase
	3.2 By 2013, the statewide average for adult CAHPS getting needed care-always or usually will increase to 82%.	80.10%	Above 2008 national average	Increase
	3.3 By 2013, the statewide average for child CAHPS getting care quickly-always or usually will increase to 81%.	90.53%	NA-No benchmarking data available since few states reported data using the 4.0H version in 2008.	NA-Results for 2009 not trendable with results for previous years since new version of CAHPS (4.0H) used for children in 2009.
4. Improve health care for program enrollees.	4.1 By 2013, the statewide weighted HEDIS rate for HbA1c testing will be maintained at 73% or above.	76.10%	Within 5 percentage points	Increase
	4.2 By 2013, the statewide weighted HEDIS rate for controlling high blood pressure will increase to 55%.	52.79%	Within 5 percentage points	Increase

<b>Quality Strategy Objectives</b>				
<b>Goals</b>	<b>Objectives</b>	<b>2009 HEDIS/CAHPS Result</b>	<b>Percentage Point Difference Between 2009 HEDIS/CAHPS Statewide Rate and 2008 National Average</b>	<b>Change from Statewide Rate 2008 to Statewide Rate 2009</b>
	4.3 By 2013, the statewide weighted HEDIS rate for follow-up after hospitalization for mental illness will be maintained at 51% for follow-up within 7 days of discharge and 72% for follow-up within 30 days of discharge.	7 day-51.72% 30 day-72.48%	7 day and 30 day-Above 2008 national average	NA-Services not integrated HEDIS 2008
	4.4 By the end of each demonstration year, the state will achieve a total statewide EPSDT screening rate of at least 80%.	NA	NA	NA
	4.5 By 2013, the statewide weighted HEDIS rate for antidepressant medication management will be maintained at 63% for acute phase and 48% for continuation phase.	Acute-63.06% Continuation-48.16%	Acute and continuation-Above 2008 national average	NA-Services not integrated HEDIS 2008
	4.6 By 2013, the statewide weighted HEDIS rate for follow-up care for children prescribed ADHD medication will be maintained at 36% for initiation	Initiation-36.40% Continuation-46.34%	Initiation and continuation-Above 2008 national average	NA-Services not integrated HEDIS 2008

Quality Strategy Objectives				
Goals	Objectives	2009 HEDIS/CAHPS Result	Percentage Point Difference Between 2009 HEDIS/CAHPS Statewide Rate and 2008 National Average	Change from Statewide Rate 2008 to Statewide Rate 2009
	and 46% for continuation and maintenance.			

With HEDIS 2010, TennCare expects to set new baselines for all statewide weighted HEDIS/CAHPS results. With the changes in MCOs and contracts that TennCare has experienced in the last several years, HEDIS 2010 will be the first opportunity since 2006 for MCO HEDIS results from MCOs operating in all regions of the state to be included in the calculation of the statewide weighted rates for medical measures. In addition, HEDIS 2010 will be the very first opportunity for MCO HEDIS results from MCOs operating in all regions of the state to be included in the calculation of statewide weighted rates for behavioral health measures. The new baselines will allow TennCare to reevaluate the current Quality Strategy Objectives. Following this evaluation, TennCare will either continue with the current objectives or will choose new objectives. If TennCare chooses to continue with the current objectives, new targets may be set, if appropriate.

### Reporting requirements for MCOs to State

#### Data Source

##### MCO

The majority of the Quality Strategy objectives require statewide weighted HEDIS rates or statewide CAHPS averages based on MCO HEDIS/CAHPS results. These MCO HEDIS/CAHPS results are submitted to TennCare annually by the MCOs in mid-June. From the individual MCO results, the EQRO calculates the statewide weighted HEDIS rates and the statewide CAHPS averages in the annual HEDIS/CAHPS Report: A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs). This report is typically available in October.

##### TennCare

One of the strategy objectives is a statewide average based on MCO results obtained from the annual EPSDT Medical Record Review conducted by TennCare Quality Oversight. The review determines the extent to which medical providers are in compliance regarding the documentation of the delivery of the

seven components of the EPSDT exam. The medical record review is conducted annually in March or April. The completed report is typically available in May or June.

One of the strategy objectives is based on the TENNderCare screening ratio. This ratio is calculated by utilizing MCO encounter data submissions in accordance with specifications for the CMS-416 report. TennCare determines the statewide TENNderCare screening ratio annually in April.

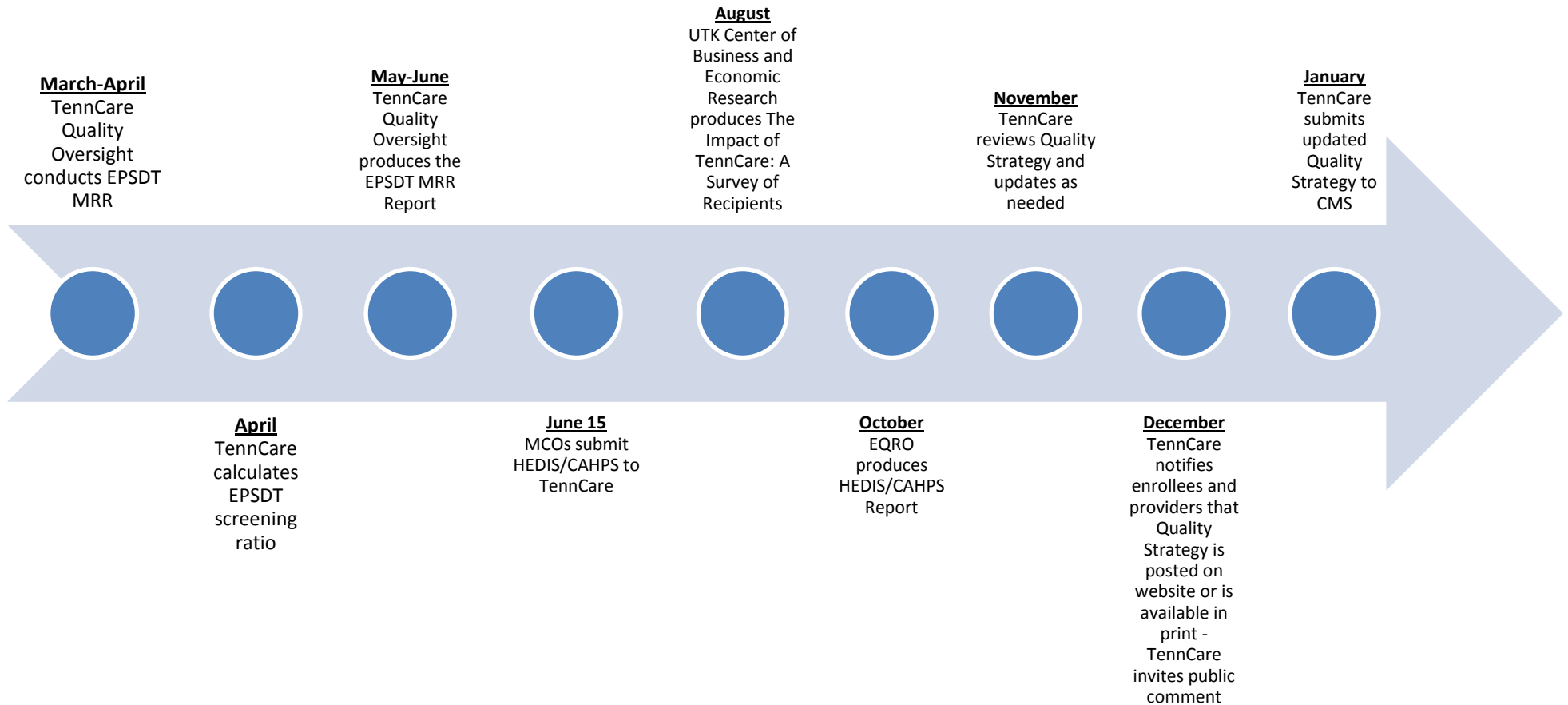
#### University of Tennessee Knoxville-Center for Business and Economic Research

Two of the strategy objectives rely on information obtained from an annual survey conducted by the Center for Business and Economic Research at the University of Tennessee Knoxville. TennCare contracts with the Center to conduct a survey of 5,000 Tennesseans to gather information on their perceptions of their health care. The design for the survey is a “household sample,” and the interview is conducted with the head of the household. The report, *The Impact of TennCare: A Survey of Recipients* allows comparison between responses from all households and households receiving TennCare. The completed report is typically available in August.

#### **Planned frequency of reporting Quality Strategy updates to CMS**

Annually, in November, TennCare plans to review the Quality Strategy and provide an update to CMS by January 31 of each year. For more detailed information, see the [TennCare Quality Strategy Review and Revision Timeline](#) on page 55.

## TennCare Quality Strategy Review and Revision Timeline



## V. Conclusions

### Successes considered best practices

The following MCO promising practices have been identified for 2009:

#### Performance Measure Validation

- a strong commitment to and knowledge of the HEDIS reporting process.
- robust internal quality control practices to ensure overall, procedural, financial and payment accuracy of data for performance measure reporting
- a commitment to ensuring medical data completeness via processes/procedures, trend assessments and reports, provider education efforts and incentives

#### Performance Improvement Projects

- strong data collection, analysis, study topics and quality outcomes
- efforts to focus on clinical topics relative to each MCO's enrollee population
- effective performance improvement activities and interventions that enhanced healthcare quality and outcomes

#### Annual Network Adequacy and Benefit Delivery Review

- a commitment to ensuring accessible provider networks – the majority of MCCs meet or exceed network requirements – when specific network deficiencies existed, MCCs made arrangements to ensure the provision of services
- attempts to accurately notify members and providers of existing or changes to benefits via newsletters, websites, etc.
- the necessary processes to ensure qualified providers

#### Annual Quality Survey

- strength in the area of medical necessity via barrier analysis, inter-rater reliability testing and a commitment to performing above the required consistency standards
- strength in helping members with prenatal appointment assistance via thorough outreach communication
- strength in tracking systems, particularly regarding the screening, diagnosis, and treatment of young enrollees, as well as the comprehensive collection of eligibility and contact information
- a commitment to cultural competency and sensitivity via interpretation and translation services for those with Limited English Proficiency (LEP) and with special needs

#### EPSDT Medical Record Review

An Annual Early Periodic Screening Diagnosis and Treatment (EPSDT) Medical Record Review (MRR) is conducted in order to confirm the documentation of comprehensive EPSDT screens. The overall statewide weighted average for provider compliance with the seven (7) required components of an EPSDT screen (well child check-up) for the data year 2008 was 91.8 percent. This represents a 1.0 percentage increase from the 90.8 percent compliance rate for overall documentation reported for 2007. The Adjusted Periodic Screening

Percentage (APSP), based on the 2008 416 screening rate of 94.5 percent, was 86.3 percent. This represents a 3.9 percentage point increase from the APSP of 82.4 percent recorded for 2007.

### HEDIS/CAHPS 2009

Most child health measures demonstrated improved performance, many of which exceeded the HEDIS 2008 Medicaid National Average. Specifically, there was an increase in statewide weighted rates from HEDIS 2008 to 2009 for: Childhood Immunization Status (all antigens with the exception of hepatitis B), Appropriate Testing for Children with Pharyngitis, Appropriate Treatment of Children with Upper Respiratory Infection, Well-Child Visits in the First 15 Months of Life, and Children and Adolescents' Access to Primary Care Practitioners (ages 12-24 months and 25 months-6 years).

In the area of women's preventive care, the statewide weighted rate for Breast Cancer Screening increased.

Chronic disease management continues to improve across the state. All numerators of the Comprehensive Diabetes Care that could be compared with HEDIS 2008 statewide weighted rates demonstrated improvement. Additionally, all numerators of the statewide weighted rate of Use of Appropriate Medications for People with Asthma demonstrated improvement and all of the asthma numerators were higher than the HEDIS 2008 Medicaid National Average.

Several measures in the access/availability of care domain also demonstrated improvement. Specifically, there was an increase in statewide weighted rates from HEDIS 2008 to 2009 for: Adults' Access to Preventive/Ambulatory Health Services and Prenatal and Postpartum Care.

HEDIS 2009 is the first year for reporting of behavioral health measures by TennCare MCOs. These measures were reported by the Middle Grand Region MCOs following the integration of medical-behavioral health services. For the measures, Antidepressant Medication Management, Follow-Up Care for Children prescribed ADHD Medication, Follow-Up After Hospitalization for Mental Illness, and Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, the statewide weighted rate was greater than the HEDIS 2008 Medicaid National Average.

### **Ongoing challenges for the State in improving the quality of care for Medicaid beneficiaries**

**The following MCO opportunities have been identified for 2009:**

#### Performance Measure Validation

Better vendor oversight and further developed/improved quality practices should help MCOs reach even higher levels of data integrity.

#### Performance Improvement Projects

Overall, MCOs were successful in establishing the appropriate framework for conducting a PIP and reliably used sound study methodologies. MCOs should improve the documentation related to all PIP materials including: study narratives, data collection tools and instructions, analysis algorithms, and numerator and denominator specifications for study indicators. PIP documentation should be comprehensive including all aspects of the study. These opportunities were identified across health plans.

The areas of sufficient data analysis and demonstration of sustained improvement appear to be the most challenging.

#### Annual Network Adequacy and Benefit Delivery Review

The middle and West Grand Region MCOs faced challenges in adequately maintaining behavioral-health-related networks. Examples include complete and partial inpatient, residential and outpatient day treatment care; and crisis respite services for children and adults. The new West MCOs will need to improve enrollee access to specialists in neurology, neurosurgery and urology.

Further improvement is necessary to address omissions and errors in Member Handbooks and health plan policies.

#### Annual Quality Survey

While tracking systems were strong, provider outreach and education should continue to ensure accurate, up-to-date data are maintained in the tracking systems and in medical records for Early Periodic Screening Diagnosis and Treatment (EPSDT) screenings.

MCOs should increase efforts to ensure providers receive written information and instructions on all DM programs. Additionally, MCOs should notify providers which of their patients have been enrolled in/terminated from DM programs and should develop the appropriate procedures to inform enrollees of their right to opt-out of the program(s) when automatically enrolled.

Member Handbooks, web-based provider directories and other enrollee communication should contain all required elements.

#### HEDIS/CAHPS 2009

The statewide weighted rates for Children and Adolescents' Access to Primary Care Practitioners (7-11 years and 12-19 years) declined slightly. The statewide weighted rates of Well-Child Visits in the Third, Fourth, Fifth and Sixth years of Life and Adolescent Well-Care Visits also declined.

Preventive care, as measured by HEDIS 2009 rates for women's health screenings, presents additional opportunities for improvement. Although there were improvements in the statewide weighted rate for Breast Cancer Screening, the statewide weighted rate for Cervical Cancer Screening declined slightly.

## Recommendations by the State for ongoing Medicaid quality improvement activities in the State

In July 2009, CMS approved an amendment to the TennCare waiver that will allow MCOs to coordinate all of the care a TennCare member needs, which will now include medical, behavioral and long-term care. Implementation of CHOICES for the Middle Grand Region MCOs is planned for March 2010 with the East and West Grand Region MCOs to follow in 6-12 months. TennCare will be requiring the MCOs to participate in a CHOICES Special Study focusing on the topic of rebalancing the long-term care system. The MCOs have participated in an initial discussion in which the definitions of the study question and the study indicators were established and the sources for data collection were identified. *CMS Protocols for Conducting Performance Improvement Projects* will be used as a resource. Another resource will be the Money Follows the Person (MFP) Demonstration Grant.

TennCare is considering implementation of the following recommendations from the EQRO 2009 *Technical Report*:

- Quality-
  - Consider rotating Performance Improvement Project (PIP) study topics for validation to ensure Managed Care Contractors (MCC) are universally applying sound methodologies to all PIPs.
  - For the Benefit Delivery component of the Annual Network Adequacy (ANA) review, consider operationally defining complaints to ensure this measure can reliably be compared across all MCCs.
- Timeliness-
  - Continue to review and evaluate MCC compliance using Performance Activity indicators for the Annual Quality Survey (AQS), and continue to emphasize provider educational outreach related to documentation.
- Access-
  - As the integration of physical and mental health services occur, continue to monitor coordination of services between providers of care.
- All Dimensions of Care and Service-
  - Consider additional statewide collaborative for performance measures that do not demonstrate improvement or continue to fall below national benchmarks.
  - Consider conducting additional EQRO optional activities. QSource would recommend the performance of a quality study related to TennCare Quality Strategy objective.
  - Continue linking performance measure (PMV, PIP, ANA, and AQS) outcomes and improvements with the state Quality Strategy by aligning state goals and objectives with EQRO oversight activities.
  - Present MCO-specific promising practices to all MCCs to promote exemplary performance and quality healthcare delivery among all TennCare health plans.

## Appendix A: State Requirements Deemed Met by NCQA Accreditation Survey

### Access to Care

Federal Requirements	State Standards	2009 NCQA Accreditation Standards
<b>42 CFR 438.206</b> <b>Availability of Services</b>	<i>CRA § 2.11.1.5.1-4 (E/W, Middle and TCS)</i>	
	<b>[AQS Criteria] 2 Affirmative statement</b>	<b>QI 3B Affirmative Statement</b>
	All MCO contracts with practitioners and providers include an affirmative statement indicating that they may freely communicate with members about their treatment, regardless of benefit coverage limitations.	Contracts with practitioners include an affirmative statement indicating that practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.
	<i>CRA § 2.12.7.16, .18 and .42 (E/W and TCS); CRA § 2.12.9.18, .20 and .50 (Middle)</i>	
	<b>[AQS Criteria] Network: Contracting, Availability, Access and Documentation - 1 Contract inclusions</b>	<b>QI 3A Practitioner Contracts and QI 3C Provider Contracts</b>
The MCO's contracts with all practitioners (individual professionals) and providers (institutions and organizations) specify that: <ul style="list-style-type: none"> <li>● they participate in and cooperate with any internal and external quality management/quality improvement (QM/QI), utilization review, peer review and appeal procedures established by the contractor and/or TennCare;</li> <li>● the MCO has access to practitioner/provider medical records, to the extent permitted by state and federal law. Records are made available to the MCO and furnished immediately upon request for fiscal audit, medical audit, medical review, utilization review, Healthcare Effectiveness Data and Information Set (HEDIS), National Committee for Quality Assurance (NCQA), External Quality Review Organization (EQRO), Early and Periodic Screening, Diagnosis and Treatment (EPSDT), and other periodic monitoring</li> </ul>	<b>QI 3A Practitioner Contracts</b> Contracts with practitioners specifically require that: <ol style="list-style-type: none"> <li>1. Practitioners cooperate with QI activities</li> <li>2. The organization has access to practitioner medical records, to the extent permitted by state and federal law</li> <li>3. Practitioners maintain the confidentiality of member information and records</li> </ol> <b>QI 3C Provider Contracts</b> Contracts with organization providers specifically require that: <ol style="list-style-type: none"> <li>1. Providers cooperate with QI activities</li> <li>2. The organization has access to provider medical records, to the extent permitted by state and federal law</li> <li>3. Providers maintain the confidentiality of member information and records</li> </ol>	

Federal Requirements	State Standards	2009 NCQA Accreditation Standards
	<p>upon request of authorized representative of the MCO or TennCare and authorized federal, state and comptroller personnel; and</p> <ul style="list-style-type: none"> <li>● they are required to safeguard information about members according to applicable state and federal laws and regulations (and as described in § 2.27 and 4.33 of the CRA).</li> </ul>	
	<p><i>CRA § 2.18.1.1 and .4, and 2.18.4.3 and .4 (E/W, Middle and TCS)</i></p>	
	<p><b>[AQS Criteria] Network: Contracting, Availability, Access and Documentation - UM Communications - 1 Member and provider communications</b></p>	<p><b>UM 3A Access to Staff</b></p>
	<p>The MCO provides the following communication services for its practitioners and members:</p> <ol style="list-style-type: none"> <li>a member service line (member services hotline) staffed adequately to respond to members' questions during normal business hours (at least 8AM - 5PM), five days a week;</li> <li>a provider service line staffed adequately to respond to providers' questions during normal business hours (at least 8AM - 5PM), including appropriate and timely responses regarding prior authorization requests;</li> <li>ability of staff to receive inbound communication after normal business hours regarding UM issues (live person, fax, e-mail, voicemail, etc);</li> <li>outbound communication from staff regarding inquiries about UM during normal business hours, unless otherwise agreed upon;</li> <li>provisions for a toll-free number or acceptance of collect calls regarding UM issues;</li> <li>access to staff for callers with questions about the UM process; and</li> <li>staff are identified by name, title and MCO name</li> </ol>	<p>The organization provides the following communication services for members and practitioners.</p> <ol style="list-style-type: none"> <li>1. Staff are available at least eight hours a day during normal business hours for inbound calls regarding UM issues</li> <li>2. Staff can receive inbound communication regarding UM issues after normal business hours</li> <li>3. Staff can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon</li> <li>4. Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues</li> <li>5. Staff or a toll-free number are available to accept collect calls regarding UM issues</li> <li>6. Staff are accessible to callers who have questions about the UM process</li> </ol>

Federal Requirements	State Standards	2009 NCQA Accreditation Standards
	when initiating or returning calls regarding UM issues.	
	<i>CRA § 2.18.3 (E/W, Middle and TCS)</i>	<b>QI 4A Cultural Needs and Preferences and RR 4B Interpreter Services</b>
	As required by 42 CFR 438.206, the CONTRACTOR shall participate in the State’s efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency and diverse cultural and ethnic backgrounds.	<b>QI 4A Cultural Needs</b> The organization assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary. <b>RR 4B Interpreter Services</b> The organization provides interpreter or bilingual services within its Member Services Department and telephone function based on the linguistic needs of its members.
<b>42 CFR 438.208 Coordination and Continuity of Care</b>	<i>CRA § 2.9.3.1 (E/W and TCS); Middle CRA § 2.9.4.1.1-.2</i>	
	<b>[AQS Criteria] QI Activities - 21 Continuation of access following provider termination</b>	<b>QI 10C Continued Access to Practitioners</b>
	In the event that a practitioner’s contract is discontinued, the MCO allows affected members continued access to his/her practitioner, as follows: <ul style="list-style-type: none"> <li>• continuation of treatment through the lesser of the current period of active treatment, or for up to 90 calendar days for members undergoing active treatment for a chronic or acute medical condition; and</li> <li>• continued access to the practitioner through the postpartum period for members in their second or third trimester of pregnancy.</li> </ul>	If the practitioner’s contract is discontinued, the organization allows affected members continued access to the practitioner, as follows. 1. Continuation of treatment through the lesser of the current period of active treatment, or for up to 90 calendar days for members undergoing active treatment for a chronic or acute medical condition 2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy
	<i>CRA § 2.9.3.1 (E/W and TCS); CRA § 2.9.4.1 (Middle)</i>	
	<b>[AQS Criteria] Clinical Criteria for UM Decisions - 4</b>	<b>QI 10D Transition to Other Care</b>

Federal Requirements	State Standards	2009 NCQA Accreditation Standards
	<p><b>Transition to other care</b></p> <p>The MCO has policies and procedures and shows evidence it assists with either an member’s transition to other care, if necessary, when benefits end or to another provider when the current provider has terminated participation with the MCO.</p> <p>QSource Recommendation: Remove wording relating to the ending of benefits as this is covered by NCQA.</p>	<p>The organization assists with a member’s transition to other care, if necessary, when benefits end.</p>
<p><b>42 CFR 438.210 Coverage and Authorization of Services</b></p>	<p><i>CRA § 2.7.1.2-.3 (E/W and Middle); CRA § 2.9.8.7 (closest TCS reference)</i></p>	
	<p><b>[AQS Criteria] Clinical Criteria for UM Decisions - 5 Coverage of emergency services</b></p>	<p><b>UM 12A Policies and Procedures and UM 12C Organization’s Authorized Representative</b></p>
	<p>The MCO has emergency services policies and procedures that state prior authorization is not required for emergency services to screen and stabilize a member (as identified when a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed).</p>	<p><b>UM 12A Policies and Procedures</b> The organization’s emergency services policies and procedures require coverage of emergency services in the following situations.</p> <ol style="list-style-type: none"> <li>1. To screen and stabilize the member without prior approval, where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed</li> <li>2. If an authorized representative, acting for the organization, authorized the provision of emergency services</li> </ol> <p><b>UM 12C Organization’s Authorized Representative</b> The organization covers emergency services approved by an authorized representative.</p>
	<p><i>CRA § 2.8.4 (E/W, Middle and TCS)</i></p>	
	<p><b>[AQS Criteria] QI Activities - 2 DM program content</b></p> <p>For each condition, the MCO’s DM programs contain sections addressing:</p> <ul style="list-style-type: none"> <li>● monitoring of condition;</li> </ul>	<p><b>QI 8B Program Content</b></p> <p>The content of the organization’s programs addresses the following for each condition.</p> <ol style="list-style-type: none"> <li>1. Condition monitoring</li> </ol>

Federal Requirements	State Standards	2009 NCQA Accreditation Standards
	<ul style="list-style-type: none"> <li>• member compliance with the program’s treatment plans;</li> <li>• consideration of other health conditions; and</li> <li>• lifestyle issues as indicated by practice guidelines (e.g., goal-setting techniques, problem solving).</li> </ul>	<ol style="list-style-type: none"> <li>2. Patient adherence to the program’s treatment plans</li> <li>3. Consideration of other health conditions</li> <li>4. Lifestyle issues, as indicated by practice guidelines (e.g., goal-setting techniques, problem solving)</li> </ol>
	CRA § 2.8.2.1--2 (E/W, Middle and TCS)	
	<p><b>[AQS Criteria] QI Activities - 3 Identification of eligible participants</b></p> <p>Annually, the MCO systematically identifies members who qualify for its DM or case management (CM) programs utilizing the following data sources/methods:</p> <ul style="list-style-type: none"> <li>• Members who have reached the service threshold for inpatient hospital services</li> <li>• <b>Opt-out methodology (DM services will be provided to eligible members unless they specifically ask to be excluded)</b></li> <li>• Claims/Encounter data</li> <li>• Pharmacy data, if applicable</li> <li>• Health risk appraisals</li> <li>• Laboratory results, if applicable</li> <li>• UM or CM data, if applicable</li> <li>• Member and practitioner referral</li> </ul>	<p><b>QI 8C Identifying Members for DM Programs and QI 8D Frequency of Member Identification</b></p> <p><b>QI 8C Identifying Members for DM Programs</b> The organization uses the following sources to identify members who qualify for DM programs.</p> <ol style="list-style-type: none"> <li>1. Claim or encounter data</li> <li>2. Pharmacy data, if applicable</li> <li>3. Health risk appraisal results</li> <li>4. Laboratory results, if applicable</li> <li>5. Data collected through the case management or UM process, if applicable</li> <li>6. Member and practitioner referrals</li> </ol> <p><b>QI 8D Frequency of Member Identification</b> The organization systematically identifies members who qualify for each of its DM programs. (Scored at 100% if done monthly; at 80% if done quarterly; 20% if done every 6 months and 0% if less frequently.)</p>
	QSource Recommendation: Remove all except bullet #2: Opt-out methodology, as it is not part of NCQA.	
	CRA §2.8.2.2 and 2.17.4.5.4	
	<b>[AQS Criteria] QI Activities - 4 Sharing DM program information</b>	<b>QI 8E Providing Members with Information</b>
	The MCO provides eligible members with written	The organization provides eligible members with the following

Federal Requirements	State Standards	2009 NCQA Accreditation Standards
	program information about: <ul style="list-style-type: none"> <li>● using DM services</li> <li>● eligibility</li> <li>● electing/declining participation in DM programs</li> </ul>	written information about the program. <ol style="list-style-type: none"> <li>1. How to use the services</li> <li>2. How members become eligible to participate</li> <li>3. How to opt in or opt out</li> </ol>
	<i>CRA § 2.8.3 (E/W, Middle and TCS)</i>	
	<b>[AQS Criteria] QI Activities - 5 DM program interventions</b>	<b>QI 8F Interventions Based on Stratification</b>
	The MCO provides interventions to its members based on stratification and tailors the program content, education activities, and benchmarks and goals for each risk level.	The organization provides interventions to members based on stratification.
	QSource Recommendation: Remove "provides interventions to its members based on stratification," as this is covered by NCQA.	
	<i>CRA § 2.8.7.2.5</i>	
	<b>[AQS Criteria] QI Activities - 6 DM program participation</b>	<b>QI 8G Eligible Member Participation</b>
	No less than annually, the MCO measures member participation rates.	The organization annually measures member participation rates.
	<i>CRA § 2.8.6 (E/W, Middle and TCS)</i>	
	<b>[AQS Criteria] QI Activities - 8 Informing and educating practitioners</b>	<b>QI 8H Informing and Educating Practitioners</b>
	The MCO provides practitioners with written information on DM programs, which includes: <ul style="list-style-type: none"> <li>● instructions on how to use services;</li> <li>● how the MCO works with a practitioner’s members in the DM program; and</li> <li>● <b>a list for each PCP of his/her members in each DM program, upon the member's initial enrollment and</b></li> </ul>	The organization provides practitioners with written information about the program that includes the following. <ol style="list-style-type: none"> <li>1. Instructions on how to use disease management services</li> <li>2. How it works with a practitioner’s patients in the program</li> </ol>

Federal Requirements	State Standards	2009 NCQA Accreditation Standards
	<p><b>at least annually thereafter.</b></p>	
	<p>QSource Recommendation: Remove first two bulleted items as they are covered by NCQA.</p>	
	<p><i>CRA § 2.8.7.1 (E/W, Middle and TCS)</i></p>	
	<p><b>[AQS Criteria] QI Activities - 19 DM satisfaction</b></p>	<p><b>QI 8J Satisfaction With Disease Management</b></p>
	<p>Member satisfaction with DM services is evaluated annually by:</p> <ul style="list-style-type: none"> <li>● obtaining feedback from the DM population through DM-specific satisfaction surveys;</li> <li>● analyzing feedback regarding DM services; and</li> <li>● analyzing complaints and inquiries related to DM services.</li> </ul>	<p>The organization annually evaluates satisfaction with its disease management services by:</p> <ol style="list-style-type: none"> <li>1. Obtaining member feedback</li> <li>2. Analyzing member complaints and inquiries</li> </ol>
	<p><i>CRA § 2.14.1.1 (E/W, Middle and TCS)</i></p>	
	<p><b>[AQS Criteria] UM Structure - 1 Written program description</b></p>	<p><b>UM 1A Written Program Description</b></p>
	<p>The MCO's written UM program description includes the following:</p> <ul style="list-style-type: none"> <li>● program structure including behavioral health aspects of the program;</li> <li>● involvement of a designated senior physician and designated behavioral healthcare practitioner in UM program implementation; and</li> <li>● the scope of the program and the processes and information sources used to make determinations of benefit coverage and medical necessity.</li> </ul>	<p>The organization's UM program description includes the following.</p> <ol style="list-style-type: none"> <li>1. A written description of the program structure</li> <li>2. Behavioral healthcare aspects of the program</li> <li>3. A designated senior physician is involved in UM program implementation</li> <li>4. A designated behavioral healthcare practitioner is involved in the implementation of the behavioral healthcare aspects of the UM program</li> <li>5. The program scope and process used to determine benefit coverage and medical necessity</li> <li>6. Information sources used to determine benefit coverage and medical necessity</li> </ol>

Federal Requirements	State Standards	2009 NCQA Accreditation Standards
	<i>CRA § 2.14.1.1 (E/W, Middle and TCS)</i>	
	<b>[AQS Criteria] UM Structure - 2 UM program evaluation</b>	<b>UM 1D Annual Evaluation</b>
	The MCO annually evaluates and updates the UM program as necessary.	The organization annually evaluates and updates the UM program as necessary.
	<i>CRA § 2.14.1.1 (E/W, Middle and TCS)</i>	
	<b>[AQS Criteria] UM Structure - 3 Program oversight</b>	<b>UM 1B Physician Involvement and UM 1B Physician Involvement</b>
	A designated senior physician (medical director, associate medical director or equivalent) and a designated behavioral healthcare practitioner are actively involved in implementing the MCO's UM program.	<b>UM 1B Physician Involvement</b> A senior physician is actively involved in implementing the organization's UM program. <b>UM 1C Behavioral Health Involvement</b> A BHP is actively involved in implementing the behavioral health aspects of the UM program.
	<i>CRA § 2.14.1.2 and .7 (E/W, Middle and TCS)</i>	
	<b>[AQS Criteria] UM Structure - 4 UM incentives</b>	<b>UM 4F Affirmative Statement About Incentives</b>
	Compensation for the MCO's UM activities is structured such that financial incentives for UM decision-makers do not encourage decisions that result in under-utilization of medically necessary services. This information is included in UM-related materials given to all network providers.	The organization distributes a statement to all members and to all practitioners, providers and employees who make UM decisions, affirming the following. <ol style="list-style-type: none"> <li>1. UM decision making is based only on appropriateness of care and service and existence of coverage</li> <li>2. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care</li> <li>3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization</li> </ol>
	<i>CRA § 2.14.1.4 (E/W and TCS); § 2.14.1.6 (Middle)</i>	
	<b>[AQS Criteria] UM Structure - 5 UM personnel/supervision</b>	<b>UM 4A Licensed Health Professionals</b>
	The MCO has written procedures that: <ul style="list-style-type: none"> <li>● require appropriately licensed professionals to supervise all physical and behavioral health medical</li> </ul>	The organization has written procedures: <ol style="list-style-type: none"> <li>1. Requiring appropriately licensed professionals to supervise all medical necessity decisions</li> </ol>

Federal Requirements	State Standards	2009 NCQA Accreditation Standards
	necessity decisions; and <ul style="list-style-type: none"> <li>specify the type of personnel responsible for each level of utilization management.</li> </ul>	2. Specifying the type of personnel responsible for each level of UM decision-making
	<i>CRA § 2.14.1.4</i>	
	<b>[AQS Criteria] UM Structure - 6 UM staff job descriptions</b>	<b>UM 4B Use of Practitioners for UM Decisions, UM 4C Practitioner Review of Non-BH Denials, and UM 4D Practitioners Review of BH Denials</b>
	The MCO has a written job description, with qualifications for clinical staff who review denials of care based on medical necessity, that requires: <ul style="list-style-type: none"> <li>education, training or professional experience in medical or clinical practice; and</li> <li>a current unrestricted license to practice.</li> </ul>	<b>UM 4B Use of Practitioners for UM Decisions</b> The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: <ol style="list-style-type: none"> <li>Education, training or professional experience in medical or clinical practice</li> <li>A current license to practice without restriction</li> </ol> <b>UM 4C Practitioner Review of Non-BH Denials</b> The organization ensures that a physician, or other health care professional, as appropriate, reviews any non-behavioral health denial of care based on medical necessity. <b>UM 4D Practitioners Review of BH Denials</b> The organization ensures that a physician, appropriate behavioral health practitioner or pharmacist, as appropriate, reviews any behavioral health denial of care based on medical necessity.
	<i>CRA § 2.14.1.4 (E/W and TCS); CRA § 2.14.1.6 (Middle)</i>	
	<b>[AQS Criteria] UM Structure - 7 Consultants</b>	<b>UM 4E Use of Board-Certified Consultants</b>
	The MCO has written procedures for using board-certified consultants, and evidence that it uses these procedures to assist in making medical necessity determinations.	The organization has written procedures for using board-certified consultants and evidence that it uses these procedures to assist in making medical necessity determinations.

Federal Requirements	State Standards	2009 NCQA Accreditation Standards
	<p><i>CRA § 2.14.1.3.1-5 (E/W and TCS);</i>  <i>CRA § 2.14.1.4.1-5 (Middle)</i></p>	
	<p><b>[AQS Criteria] Clinical Criteria for UM Decisions - 1 UM criteria</b></p>	<p><b>UM 2A UM Criteria</b></p>
	<p>The MCO's UM program has criteria that:</p> <ul style="list-style-type: none"> <li>● are objective and based on medical and/or behavioral health evidence;</li> <li>● are applied criteria based on individual needs;</li> <li>● are based on an assessment of the local delivery system;</li> <li>● involve appropriate practitioners in developing, adopting and reviewing criteria; and</li> <li>● provide for annual review, update, and approval of the UM criteria and the procedures for applying them.</li> </ul>	<p>The organization:</p> <ol style="list-style-type: none"> <li>1. Has written UM decision-making criteria that are objective and based on medical evidence</li> <li>2. Has written policies for applying the criteria based on individual needs</li> <li>3. Has written policies for applying the criteria based on an assessment of the local delivery system</li> <li>4. Involves appropriate practitioners in developing, adopting and reviewing criteria</li> <li>5. Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate</li> </ol>
	<p><i>CRA § 2.14.2.1 (E/W, Middle and TCS)</i></p>	<p><b>UM 7A Notification of Reviewer Availability, UM 7B Discussing a Denial With a Reviewer, and UM 7E Discussing a BH Denial With a Reviewer</b></p>
	<p>...The policies and procedures shall provide for consultation with the requesting provider when appropriate...</p>	<p><b>UM 7A Notification of Reviewer Availability</b>  The organization notifies practitioners:</p> <ol style="list-style-type: none"> <li>1. The organization's policy for making an appropriate practitioner reviewer available to discuss any Um denial decision</li> <li>2. How to contact a reviewer.</li> </ol> <p><b>UM 7B Discussing a Denial With a Reviewer</b>  The organization provides practitioners with the opportunity to discuss any non-behavioral health UM denial decision with a physician or other appropriate reviewer.</p> <p><b>UM 7E Discussing a BH Denial With a Reviewer</b>  The organization provides practitioners with the opportunity to discuss any behavioral health UM denial decision with a physician, appropriate behavioral health or pharmacist reviewer.</p>

Federal Requirements	State Standards	2009 NCQA Accreditation Standards
	<i>CRA § 2.14.1.1 (E/W, Middle and TCS)</i>	
	<b>[AQS Criteria] Clinical Criteria for UM Decisions - 3 Written description</b>	<b>UM 6A Information for UM Decision Making</b>
	The MCO has a written description that identifies the information needed to support UM decision-making.	For at least 12 months, the organization has had in place a written description that identifies the information needed to support UM decision making.
	<i>CRA § 2.14.1.8 (E/W and TCS); CRA § 2.14.1.10 (Middle)</i>	
	<b>[AQS Criteria] Clinical Criteria for UM Decisions - 6 UM satisfaction</b>	<b>UM 11A Assessing Satisfaction With the UM Process</b>
The MCO's annual assessment of satisfaction with the UM process includes: <ul style="list-style-type: none"> <li>● collecting and analyzing data on member and practitioner satisfaction for the identification of improvement opportunities; and</li> <li>● taking action designed to improve member and practitioner satisfaction based on its assessment of member data.</li> </ul>	The organization's annual assessment of satisfaction with the UM process includes: <ol style="list-style-type: none"> <li>1. Collecting and analyzing data on member satisfaction for the identification of improvement opportunities</li> <li>2. Collecting and analyzing data on practitioner satisfaction for the identification of improvement opportunities</li> <li>3. Taking action designed to improve member satisfaction based on its assessment of member data</li> <li>4. Taking action designed to improve practitioner satisfaction based on its assessment of practitioner data</li> </ol>	

## Structure and Operations

Federal Requirements	State Standards	2009 NCQA Standards
<p><b>42 CFR 438.218</b> <b>Enrollee Information</b></p>	<p><i>CRA § 2.17.4.1 (E/W, Middle and TCS); CRA § 2.17.4.5.14 (E/W and TCS); CRA § 2.17.4.7.25 (Middle)</i></p>	
	<p><b>[AQS Criteria] Member Rights and Responsibilities - 1 Handbook</b></p>	<p><b>RR 1A Statement of Members' Rights and Responsibilities and RR 2A Distribution of Rights Statement to Members and Practitioners</b></p>
	<p>The MCO has a written policy explaining member rights and responsibilities, and these rights and responsibilities are included in the Member Handbook or as a separate statement.</p>	<p><b>RR 1A Statement of Members' Rights and Responsibilities</b> The organization has a written policy that states its commitment to treating members in a manner that respects their rights, and its expectations of members' responsibilities. <b>RR 2A Distribution of Rights Statement to Members and Practitioners</b> The organization distributes its member rights and responsibilities statement to members and participating practitioners.</p>
	<p><i>CRA § 2.17.4.5.14</i></p>	
	<p><b>[AQS Criteria] Member Rights and Responsibilities - 3 Member rights and responsibilities</b></p> <p>The MCO has a written policy for member rights and responsibilities that includes:</p> <ul style="list-style-type: none"> <li>a. a right to a candid discussion of appropriate or medically necessary treatment options or their conditions, regardless of cost or benefit coverage;</li> <li>b. a right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities;</li> <li>c. a right to voice complaints or appeals about the organization or the care it provides;</li> <li>d. the right to make recommendations regarding the MCO's rights and responsibilities policies;</li> <li>e. the responsibility to respond to requests for information (to the extent possible) that the MCO and</li> </ul>	<p><b>RR 1A Rights and Responsibilities Statement</b></p> <p>The organization's member rights and responsibilities statement specifies that members have:</p> <ul style="list-style-type: none"> <li>1. A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities</li> <li>2. A right to be treated with respect and recognition of their dignity and right to privacy</li> <li>3. A right to participate with practitioners in making decisions about their health care</li> <li>4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage</li> <li>5. A right to voice complaints or appeals about the organization or the care it provides</li> </ul>

Federal Requirements	State Standards	2009 NCQA Standards
	<p>its practitioners and providers need in order to provide care;</p> <p>f. a responsibility to follow the plan(s) and instructions that they agreed upon with their practitioner;</p> <p>g. a responsibility to understand their health condition, to the degree possible, and participate in the development of treatment goals;</p> <p>h. a right to privacy and to be treated with respect and dignity; and</p> <p>i. a right to participate with practitioners in healthcare decisions.</p>	<p>6. A right to make recommendations regarding the organization's member rights and responsibilities policy</p> <p>7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care</p> <p>8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners</p> <p>9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible</p>
<p><b>42 CFR 438.224 Confidentiality</b></p>	<p><i>CRA § 2.17.4.5.24</i></p>	
	<p><b>[AQS Criteria] Member Rights and Responsibilities - 11 Authorization of Protected Health Information (PHI) release</b></p>	<p><b>RR 6C Authorization</b></p>
	<p>The MCO has policies and procedures addressing a member's right to deny or authorize release of PHI for things other than treatment, payment or healthcare operations.</p>	<p>The organization has policies and procedures that address members' right to authorize or deny the release of PHI beyond uses for treatment, payment or health care operations.</p>
	<p><i>CRA § 2.27.2.8, .13, .15-.17, .22 and .24 (E/W, Middle and TCS); 45 CFR Parts 160 and 164</i></p>	
	<p><b>[AQS Criteria] Member Rights and Responsibilities - 12 Confidentiality/HIPAA compliance</b></p> <p>The MCO creates and adopts policies and procedures to periodically audit adherence to all HIPAA regulations, and for which the MCO acknowledges and promises to perform, including but not limited to the following obligations and actions:</p> <p>a. responsibility for informing members of their privacy rights in the manner specified under the regulations;</p> <p>b. setting up appropriate mechanisms to ensure its</p>	<p><b>RR 6A Adopting Written Policies</b></p> <p>The organization adopts written PHI policies and procedures that address:</p> <ol style="list-style-type: none"> <li>1. Information included in notification of privacy practices</li> <li>2. Access to PHI</li> <li>3. The process for members to request restrictions on use and disclosure of PHI</li> <li>4. The process for members to request amendments to PHI</li> <li>5. The process for members to request an accounting of disclosures of PHI</li> </ol>

Federal Requirements	State Standards	2009 NCQA Standards
	<p>staff has minimum necessary access to PHI;</p> <p>c. adopting the appropriate procedures and access safeguards to restrict and regulate access to and use by MCO employees and other persons performing work for said MCO to have only minimum necessary access to personally identifiable data within their organization;</p> <p>d. the process for members to request restrictions on use/disclosure of PHI;</p> <p>e. making available to members the right to amend their PHI data in accordance with federal HIPAA regulations;</p> <p>f. sending information to members educating them of their rights and necessary steps in this regard;</p> <p>g. creating and implementing policies and procedures to address present and future HIPAA regulation requirements as needed including: use and disclosure of data; de-identification of data; minimum necessity access; accounting of disclosures; members' rights to amend, access, request restrictions, and right to file a complaint; and</p> <p>h. implementing all appropriate administrative, technical, and physical safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of the CRA, including but not limited to confidentiality requirements in 45 Code of Federal Regulations (CFR) Parts 160 and 164.</p>	<p>6. Internal protection of oral, written and electronic information across the organization</p>
	<p><i>CRA § 2.27.2.17 and .18 (E/W, Middle and TCS)</i></p>	
	<p><b>[AQS Criteria] Member Rights and Responsibilities - 13 Communication regarding PHI</b></p>	<p><b>RR 6D Communication of PHI Use and Disclosure</b></p>

Federal Requirements	State Standards	2009 NCQA Standards
	<p>The MCO informs its members about the policies and procedures regarding PHI collection, use, and disclosure. The communication includes:</p> <ul style="list-style-type: none"> <li>● the MCO's routine use and disclosures of member PHI;</li> <li>● use of authorizations;</li> <li>● access to PHI; and</li> <li>● MCO protection of all forms of PHI (oral, written and electronic).</li> </ul>	<p>Upon member enrollment and annually thereafter, the organization informs members of its policies and procedures regarding the collection, use and disclosure of member PHI. Communication includes:</p> <ol style="list-style-type: none"> <li>1. The organization's routine use and disclosure of PHI</li> <li>2. Use of authorizations</li> <li>3. Access to PHI</li> <li>4. Internal protection of oral, written and electronic PHI across the organization</li> <li>5. Protection of information disclosed to plan sponsors or to employers</li> </ol>
<p><b>42 CFR 438.230 Subcontractual Relationships and Delegation</b></p>	<p><i>CRA § 2.26.1.1 (Middle)</i></p>	<p><b>CR (Credentialing)12, RR (Rights and Responsibilities) 8, UM (Utilization Management)15, and/or QI (Quality Improvement)13 D Predelegation Evaluation</b></p>
	<p>If the CONTRACTOR delegates responsibilities to a subcontractor, the CONTRACTOR shall ensure that the subcontracting relationship and subcontracting document(s) comply with federal requirements, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b) and 42 CFR 434.6 as described below: The CONTRACTOR shall evaluate the prospective subcontractor's ability to perform the activities to be delegated;</p>	<p>For delegation agreements that have been in effect for less than 12 months, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.</p>
	<p><i>CRA § 2.26.1.2 (Middle)</i></p>	<p><b>CR (Credentialing)12, RR (Rights and Responsibilities) 8, UM (Utilization Management)15, and/or QI (Quality Improvement)13 A Written Delegation Agreement</b></p>
	<p>The CONTRACTOR shall require that the agreement be in writing and specify the activities and report responsibilities delegated to the subcontractor and provide for revoking delegation or imposing other sanctions if the subcontractor's performance is</p>	<p>There is a written delegation document:</p> <ol style="list-style-type: none"> <li>1. Is mutually agreed upon</li> <li>2. Describes the responsibilities of the organization and the delegated entity</li> <li>3. Describes the delegated activities</li> </ol>

Federal Requirements	State Standards	2009 NCQA Standards
	inadequate;	4. Requires at least semiannual reporting to the organization 5. Describes the process by which the organization evaluates the delegated entity's performance 5. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.
	<i>CRA § 2.26.1.3 (Middle)</i>	<b>CR (Credentialing)12, RR (Rights and Responsibilities) 8, UM (Utilization Management)15, and/or QI (Quality Improvement)13 E Annual Evaluation</b>
	The CONTRACTOR shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review, on at least an annual basis, consistent with NCQA standards and state MCO laws and regulations;	For delegation arrangements in effect for 12 months or longer, the organization annually evaluated delegate performance against NCQA standards for delegated activities.
		<b>CR (Credentialing)12, RR (Rights and Responsibilities) 8, UM (Utilization Management)15, and/or QI (Quality Improvement)13 F Reporting</b>
		For delegation arrangements in effect for 12 months or longer, the organization evaluates regular reports, as specified in Element A.
	<i>CRA § 2.26.1.4 (Middle)</i>	<b>CR (Credentialing)12, RR (Rights and Responsibilities) 8, UM (Utilization Management)15, and/or QI (Quality Improvement)13 G Opportunities for Improvement</b>
	The CONTRACTOR shall identify deficiencies or areas for improvement, and the CONTRACTOR and the subcontractor shall take corrective action as necessary...	For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization has identified and followed up on opportunities for improvement, if applicable.

## Quality Measurement and Improvement

Federal Requirements	State Standards	2009 NCQA Standards
<b>42 CFR 438.236 Practice Guidelines</b>	<i>CRA § 2.8.1.2 (E/W, Middle and TCS)</i>	
	<b>[AQS Criteria] QI Activities - 13 Clinical basis for guidelines</b>	<b>QI 9A Factor 2 Adoption and Distribution of Guidelines</b>
	The MCO establishes a clinical basis for its practice guidelines by: <ul style="list-style-type: none"> <li>obtaining approval by the MCO's QI committee.</li> </ul>	The organization ensures that practitioners are using relevant clinical practice guidelines by: <ol style="list-style-type: none"> <li>Establishing the clinical basis for the guidelines</li> </ol>
	<i>CRA § 2.15.5.1</i>	
	<b>[AQS Criteria] QI Activities - 14 Updating guidelines</b>	<b>QI 9A Factor 3 Adoption and Distribution of Guidelines</b>
	The guidelines are reviewed and updated at least every two years or whenever the guidelines change.	The organization ensures that practitioners are using relevant clinical practice guidelines by: <ol style="list-style-type: none"> <li>Updating the guidelines at least every two years</li> </ol>
	<i>CRA § 2.15.5.2</i>	
<b>42 CFR 438.240(a) Program</b>	<b>[AQS Criteria] QI Activities - 15 Distributing guidelines</b>	<b>QI 9A Factor 4 Adoption and Distribution of Guidelines</b>
	The MCO distributes the clinical practice guidelines and any revisions to all appropriate practitioners as they occur.	The organization ensures that practitioners are using relevant clinical practice guidelines by: <ol style="list-style-type: none"> <li>Distributing the guidelines to the appropriate practitioners.</li> </ol>
	<i>Contractor Risk Agreement (CRA) § 2.15.1.1(1-6), 2.15.1.3 and 2.15.2.1 (E/W, Middle and TCS)</i>	
<b>[AQS Criteria] Quality Improvement (QI) Program - 1 Quality Improvement (QI) program structure</b>	<b>QI 1A Quality Improvement Program Structure</b>	
The MCO's QI program structure includes the following: <ol style="list-style-type: none"> <li>a written description that clearly defines its QI structures and processes</li> </ol> and assigns responsibility to appropriate individuals;	The organization's QI program description includes the following. <ol style="list-style-type: none"> <li>A written description of the QI program structure</li> <li>Behavioral healthcare aspects of the program</li> <li>Patient safety is specifically addressed in the program description</li> </ol>	

Federal Requirements	State Standards	2009 NCQA Standards
	b. specifically addresses behavioral healthcare; c. the MCO's plan for improving member safety; d. accountability to the Governing Body to include a quarterly report to the MCO Governing Body and TennCare; e. an MCO physician and behavioral health practitioner are identified to have substantial involvement in the QI program; f. a QI committee that includes medical and behavioral health staff and providers is identified to oversee the quality functions of the organization; g. descriptions of the role, structure, function, and meeting frequency of MCO QI committee (and other committees); h. an annual QI work plan; and i. a description of the material resources and staff that the organization designates to carry out the needs of the QI program.	4. The QI program is accountable to the governing body 5. A designated physician has substantial involvement in the QI program 6. A designated behavioral healthcare practitioner is involved in the behavioral healthcare aspects of the QI program 7. A QI committee oversees the QI functions of the organization 8. The specific role, structure and function of the QI committee and other committees, including meeting frequency, are addressed in the program description 9. An annual work plan 10. A description of resources that the organization devotes to the QI program
	<i>CRA § 2.15.2.1 (E/W, Middle and TCS)</i>	
	<b>[AQS Criteria] Quality Improvement (QI) Program - 3 QI committee responsibilities</b>	<b>QI 2A QI committee Responsibilities</b>
	The MCO's QI committee responsibilities include: <ul style="list-style-type: none"> <li>● recommendations for policy decisions;</li> <li>● analysis and evaluation of QI activities outcomes;</li> <li>● ensuring practitioner participation in the organization's QI program through participation in QI committees or subcommittees;</li> <li>● taking action as needed; and</li> <li>● ensuring follow-up as appropriate.</li> </ul>	1. Recommends policy decisions 2. Analyzes and evaluates the results of QI activities 3. Ensures practitioner participation in the QI program through planning, design, implementation or review 4. Institutes needed actions 5. Ensures follow-up, as appropriate

Federal Requirements	State Standards	2009 NCQA Standards
	<i>CRA § 2.15.2.2 (E/W, Middle and TCS)</i>	
	<b>[AQS Criteria] Quality Improvement (QI) Program - 4 QI committee minutes</b>	<b>QI 2B QI committee Minutes</b>
	<p>Written minutes are kept of all meetings of the QI committee. Minutes include:</p> <ul style="list-style-type: none"> <li>● committee decisions;</li> <li>● actions taken by the committee;</li> <li>● signature of the committee chairman; and</li> <li>● date of signature.</li> </ul>	<p>QI committee meeting minutes reflect all committee decisions and actions, and are signed and dated.</p>
	<i>CRA § 2.15.1.2 (E/W, Middle and TCS)</i>	
	<b>[AQS Criteria] Quality Improvement (QI) Program - 5 Informed practitioners and members</b>	<b>QI 2C Informing Practitioners and Members</b>
	<p>The MCO makes information about its QI program available to practitioners and members at least annually.</p>	<p>The organization annually makes information about its QI program available to the following groups.</p> <ol style="list-style-type: none"> <li>1. Members</li> <li>2. Practitioners</li> </ol>
<i>CRA § 2.15.1.1.7 (E/W, Middle and TCS)</i>		
<b>[AQS Criteria] Quality Improvement (QI) Program - 2 Annual evaluation</b>	<b>QI 1B Annual Evaluation</b>	
<p>The MCO has an annual written evaluation of the QI program for the prior year that includes:</p> <ul style="list-style-type: none"> <li>● a description of completed and ongoing QI activities that address the quality and safety of clinical care and quality of service;</li> <li>● trending of measures to assess performance in the quality and safety of clinical care and quality of service;</li> <li>● analysis of the results of QI activities, including barrier analysis explaining any delays encountered for any of the planned activities</li> </ul>	<p>There is an annual written evaluation of the QI program that includes the following information.</p> <ol style="list-style-type: none"> <li>1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service</li> <li>2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service</li> <li>3. Analysis of the results of QI initiatives, including barrier analysis</li> <li>4. Evaluation of the overall effectiveness of the QI program, including progress toward influencing networkwide safe clinical practices</li> </ol>	

Federal Requirements	State Standards	2009 NCQA Standards
	and the plan for completing any delayed scheduled activities; and <ul style="list-style-type: none"> <li>● evaluation of the overall effectiveness of the QI program, including progress toward influencing networkwide safe clinical practices.</li> </ul>	