

**STATE OF TENNESSEE
BUREAU OF TENNCARE**



2011

**QUALITY ASSESSMENT AND PERFORMANCE
IMPROVEMENT STRATEGY**

And

Quality Strategy: Annual Update Report

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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, and was designed as a managed care model, essentially replacing the Medicaid program in Tennessee. At the start of TennCare I, Tennessee moved almost its entire 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 (MCOs) 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 waiver expiration date of December 30, 1999. It should be noted that enrollees under the TennCare program are eligible to receive only those medical items and services that are within the scope of defined benefits for which the enrollee is eligible and determined by the TennCare program to be medically necessary. To be determined to be medically necessary, a medical item or service must be recommended by a health care provider, and must satisfy each of the following criteria:

- It must be required in order to diagnose or treat an enrollee's medical condition
- It must be safe and effective
- It must be the least costly alternative course of diagnosis or treatment that is adequate for the medical condition
- It must not be experimental or investigational

TennCare II, the new demonstration program 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 eligible's, 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 below 200 percent of poverty be classified as Title XXI children. The extension also mandated a new cap on supplemental payments to hospitals.

In 1996, Behavioral Health services were carved out and the Partner's program was established whereby Behavioral Health Organizations (BHOs) contracted directly with the Bureau of TennCare to manage behavioral health services. A primary focus of the carve-out was to provide services for the priority population; a group that included adults with serious and persistent mental illness (SPMI) and children with serious emotional disturbance (SED). The Bureau began integrating behavioral and medical health care delivery for Middle Tennessee members in 2007 with the implementation of two expanded MCOs. TennCare continued the process with the execution of new MCO contracts in West Tennessee in November 2008 and East Tennessee in January 2009. The transferring of behavioral health services to Volunteer State health Plan of Tennessee for TennCare Select members completed the Bureau's phased in implementation of a fully integrated service delivery system that works with health care providers, including doctors, and hospitals, to ensure that TennCare members receive all of their medical and behavioral services in a coordinated and cost-effective manner.

On December 15, 2009, TennCare received approval from CMS for another three-year extension of the waiver, to begin on July 1, 2010, and to continue through June 30, 2013. The extension included several new amendments including approval for the implementation of the CHOICES program outlined by the General Assembly's Long-term Care and Community Choices Act of 2008. Under the amendment, the State provides new community alternatives to people who would otherwise require Medicaid-reimbursed care in a Nursing Facility. The new CHOICES program utilizes the existing Medicaid MCOs to provide eligible individuals with nursing facility services or home and community based services. Tennessee is now one of the few states in the country to deliver managed Medicaid long-term care and the only state to do so in a manner that does not require enrollees to change their managed Care Organization (MCO).

Major operational changes were required in order to ensure that the CHOICES program could be smoothly integrated into the existing managed care structure. MCO contract amendments had to be approved, training materials prepared, systems changes made, contracts executed with Nursing Facilities and Home and Community Based Services (HCBS) providers, an electronic visit verification (EVV) system put in place, and the development of numerous protocols covering all aspects of the

program. The CHOICES program was implemented in stages over time in different geographic areas of the state. The first phase of the CHOICES program was successfully implemented in Middle Tennessee on March 1, 2010 with the East and West Grand Region MCOs implementation occurring in August 2010. Also, in August 2010, the Statewide Home and Community Based Waiver for the Elderly and Disabled was terminated as it was no longer needed with full implementation of the CHOICES program.

With implementation of the CHOICES program, the MCOs became responsible for coordination of all medical, behavioral, and long-term care services provided to their members. Currently, the only remaining carve-out services are for dental and pharmacy services.

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.

Dental Benefits Manager (DBM)

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

On October 1, 2010, following a competitive bid process and a thorough readiness review and implementation period, Delta Dental assumed its responsibilities as the new TennCare Dental Benefits Manager (DBM). Delta Dental named its TennCare product "TennDent" and is responsible, among other things, for establishing and managing an adequate statewide network of dentists, processing and paying dental claims, utilization management and utilization review, detecting fraud and abuse, meeting utilization benchmarks and conducting outreach efforts reasonably calculated to ensure participation of children who have not received dental services. TennCare has approved Delta Dental's 2011 proposed EPSDT outreach program which includes the following nine initiatives designed to educate enrollees and their caregivers about the availability of EPSDT services and to increase the number of enrollees utilizing dental services:

- Collaboration
- Oral Health Educational Series
- Dental Screening Program
- Member Mailings (annual reminder notices, annual Member Handbook, quarterly Member Newsletter)
- Member Education
- Rural County Targeted Outreach
- Preconception/ Prenatal Oral Health Care and Coordination
- Teens
- "See Your Dentist" Reminder Pad

Pharmacy Benefits Manager (PBM)

TennCare's quality strategy encompasses many different aspects of the pharmacy benefit. The following highlights major components of the pharmacy program:

- To ensure **clinical quality**, the following initiatives are performed:
 - Every drug class on the preferred drug list (PDL) is reviewed by the Pharmacy Advisory Committee (PAC). TennCare uses their recommendations to guide the listing of preferred and non-preferred products on the PDL. In addition, the committee discusses/votes on any proposed prior authorization (PA) criteria or quantity limits.
 - Clinical pharmacists within SXC (TennCare's PBM) convert the PAC's recommendations for PA criteria and quantity limits into objective questions on a decision tree, thus helping ensure consistent decisions when applying clinical criteria.
 - Individuals who are denied PA for a drug are issued a letter informing them why their request was denied, and explaining their appeal rights. Pharmacy appeals are reviewed by a committee of pharmacists within SXC to evaluate if the request was appropriately denied.
 - Prospective Drug Utilization Review (ProDUR) Edits function at point of sale (POS) identifying potential drug interactions, high doses, and therapeutic duplications. These edits help to prevent adverse drug actions.
 - The TennCare Drug Utilization Review Board (DUR) board meets quarterly to review TennCare drug utilization trends for appropriateness.

- To ensure **data integrity**, the following quality strategies have been implemented:
 - Quarterly pharmacy desk and field audits are performed to identify misbilled or fraudulent claims.
 - Daily error report to identify any problems that are then investigated in coordination with Member Services and the Department of Human Services (DHS), so that correct eligibility information is reflected within pharmacy benefit.
 - TennCare requires that the POS claims adjudication system check all submitted pharmacy claims for valid NPIs for prescriber and pharmacy, as well as valid drug NDCs.

- To ensure quality within **pharmacy network**, the following steps are taken:
 - All pharmacies within the network are required to submit a pharmacy application, agreement, and disclosure form which is used to verify that the pharmacy is licensed and in good standing. The agreement sets forth all of the responsibilities of the pharmacies when serving TennCare recipients (Grier notices, 3-day emergency supplies, no automatic refills, monthly LEIE list checks for all pharmacy employees, etc.).
 - TennCare closely monitors pharmacies in its network to determine whether geoaccess standards, as set forth in the PBM contract, are met.

- To guard against **fraud and abuse**, we have incorporated the following quality strategies:
 - Annual fraud and abuse report required from the PBM.
 - TennCare developed specific criteria, involving multiple controlled substances, multiple prescribers, and multiple pharmacies, to identify candidates for pharmacy lock-in. This criterion is run on a monthly basis and reviewed by pharmacists to select individuals for pharmacy lock-in.
 - Verification of benefits (VOB) letters are sent to recipients to ensure they received medications for which TennCare was billed.
 - Twice annually, TennCare runs a report to identify the top 100 prescribers of narcotics based on a composite rank involving overall narcotic prescription volume and percentage of total prescriptions represented by narcotics. Letters are sent to these prescribers, and the report is shared with the MCOs.
 - Referrals from TennCare/SXC to OIG and TBI of suspected cases of TennCare fraud and abuse.

- **Additional quality control measures include:**
 - Monitoring of call center metrics, to ensure acceptable handle times, wait times, etc.
 - Monthly monitoring and refresh of MAC pricing list, including analysis of MAC disputes.
 - Monitoring of prompt pay requirements for the PBM.
 - Monitoring of call center PA turnaround time (max 24 hrs once complete request received)
 - Standard reporting to monitor: claims processing time, high dollar edits, 3-day emergency supply, etc.

Population description/changes

All Medicaid and demonstration eligible's are enrolled in TennCare, including those who are dually eligible for TennCare and Medicare. There are approximately 1.2 million persons currently enrolled in TennCare. There are two mechanisms for TennCare eligibility; 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 live in a nursing home and have income below \$2,022 per month (300% of SSI benefit), or receive 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 these children can qualify and be able to keep their healthcare benefits:

- To qualify as UNINSURED:
 - The child's eligibility through TennCare Medicaid is ending and
 - The child must be under the age of 19 and
 - 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, see below).
- To qualify as "MEDICALLY ELIGIBLE": The child must be under the age of 19, and have a health condition which makes the child "uninsurable" (or unable to access private health insurance because of their health condition), and 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 allows MCOs to coordinate all of the care a TennCare member needs, including medical, behavioral and long-term care. Implementation of CHOICES for the Middle Grand Region MCOs occurred on March 1, 2010 and subsequently for the East and West Grand Region MCOs on August 1, 2010. Initial implementation included two CHOICES groups, CHOICES Group 1 and CHOICES Group 2:

- 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 include CHOICES Group 3 at such time that the State is permitted to modify nursing facility level of care based on interpretation of the maintenance of effort requirements delineated in the Affordable Care Act.

- 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.

In November 2010, Tennessee was recognized by the Center for Health Care Strategies (CHS) for its statewide implementation of the new TennCare CHOICES Long-Term Care program. In its report (*Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services*) CHCS identified

Tennessee as one of five innovative states with demonstrated expertise in managed care approaches to long-term care. Tennessee, along with Arizona, Hawaii, Texas and Wisconsin, were noted as “true pioneers” in designing innovative approaches to delivering care to the elderly and adults with disabilities. Tennessee in particular was recognized for its open communication and collaboration with the public and stakeholders in designing and implementing the new program.

The key component of the CHOICES program is care coordination. The “whole person” care coordination approach includes:

- 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.

Strategy evaluation and revision

Annually, in January, TennCare plans to review the Quality Strategy and provide a report to CMS by April 1 of each year that will include information on the implementation and effectiveness of the strategy. A revised strategy will be provided whenever significant changes occur in the TennCare Program. These changes may include additional programs, new Managed Care Contractors, etc.

Process to obtain public input on strategy

The Quality Strategy will be available on TennCare’s Web site. When the Quality Strategy is updated, TennCare will notify MCOs, 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>2.4 By 2013, the statewide weighted HEDIS rate for cervical cancer</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> <i>A Comparative Analysis of Audited Results from TennCare Managed Care</i></p>

Goal	Objective	Additional Information
	<p>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><i>Organizations (MCOs).</i></p> <p><u>Data source:</u> EPSDT Medical Record Review.</p>
<p>3. Assure enrollees' satisfaction with services.</p>	<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>
<p>4. Improve health care for program enrollees.</p>	<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 achieve a total statewide EPSDT screening rate of at least 80%.</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> <i>CMS-416.</i></p>

Goal	Objective	Additional Information
	<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 allows TennCare to integrate nursing facility services and HCBS for the elderly and adults with physical disabilities into the existing managed care program. MCOs now coordinate all of the care a TennCare member needs, including medical, behavioral and long-term care. Implementation of CHOICES for the Middle Grand Region MCOs occurred March 1, 2010 and the East and West Grand Region MCOs on August 1, 2010.

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 of Medicaid-reimbursed HCBS.	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 enrollment in CHOICES and receipt of Medicaid-reimbursed HCBS.	<p><u>Data Source:</u> MMIS report</p> <p><u>Sampling Approach:</u> 100% of all CHOICES Group 2 members enrolled</p> <p><u>Frequency:</u> Quarterly</p>

Assurance	Sub-Assurance	Performance Measure	Additional Information
			<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 November</p> <p><u>Remediation:</u> TennCare is responsible for semi-</p>

Assurance	Sub-Assurance	Performance Measure	Additional Information
			annual member record review and review/ analysis of data. MCOs will be responsible for remediation of individual findings with review/ validation by TennCare.
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 and review/ analysis of data. MCOs will be responsible for remediation of individual</p>

Assurance	Sub-Assurance	Performance Measure	Additional Information
			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, analyzed, and conclusions drawn. Conclusions relate to the quality and timeliness of, and access to, care furnished to TennCare-enrolled recipients by its contracted MCOs 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). 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 from the 2009 Technical Report to the 2010 Technical Report will not be possible due to the transition of health plans and subsequent changes in their enrollee populations. More complete trending will again be possible with the 2011 Technical Report since all MCOs will have returned to an integrated service model and 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 (MRR) 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, Congestive Heart Failure, Asthma, Coronary Artery Disease, Chronic obstructive pulmonary disease, 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>42 CFR 438.206 Availability of Services</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.23 - 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 Reportⁱ, an EQRO contractual activity.</p>	
		<p>Some of these requirements are evaluated as part of the Annual Network Adequacy (ANA)ⁱⁱ, an EQRO mandatory activity.</p>	
		<p>Some of these requirements are evaluated as part of the Annual Quality Survey (AQS)ⁱⁱⁱ, 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- Availability of Services .	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.
42 CFR 438.208 Coordination and Continuity of Care	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"> 11. Service coordination policies and procedures that ensure compliance with Section 2.9.1. 12. Policies and procedures for transition of new members that ensure compliance with the requirements of Section 2.9.2. 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. 14. Transition of care policies and procedures that ensure compliance with Section 2.9.4. 15. MCO case management policies and procedures that ensure compliance with Section 2.9.5. 16. Care coordination policies and procedures that ensure compliance with Section 2.9.6. 17. Policies and procedures for consumer direction of HCBS that ensure compliance with Section 2.9.7. 18. Policies and procedures for coordination of physical health, behavioral health, and long-term 	

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)ⁱⁱⁱ, 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-Coordination and Continuity of Care.</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>42 CFR 438.210 Coverage and Authorization of Services</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- Coverage and Authorization of Services.</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
42 CFR 438.214 Provider Selection	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.22 – 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) ⁱⁱ , an EQRO mandatory activity.	
42 CFR 438.218 Enrollee Information	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)ⁱⁱⁱ, 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
		Enrollee Information.	
<p>42 CFR 438.224 Confidentiality</p>	<p>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.</p>	<p>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.</p>	<p>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.</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: 87. HIPAA policies and procedures that ensure compliance with Section 2.27.</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- Confidentiality .	damages can be assessed for failure to submit NCQA Accreditation Report within 10 days of receipt.
<p>42 CFR 438.226 Enrollment and Disenrollment</p>	<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>42 CFR 438.228 Grievance Systems - Complaints</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)ⁱⁱⁱ, 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.
42 CFR 438.228 Grievance Systems - Appeals	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) ⁱⁱⁱ , 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.
42 CFR 438.230 Subcontractual Relationships and Delegation	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, daims 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- Subcontractual Relationships and Delegation .	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>42 CFR 438.236 Practice Guidelines</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>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>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>Some of these requirements are evaluated as part of the Annual Quality Survey (AQS)ⁱⁱⁱ, 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</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- Practice Guidelines .	damages can be assessed for failure to submit NCQA Accreditation Report within 10 days of receipt.
42 CFR 438.240 Quality Assessment and Performance Improvement Program - 42 CFR 438.240(a) Program	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) ⁱⁱⁱ , 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- Program .	4.20.2.2.7 B.4 – Liquidated damages can be assessed for failure to submit NCQA Accreditation Report within 10 days of receipt.
42 CFR 438.240(c) Performance Measurement	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 ^{iv} , 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) ^v , 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) ^v , an EQRO contractual activity.	
42 CFR 438.240(d) Performance Improvement Projects	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 nondinical 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 ^{vi} , an EQRO mandatory activity.	
42 CFR 438.242 Health Information Systems	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.		

ⁱ 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.

ⁱⁱ 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.

ⁱⁱⁱ 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

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.

^{iv} 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.

^v 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.

^{vi} 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*.

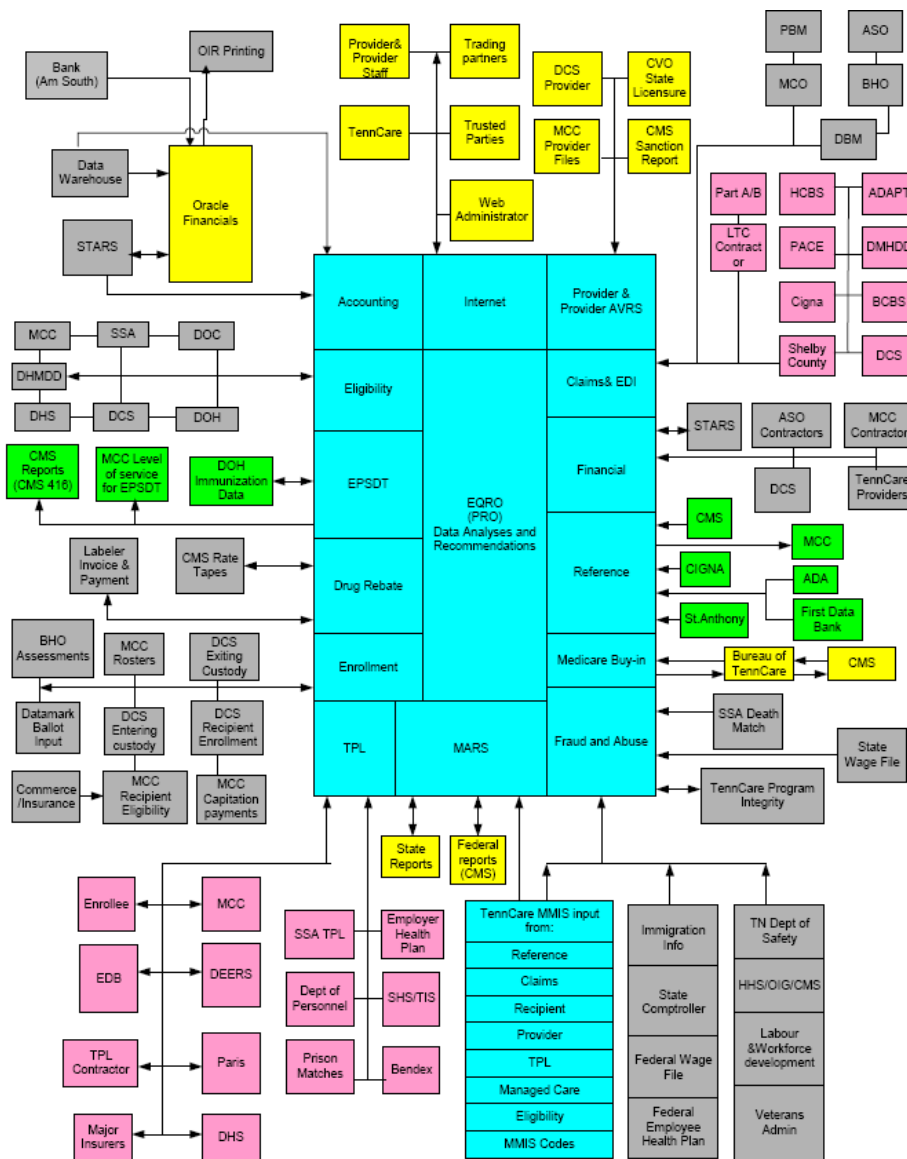
II.C Evolution of Health Information Technology

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.

Progress towards Health Information Exchange (HIE)

Tennessee continues to advance the adoption and meaningful use of health information technology (HIT) and health information exchange (HIE) to drive improvements in patient healthcare outcomes. It is anticipated that these advancements will not only enable vital, secure, decision-ready information to be available to clinicians at the point of care, but will also empower patients by making critical health information available to them. HIT and HIE is necessary to build Tennessee's health care delivery

foundation to improve both individual and population health. Substantial progress has been made to develop the infrastructure and capabilities for HIT and HIE at the state, regional, and institutional levels, the result of which is a dynamic environment enabling Tennessee to be at the forefront of delivering better health care. Tennessee is building its commitment to statewide HIE on quality and value, multi-sector collaboration, and sustainability. The Office of eHealth Initiatives, in the Tennessee Department of Finance and Administration, is the single coordinating authority for HIE in Tennessee and provides leadership, guidance, and operational support for e-Health efforts throughout the state.

Tennessee's statewide HIE framework consists of three categories of services:

- Core Services to help organizations locate, positively identify, and determine how to exchange information securely across organization boundaries
- Enterprise services to help organizations meet the federal criteria and state requirements for the meaningful use of certified EHR technologies
- Value-added services for inclusion within the statewide HIE framework based on the feasibility, cost, and value of the proposed service.

Currently clinical summary information is being exchanged through three operational Health Information Organizations (HIOs) and on a limited basis elsewhere in the state. Many geographic areas of the State are not currently served by HIOs and steps are being taken to initiate a number of local HIOs in these gaps. Among the first web-services proposed for the statewide HIE program is the development of a set of services that would allow HIOs and State departments to both create and consume a Continuity of Care Document (CCD). Many stakeholders view this as a key requirement for statewide HIE and for meaningful use as a means to enhance the coordination of care.

In Tennessee, a number of state-level databases are currently available to authorized users through the eHealth Network, including registries for immunization, licensure renewal and verification, and domestic violence. In addition, we are assessing the viability of using the eHealth Network to facilitate access to registries for cancer, controlled substances, newborn screening, and traumatic brain injury. As HIE capabilities continue to expand, Tennessee will explore opportunities to use the eHealth Network to build chronic disease registries for conditions like diabetes, stroke, etc.

Much progress has also been achieved in the area of electronic prescribing and Tennessee's Office of e-Health Initiatives has approved 1,961 healthcare providers and more than 420 treatment sites in its Tennessee as Physician Connectivity Grant recipients. Now expired, the Grant program required recipients to electronically prescribe for two years and has been a critical factor in Tennessee's HIE success. According to data compiled by Surescripts, a national electronic prescribing clearinghouse, the total percentage of prescriptions routed electronically in Tennessee has been: 0.45 percent in 2006, 1.14 percent in 2007, and 4.02 percent in 2008. Another measure of the use of electronic prescribing capabilities is the percentage of physicians who route their prescriptions electronically. The percentage of Tennessee providers who were routing electronic prescriptions was 1.74 percent in 2006, 6.45 percent in 2007, and 15.76 percent in 2008.

The Electronic Health Record (HER) Provider Incentive Program supports the adoption of Electronic Health Records (EHRs) by Eligible Professionals (EPs) and Eligible Hospitals (EHs) by providing financial incentives to providers that implement and demonstrate meaningful use of certified HER technology. Tennessee was the second state in the country to receive approval for implementation of the EHR Provider Incentive Program. As of May 2011, a total of 61 Acute Care hospitals, 24 Dentists, 664 physicians, 25 certified nurse midwives, 414 nurse practitioners, and 25 physicians assistants have applied to TennCare for the EHR incentive program. Tennessee is currently second in number of EPs/EHs who have applied to participate in the EHR Incentive Program and first in terms of the number who have been verified for participation. We look forward to the attestation process beginning April 4, 2011 where the eligible registrants will begin providing us their Medicaid encounter data so that we can verify the information in our system and make payments accordingly.

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. By the end of 2009, all TennCare MCOs were NCQA accredited. TennCare MCOs are contractually required to maintain accreditation once it is obtained, and Reccreditation will occur in 2012.

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 are contracted by TennCare. To strengthen outreach efforts, TennCare has contracted with the Tennessee Department of Health to provide a comprehensive outreach 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 a Managed Care Contractor (MCC) Collaborative. Meetings are held on a quarterly basis to identify innovative methods of providing TENNderCARE outreach to Youth under the age of 21 with a focus on teens. Through the collaborative, the MCCs decide on topics of special interest to adolescents for the quarterly teen newsletters. Each quarter an MCO is assigned the responsibility of writing articles for the newsletters and the DBM provides an article each quarter. The MCOs are responsible for printing and distributing the teen newsletters to their members between the ages of 15-20.

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 began in all three Grand Regions of the state: the Volunteer State Health Plan (VSHP) Partnership, the Haywood County Clinic, and the Nashville Medial Home Connection. The intent was to develop alternative service delivery systems to prevent the use of hospital emergency departments for primary and non-urgent care. Grant funding was extended for an additional year. The grant concludes in April 2011 with two sites completing the project: VSHP Partnership in the East region and the Haywood County Clinic in the West region. The objective of each site is to treat patients whose medical needs do not meet the intensity of receiving emergency department services and to facilitate the relationship with Primary Care Providers. Since December 2008 through the end of 2010, VSHP Partnership at the Erlanger-Pediatric Clinic has treated 14,813 patients, with 64% being Medicaid recipients. From June 2009 through the end of 2010, the Haywood County Clinic has treated 2,206 patients, with 52% being Medicaid recipients.

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 offered 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 offered quality incentive payments for three behavioral health HEDIS measures to the MCOs in the East, Middle, and West regions. MCOs were eligible for incentive payment if they demonstrated significant improvement from baseline for the specified measures or met a specified goal. Significant improvement was determined by using NCQA's minimum effect size change methodology. In 2010, AmeriChoice met the criteria for three quality incentive payments, Amerigroup met the criteria for four quality incentive payments, and VSHP met the criteria for nine quality incentive payments. TennCare plans to continue the pay-for-performance quality incentive payment program in 2011 and beyond.

Disease Management Programs

Each TennCare MCO provides ten (10) Disease Management (DM) programs for their TennCare members. Each MCO is required to provide disease management programs for Asthma, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Diabetes, Maternity and Obesity as well as Bipolar Disorder, Major Depression and Schizophrenia. The programs educate, coach, and support individuals or their care givers in assuming responsibility for their health status. The empowered member can resolve disease specific knowledge gaps, take action to reduce acute episodes requiring emergent or inpatient care, and improve their quality of life and health outcomes. At this time, all TennCare MCOs provide "Opt Out" Disease Management Programs. In an "Opt Out" program, members are considered as participants and are enrolled in the program upon identification of eligibility and remain until the member actively notifies the health plan of their desire to opt-out. Disease management programs emphasize education to promote self management strategies, healthy lifestyles, medication adherence, and regular preventive visits to a primary care physician and or specialist. Each MCO has dedicated staff to provide disease management interventions. The type and intensity of Disease Management intervention provided is related to the severity of the condition and predictive future health risks of the member. Interventions range from providing general education about conditions to intense interventions including individualized care plans.

TennCare Health Plan Meetings

TennCare's External Quality Review Organization, QSource, conducts three meetings a year 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.

IV. Strategy Effectiveness

Planned evaluations

TennCare plans to reevaluate the Quality Strategy objectives annually by December 31. 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 as appropriate. The table below summarizes TennCare's 2010 evaluation of the strategy objectives. 2010 HEDIS/CAHPS results are compared to the 2010 Medicaid National Average. Change has been determined from the baseline rates.

Quality Strategy Objectives				
Goals	Objectives	2010 Statewide Rate	2010 National Average	Change from Baseline Statewide Rate to 2010 Statewide Rate
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. Baseline 2007: 70% 20-44 year olds; 74% 45-64 year olds	a. 20-44 years old-79.50% b. 45-64 years old-79.89%	a. 80.38% b. 85.27%	a. Increase – 9.5% b. Increase – 5.89%
	1.2 By 2013, the statewide weighted HEDIS rate for children and adolescents' access to PCPs will increase to 90% for enrollees 7-11 years old and 86% for enrollees 12-19 years old. Baseline 2007: 87% for 11 year olds; 82% for 12-19 year olds	a. 7-11 years old-91.43% b. 12-19 years old-87.22%	a. 90.23% b. 87.85%	a. Increase – 4.43% (objective met) b. Increase – 5.22% (objective met)

Quality Strategy Objectives				
Goals	Objectives	2010 Statewide Rate	2010 National Average	Change from Baseline Statewide Rate to 2010 Statewide Rate
	<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>Baseline 2007: 94% Heads of Household; 97% Children</p>	<p>a. Heads of household-92%</p> <p>b. Children-97%</p>	NA-Not a HEDIS/CAHPS Rate	<p>a. 2% decrease</p> <p>b. Same</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>Baseline 2007: 35%</p>	41.1%	47.64%	Increase – 6.1% (objective met)
	<p>2.2 By 2013, the statewide weighted HEDIS rate for timeliness of prenatal care will be maintained at 82% or above.</p> <p>Baseline 2007: 78%</p>	81.06%	83.33%	Increase – 3.06%
	<p>2.3 By 2013, the statewide weighted HEDIS rate for breast cancer screening will increase to 50%.</p> <p>Baseline 2007: 44%</p>	38.45%	52.31%	Decrease – 5.55%
	<p>2.4 By 2013, the statewide weighted HEDIS rate for cervical cancer screening will</p>	61.30%	65.66%	Decrease – 1.7%

Quality Strategy Objectives				
Goals	Objectives	2010 Statewide Rate	2010 National Average	Change from Baseline Statewide Rate to 2010 Statewide Rate
	increase to 68%. Baseline 2007: 63%			
	2.5 By 2013, providers of EPSDT screening services will document the delivery of 95% of the required seven components of an EPSDT screen. Baseline 2007: 89%	94.0%	NA-Not a HEDIS/CAHPS measure	Increase – 5%
3. Assure enrollees' satisfaction with services.	3.1 By 2013, 95% of TennCare enrollees will be satisfied with TennCare. Baseline 2007: 90%	94%	NA-Not a HEDIS/CAHPS rate	Increase – 4%
	3.2 By 2013, the statewide average for adult CAHPS getting needed care-always or usually will increase to 82%. Baseline 2007: 78%	76.6%	76% (national benchmark)	Decrease – 1.4%
	3.3 By 2013, the statewide average for child CAHPS getting care quickly-always or usually will increase to 81%. Baseline 2007: 79%	88.78%	86% (national benchmark)	Increase - 9.78% (objective met)
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. Baseline 2007: 68%	77.93%	80.61%	Increase – 9.93% (objective met)

Quality Strategy Objectives				
Goals	Objectives	2010 Statewide Rate	2010 National Average	Change from Baseline Statewide Rate to 2010 Statewide Rate
	4.2 By 2013, the statewide weighted HEDIS rate for controlling high blood pressure will increase to 55%. Baseline 2007: 50%	53.67%	55.22%	Increase – 3.67%
	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. Baseline 2010: 37.93% for 7 day and 61.24% for 30 day	a. 7 day-37.93% b. 30 day-61.24%	a. 42.69% b. 60.04%	Due to changes in MCOs, 2010 will become the baseline for this measure
	4.4 By the end of each demonstration year, the state will achieve a total statewide EPSDT screening rate of at least 80%. Baseline 2007: 77%	99%	Not a HEDIS/CAHPS measure	Increase – 22% (objective met)
	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. Baseline 2010: 50.11%	a. Acute-50.11% b. Continuation-32.03%	a. 49.65% b. 32.95%	Due to changes in MCOs, 2010 will become the baseline for this measure

Quality Strategy Objectives				
Goals	Objectives	2010 Statewide Rate	2010 National Average	Change from Baseline Statewide Rate to 2010 Statewide Rate
	acute phase; 32.03% for continuation phase			
	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. Baseline 2010: 34.29% initiation; 44.15% continuation	a. Initiation- 34.29% b. Continuation- 44.15%	a. 36.45% b. 41.71%	Due to changes in MCOs, 2010 will become the baseline for this measure

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's Division of 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 Early, Periodic, Screening, Diagnosis, and Treatment (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 January, TennCare plans to review the Quality Strategy and provide a report to CMS by April 1 of each year that will include information on the implementation and effectiveness of the strategy. A revised strategy will be provided whenever significant changes occur in the TennCare Program.

V. Conclusions

Successes considered best practices

The following MCO promising practices have been identified for 2010:

Performance Measure Validation

- A strong commitment to and knowledge of the HEDIS reporting process.
- Each year, the MCOs efforts have become more sophisticated and coordinated, despite their geographically diverse staff.
- The use of NCQA-certified HEDIS reporting software, ensuring compliance with measure algorithms and the accurate production of HEDIS results.
- Claims data that is increasingly aligned across MCO business lines and/or regions. Internal processes helped ensure that claims were processed completely and accurately in the face of these changes.

Performance Improvement Projects

- Well-founded study topics based on high-volume and/or high-risk conditions
- Quality improvement strategies and processes based on data-driven causal/barrier analysis
- Continuous quality improvement for monitoring and modifying interventions.

- A foundation for comparing study results and tracking progress with the potential to affect member health, functional status or satisfaction

Annual Network Adequacy and Benefit Delivery Review

- Adherence to the network access and availability requirements established by TennCare. The majority of TennCare MCOs met or exceeded network requirements.
- Appropriate policies and procedures to ensure that qualified providers were accepted into the network. Credentialing and recredentialing files were well organized and information was easily accessible. The credentialing policies maintained by the MCOs were consistent with industry standards.
- Communication of existing benefits via member and provider handbooks. The MCOs also provided evidence that members and providers were notified of benefit changes via additional written materials, newsletters or notifications posted on health plan websites.

Annual Quality Survey

- *Substantial or Total Compliance* ratings across virtually all quality process standards and performance activities.
- Strong outreach, particularly for members age 20 and younger. The health plans continued making new member calls even though they were no longer required based on the high screening rates cited above.
- A commitment to care coordination. Examples included referrals to the Department of Children's Services for high emergency department utilization, internal assessments of physical-behavioral service integration and statewide collaboratives.

HEDIS/CAHPS 2010

Continuing the trend from the previous two years, improved statewide performance was noted in child health measures with some exceeding the HEDIS 2010 Medicaid National Average. Specifically, there was an increase in rates from HEDIS 2008 to HEDIS 2010 for:

- Childhood Immunization Status- all antigens demonstrated an increase
- Lead Screening in Children
- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection
- Well-Child Visits in the First 15 months of Life (6 or more visits)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
- Adolescent Well-Care Visits

Although Chronic Disease Management was previously identified as an area for improvement, gains continue to be made in the following HEDIS measures:

- Cholesterol Management for Patients with Cardiovascular Conditions
- Comprehensive Diabetes Care

- Controlling High Blood Pressure
- Annual Monitoring for Patients on Persistent Medications
- Medical Assistance with Smoking and Tobacco Use Cessation (Advising Smokers and Tobacco Users to Quit and Discussing Cessation Medications)

HEDIS 2010 marks the first year of statewide reporting of Behavioral Health measures following integration of medical-behavioral health services among TennCare's MCOs. Antidepressant Medication Management (Effective Acute Phase Treatment) was higher than the 2010 Medicaid National Average.

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

Over the last few years some of the Managed Care Contractors have changed. The most recent change occurred in 2010 with the Dental Benefits Manager changing from Doral to Delta Dental. As is always the case when major changes occur, there is a period of transition that can be challenging. The Bureau of TennCare has worked closely with each new contractor to assure that services are continued without interruption and that enrollees are not inconvenienced. Close monitoring will continue to occur in the future through reporting mechanisms, on-site visits, meetings and conference calls.

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

- **Continue the CHOICES Special Study:** In July 2009, CMS approved an amendment to the TennCare waiver that allows MCOs to coordinate all of the care a TennCare member receives, which will now include medical, behavioral and long-term care. Implementation of CHOICES for the Middle Grand Region MCOs occurred March 1, 2010 and the East and West Grand Region MCOs August 1, 2010. TennCare is requiring the MCOs to participate in a CHOICES Special Study focusing on the topic of rebalancing the long-term care system. CMS *Protocols for Conducting Performance Improvement Projects* and the Money Follows the Person (MFP) Demonstration Grant were used as resources to develop the study topic and indicators. In 2010, workgroups were held with the MCOs to finalize the sources for data collection and methodology. 2011 marks the first year of reporting activities for the CHOICES Special Study.
- **Rotate Performance Improvement Project Validation Study Topics:** Performance Improvement Project (PIP) study topics will continue to be rotated for validation to ensure Managed Care Contractors (MCC) are universally applying sound methodologies to all PIPs. The rotation process was instituted because it seemed more attention to detail was paid to those projects that were going to be validated.
- **Enhance monitoring of integration of physical and behavioral health services:** Coordination of services between physical and behavioral health providers of care will continue to be monitored carefully.
- **Continuation of collaborative workgroups:** The Division of Quality Oversight has established collaborative workgroups that include representatives for each MCO, the EQRO, and other TennCare contractors as appropriate. At this time there are three active workgroups. Other groups will be established as needs are identified. The groups and their current areas of focus are as follows:

- Diabetes Collaborative – ways to increase HEDIS rates for retinal eye exams
- Maternity Collaborative - outreach to pregnant women. Previously this group has addressed smoking cessation
- EPSDT – outreach to teens
- **Establish performance measures for other activities conducted by the MCOs.** The Division is currently implementing performance measures for Disease Management Programs.
- **Place an increased emphasis on data collection for racial and ethnic disparities.** The MCCs are required, by October 1, 2011, to provide the Bureau of TennCare with a plan that describes how they intend to collect data in accordance with the HHS initiative to implement a multifaceted health disparities data collection strategy.

Appendix A: State Requirements Deemed Met by NCQA Accreditation Surveyⁱ

Access to Care

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
42 CFR 438.206 Availability of Services	<i>CRA § 2.11.1.5.1-.4 (E/W, Middle and TCS)</i> The CONTRACTOR may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following: The member’s health status, medical, behavioral health, or long-term care, or treatment options, including any alternative treatment that may be self administered; Any information the member needs in order to decide among all relevant treatment options; The risks, benefits, and consequences of treatment or non-treatment; or The member’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.	QI 3B Affirmative Statement 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 § 2.12.9.18, .20 and .50 (E/W, Middle and TCS)</i> All provider agreements executed by the CONTRACTOR, and all provider agreements executed by subcontracting entities or organizations, shall...meet the following requirements: Provide that TENNCARE, DHHS OIG, Office of the Comptroller of the Treasury, OIG, TBI MFCU, and DOJ, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this Agreement including, but not limited to medical records, billing records, financial	QI 3A Practitioner Contracts and QI 3C Provider Contracts QI 3A Practitioner Contracts Contracts with practitioners specifically require that: <ol style="list-style-type: none"> 1. Practitioners cooperate with QI activities 2. The organization has access to practitioner medical records, to the extent permitted by state and federal law 3. Practitioners maintain the confidentiality of member information and records QI 3C Provider Contracts Contracts with organization providers specifically require that: <ol style="list-style-type: none"> 1. Providers cooperate with QI activities 2. The organization has access to provider medical records, to the extent permitted by state and federal law

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	<p>records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. Include a statement that HIPAA does not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to, OIG, TBI MFCU, DHHS OIG and DOJ. Provide that any authorized state or federal agency or entity, including, but not limited to TENNCARE, OIG, TBI MFCU, DHHS OIG, DOJ, Office of the Comptroller of the Treasury, may use these records and information for administrative, civil or criminal investigations and prosecutions; Provide for the participation and cooperation in any internal and external QM/QI, monitoring, utilization review, peer review and/or appeal procedures established by the CONTRACTOR and/or TENNCARE; Require safeguarding of information about enrollees according to applicable state and federal laws and regulations...</p>	<p>3. Providers maintain the confidentiality of member information and records</p>
	<p><i>CRA §2.18.1.1 and .4, and 2.18.4.3 and .4 (E/W, Middle and TCS)</i></p>	<p>UM 3A Access to Staff</p>

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	<p>The CONTRACTOR shall operate a toll-free telephone line (member services information line) to respond to member questions, concerns, inquiries, and complaints from the member, the member’s family, or the member’s provider.</p> <p>The CONTRACTOR shall ensure that the member services information line is staffed adequately to respond to members’ questions, at a minimum, from 8 a.m. to 5 p.m., in the time zone applicable to the Grand Region being served (for the Middle Grand Region, the applicable time zone shall be Central Time), Monday through Friday, except State of Tennessee holidays.</p> <p>The CONTRACTOR shall develop provider service line policies and procedures that address staffing, training, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.</p> <p>The CONTRACTOR shall ensure that the provider service line is staffed adequately to respond to providers’ questions at a minimum from 8 a.m. to 5 p.m., in the time zone applicable to the Grand Region being served (for the Middle Grand Region, the applicable time zone shall be Central Time), Monday through Friday, except State of Tennessee holidays.</p>	<p>The organization provides the following communication services for members and practitioners.</p> <ol style="list-style-type: none"> 1. Staff are available at least eight hours a day during normal business hours for inbound calls regarding UM issues 2. Staff can receive inbound communication regarding UM issues after normal business hours 3. Staff can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon 4. Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues 5. Staff or a toll-free number are available to accept collect calls regarding UM issues 6. Staff are accessible to callers who have questions about the UM process
	<p><i>CRA §2.18.3 and 2.18.2-2.18.3 (E/W, Middle and TCS)</i></p>	<p>QI 4A Cultural Needs and Preferences and RR 4B Interpreter Services</p>
	<p>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.</p> <p>The CONTRACTOR shall provide interpreter and translation services free of charge to members.</p> <p>Interpreter services should be available in the form of</p>	<p>QI 4A Cultural Needs</p> <p>The organization assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary.</p> <p>RR 4B Interpreter Services</p> <p>The organization provides interpreter or bilingual services within its Member Services Department and telephone function based on the linguistic needs of its members.</p>

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	in-person interpreters, sign language or access to telephonic assistance, such as the ATT universal line.	
42 CFR 438.208 Coordination and Continuity of Care	<i>CRA § 2.9.4.1.1-.2 (E/W, Middle and TCS)</i>	QI 10C Continued Access to Practitioners
	Except as provided below regarding members who are in their second or third trimester of pregnancy, the CONTRACTOR shall provide continuation of such provider for up to ninety (90) calendar days or until the member may be reasonably transferred to another provider without disruption of care, whichever is less. For members in their second or third trimester of pregnancy, the CONTRACTOR shall allow continued access to the member’s prenatal care provider and any provider currently treating the member’s chronic or acute medical or behavioral health condition or currently providing long-term care services, through the postpartum period.	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 § 2.9.4.1 (E/W, Middle and TCS)</i>	QI 10D Transition to Other Care
The CONTRACTOR shall actively assist members with chronic or acute medical or behavioral health conditions, members who are receiving long-term care services, and members who are pregnant in transitioning to another provider when a provider currently treating their chronic or acute medical or behavioral health condition, currently providing their long-term care services, or currently providing prenatal services has terminated participation with the CONTRACTOR. For CHOICES members, this assistance shall be provided by the member’s care coordinator/care coordination team.	The organization assists with a member’s transition to other care, if necessary, when benefits end.	
42 CFR 438.210 Coverage and Authorization of Services	<i>CRA § 2.7.1.2-.3 (E/W, Middle and TCS)</i>	UM 12A Policies and Procedures and UM 12C Organization's Authorized Representative
	...The CONTRACTOR shall base coverage decisions for emergency services on the severity of the symptoms at the time of presentation and shall cover emergency	UM 12A Policies and Procedures The organization’s emergency services policies and procedures require coverage of emergency services in the following

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	<p>services where the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. The CONTRACTOR shall not impose restrictions on coverage of emergency services more restrictive than those permitted by the prudent layperson standard. The CONTRACTOR shall provide coverage for inpatient and outpatient emergency services, furnished by a qualified provider, regardless of whether the member obtains the services from a contract provider, that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard. These services shall be provided without prior authorization in accordance with 42 CFR 438.114. The CONTRACTOR shall pay for any emergency screening examination services conducted to determine whether an emergency medical condition exists and for all emergency services that are medically necessary until the member is stabilized.</p>	<p>situations.</p> <ol style="list-style-type: none"> 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 2. If an authorized representative, acting for the organization, authorized the provision of emergency services <p>UM 12C Organization's Authorized Representative 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>QI 8B Program Content</p>
	<p>Each DM program shall include the development of treatment plans, as described in NCQA Disease Management program content, that serve as the outline for all of the activities and interventions in the program. At a minimum the activities and interventions associated with the treatment plan shall address condition monitoring, patient adherence to the treatment plan, consideration of other co-morbidities, and condition-related lifestyle issues. For CHOICES members, appropriate elements of the treatment plan shall be individualized and integrated into the member's plan of care to facilitate better management of the member's condition.</p>	<p>The content of the organization's programs addresses the following for each condition.</p> <ol style="list-style-type: none"> 1. Condition monitoring 2. Patient adherence to the program's treatment plans 3. Consideration of other health conditions 4. Lifestyle issues, as indicated by practice guidelines (e.g., goal-setting techniques, problem solving)
	<p><i>CRA § 2.8.2.1, 2.8.1.4 and 2.8.1.4.2 (E/W, Middle and TCS)</i></p>	<p>QI 8C Identifying Members for DM Programs and QI 8D Frequency of Member Identification</p>

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	<p>The CONTRACTOR shall have a systematic method of identifying and enrolling eligible members in each DM program, including CHOICES members, through the same processes used for identification of non-CHOICES members and the CHOICES care coordination process. The CONTRACTOR shall develop and maintain DM program descriptions. These program descriptions shall include...the following: Member identification strategies, which shall not exclude CHOICES members, including dual eligible CHOICES members.</p>	<p>QI 8C Identifying Members for DM Programs The organization uses the following sources to identify members who qualify for DM programs.</p> <ol style="list-style-type: none"> 1. Claim or encounter data 2. Pharmacy data, if applicable 3. Health risk appraisal results 4. Laboratory results, if applicable 5. Data collected through the case management or UM process, if applicable 6. Member and practitioner referrals <p>QI 8D Frequency of Member Identification 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>
	<p><i>CRA §2.8.2.2 (E/W, Middle and TCS)</i></p>	<p>QI 8E Providing Members with Information</p>
	<p>The CONTRACTOR shall operate its disease management programs using an “opt out” methodology, meaning that disease management services shall be provided to eligible members unless they specifically ask to be excluded.</p>	<p>The organization provides eligible members with the following written information about the program.</p> <ol style="list-style-type: none"> 1. How to use the services 2. How members become eligible to participate 3. How to opt in or opt out
	<p><i>CRA § 2.8.3 (E/W, Middle and TCS)</i></p>	<p>QI 8F Interventions Based on Assessment</p>
	<p>As part of the DM programs, the CONTRACTOR shall classify eligible members into stratification levels according to condition severity or other clinical or member-provided information which, for members enrolled in the CHOICES program shall also include stratification by the type of setting in which long-term care services are delivered, i.e., nursing facility, community-based residential alternative, or home-based. The DM programs shall tailor the program content and education activities for each stratification level. For CHOICES members, this shall include targeted interventions based on the setting in which the member resides.</p>	<p>The organization provides interventions to members based on assessment.</p>

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	<i>CRA §2.8.7.2, 2.8.7.2.4 and 2.8.7.2.5 (E/W, Middle and TCS)</i>	QI 8G Eligible Member Participation
	<p>The CONTRACTOR shall establish measurable benchmarks and goals for each DM program and shall evaluate the programs using these benchmarks and goals. The calculations for the benchmarks and goals should include non-CHOICES members only. These benchmarks and goals shall include:</p> <p>The passive participation rates (as defined by NCQA) and the number of individuals participating in each level of each of the DM programs;</p> <p>Member adherence to treatment plans.</p>	<p>The organization annually measures member participation rates.</p>
	<i>CRA §2.8.6 (E/W, Middle and TCS)</i>	QI 8H Informing and Educating Practitioners
	<p>As part of the DM programs, the CONTRACTOR shall educate providers regarding the guidelines and shall distribute the guidelines to providers who are likely to treat enrollees with the DM conditions. This includes, but is not limited to, PCPs and specialists involved in treating that particular condition. The CONTRACTOR shall also provide each PCP with a list of their patients enrolled in each DM program upon the member's initial enrollment and at least annually thereafter. The CONTRACTOR shall provide specific information to the provider concerning how the program(s) works. The DM's provider education shall be designed to increase the providers' adherence to the guidelines in order to improve the members' conditions.</p>	<p>The organization provides practitioners with written information about the program that includes the following.</p> <ol style="list-style-type: none"> 1. Instructions on how to use disease management services 2. How it works with a practitioner's patients in the program
	<i>CRA §2.8.7.1 (E/W, Middle and TCS)</i>	QI 8J Satisfaction With Disease Management
	<p>The CONTRACTOR shall evaluate member satisfaction with the DM services (as described by NCQA) by systematically analyzing feedback from members and analyzing member complaints and inquiries at least annually. The feedback on satisfaction shall be specific to DM programs.</p>	<p>The organization annually evaluates satisfaction with its disease management services by:</p> <ol style="list-style-type: none"> 1. Obtaining member feedback 2. Analyzing member complaints and inquiries

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	<p><i>CRA § 2.14.1.1 (E/W, Middle and TCS)</i></p> <p>The CONTRACTOR shall develop and maintain a utilization management (UM) program. As part of this program the CONTRACTOR shall have policies and procedures with defined structures and processes. The UM program shall assign responsibility to appropriate individuals including a designated senior physician and shall involve a designated behavioral health care practitioner in the implementation of behavioral health aspects of the program and a designated long-term care professional in the implementation of the long-term care aspects of the program. The UM program shall be supported by an associated work plan and shall be evaluated annually and updated as necessary.</p>	<p>UM 1A Written Program Description and UM 1D Annual Evaluation</p> <p>UM 1A Written Program Description The organization's UM program description includes the following.</p> <ol style="list-style-type: none"> 1. A written description of the program structure 2. Behavioral healthcare aspects of the program 3. Involvement of a designated senior physician in UM program implementation 4. Involvement of a designated behavioral healthcare practitioner (BHP) in the implementation of the behavioral healthcare aspects of the UM program 5. The program scope and process used to determine benefit coverage and medical necessity 6. Information sources used to determine benefit coverage and medical necessity <p>UM 1D Annual Evaluation The organization annually evaluates and updates the UM program as necessary.</p>
	<p><i>CRA § 2.14.1.1 (E/W, Middle and TCS)</i></p> <p>The CONTRACTOR shall develop and maintain a utilization management (UM) program. As part of this program the CONTRACTOR shall have policies and procedures with defined structures and processes. The UM program shall assign responsibility to appropriate individuals including a designated senior physician and shall involve a designated behavioral health care practitioner in the implementation of behavioral health aspects of the program and a designated long-term care professional in the implementation of the long-term care aspects of the program. The UM program shall be supported by an associated work plan and shall be evaluated annually and updated as necessary.</p>	<p>UM 1B Physician Involvement and UM 1C Behavioral Health Involvement</p> <p>UM 1B Physician Involvement A senior physician is actively involved in implementing the organization's UM program.</p> <p>UM 1C Behavioral Health Involvement A BHP is actively involved in implementing the behavioral health aspects of the UM program.</p>

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	<p><i>CRA § 2.14.1.7 and 2.14.1.9 (E/W, Middle and TCS)</i></p> <p>...The CONTRACTOR shall not place maximum limits on the length of stay for members requiring hospitalization and/or surgery. The CONTRACTOR shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each member and his/her medical history. The CONTRACTOR shall consider individual member characteristics in the determination of readiness for discharge. This requirement is not intended to limit the ability of the CONTRACTOR to use clinical guidelines or criteria in placing tentative limits on the length of a prior authorization or pre-admission certification.</p> <p>The CONTRACTOR shall assure, consistent with 42 CFR 438.6(h), 42 CFR 422.208 and 422.210, that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member.</p>	<p>UM 4F Affirmative Statement About Incentives</p> <p>The organization distributes a statement to all members and to all practitioners, providers and employees who make UM decisions, affirming the following.</p> <ol style="list-style-type: none"> 1. UM decision making is based only on appropriateness of care and service and existence of coverage 2. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care 3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization
	<p><i>CRA § 2.14.1.6 (E/W, Middle and TCS)</i></p> <p>The CONTRACTOR shall use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorization and decision making. The CONTRACTOR shall have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than</p>	<p>UM 4A Licensed Health Professionals</p> <p>The organization has written procedures:</p> <ol style="list-style-type: none"> 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions 2. Specifying the type of personnel responsible for each level of UM decision-making

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	<p>requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease or, in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services.</p>	
	<p><i>CRA § 2.14.1.1 and 2.14.1.6 (E/W, Middle and TCS)</i></p>	<p>UM 4B Use of Practitioners for UM Decisions, UM 4C Practitioner Review of Non-BH Denials, and UM 4D Practitioners Review of BH Denials</p>
	<p>The CONTRACTOR shall develop and maintain a utilization management (UM) program. As part of this program the CONTRACTOR shall have policies and procedures with defined structures and processes. The UM program shall assign responsibility to appropriate individuals including a designated senior physician and shall involve a designated behavioral health care practitioner in the implementation of behavioral health aspects of the program and a designated long-term care professional in the implementation of the long-term care aspects of the program. The UM program shall be supported by an associated work plan and shall be evaluated annually and updated as necessary.</p> <p>The CONTRACTOR shall use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorization and decision making. The CONTRACTOR shall have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional who has</p>	<p>UM 4B Use of Practitioners for UM Decisions 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:</p> <ol style="list-style-type: none"> 1. Education, training or professional experience in medical or clinical practice 2. A current license to practice without restriction <p>UM 4C Practitioner Review of Non-BH Denials 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.</p> <p>UM 4D Practitioners Review of BH Denials 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.</p>

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	<p>appropriate clinical expertise in treating the member's condition or disease or, in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services.</p>	
	<p><i>CRA § 2.14.1.6 (E/W, Middle and TCS)</i></p>	<p>UM 4 E Use of Board-Certified Consultants</p>
	<p>The CONTRACTOR shall use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorization and decision making. The CONTRACTOR shall have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease or, in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services.</p>	<p>The organization has written procedures for using board-certified consultants and evidence that it uses these procedures to assist in making medical necessity determinations.</p>
	<p><i>CRA § 2.14.1.4.1-.5 (E/W, Middle and TCS)</i></p>	<p>UM 2A UM Criteria</p>
	<p>The UM program shall have criteria that: Are objective and based on medical, behavioral health and/or long-term care evidence, to the extent possible; Are applied based on individual needs; Are applied based on an assessment of the local delivery system; Involve appropriate practitioners in developing, adopting and reviewing them; and Are annually reviewed and up-dated as appropriate.</p>	<p>The organization: 1. Has written UM decision-making criteria that are objective and based on medical evidence 2. Has written policies for applying the criteria based on individual needs 3. Has written policies for applying the criteria based on an assessment of the local delivery system 4. Involves appropriate practitioners in developing, adopting and reviewing criteria 5. Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate</p>

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	<i>CRA § 2.14.1.1 (E/W, Middle and TCS)</i>	UM 6A Information for UM Decision Making
	<p>The CONTRACTOR shall develop and maintain a utilization management (UM) program. As part of this program the CONTRACTOR shall have policies and procedures with defined structures and processes. The UM program shall assign responsibility to appropriate individuals including a designated senior physician and shall involve a designated behavioral health care practitioner in the implementation of behavioral health aspects of the program and a designated long-term care professional in the implementation of the long-term care aspects of the program. The UM program shall be supported by an associated work plan and shall be evaluated annually and updated as necessary.</p>	<p>For at least 12 months, the organization has had in place a written description that identifies the information needed to support UM decision making.</p>
	<i>CRA § 2.14.2.1 (E/W, Middle and TCS)</i>	UM 7A Notification of Reviewer Availability, UM 7B Discussing a Denial With a Reviewer, and UM 7E Discussing a BH Denial With a Reviewer
	<p>...The policies and procedures shall provide for consultation with the requesting provider when appropriate...</p>	<p>UM 7A Notification of Reviewer Availability The organization notifies practitioners:</p> <ol style="list-style-type: none"> 1. The organization’s policy for making an appropriate practitioner reviewer available to discuss any UM denial decision 2. How to contact a reviewer. <p>UM 7B Discussing a Denial With a Reviewer 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>UM 7E Discussing a BH Denial With a Reviewer 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>
<i>CRA § 2.14.1.10 (E/W, Middle and TCS)</i>	UM 11A Assessing Satisfaction With the UM Process	

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	<p>...The CONTRACTOR shall assess provider/office staff satisfaction with UM processes to identify areas for improvement.</p>	<p>The organization's annual assessment of satisfaction with the UM process includes:</p> <ol style="list-style-type: none"> 1. Collecting and analyzing data on member satisfaction for the identification of improvement opportunities 2. Collecting and analyzing data on practitioner satisfaction for the identification of improvement opportunities 3. Taking action designed to improve member satisfaction based on its assessment of member data 4. Taking action designed to improve practitioner satisfaction based on its assessment of practitioner data

Structure and Operations

Federal Requirements	2010 State Standards	2010 NCQA Standards
<p>42 CFR 438.218 Enrollee Information</p>	<p><i>CRA §2.17.4.1, 2.17.4.7 and 2.17.4.7.25 (E/W, Middle and TCS)</i></p>	<p>RR 1A Statement of Members' Rights and Responsibilities and RR 2A Distribution of Rights Statement to Members and Practitioners</p>
	<p>The CONTRACTOR shall develop a member handbook based on a template provided by TENNCARE, and update it periodically (at least annually). Upon notice to TENNCARE of material changes to the member handbook, the CONTRACTOR shall make appropriate revisions and immediately distribute the revised handbook to members and providers.</p> <p>Each member handbook shall, at a minimum, be in accordance with the following guidelines: Shall include written policies on member rights and responsibilities, pursuant to 42 CFR 438.100 and NCQA's Standards and Guidelines for the Accreditation of MCOs</p>	<p>RR 1A Statement of Members' Rights and Responsibilities 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.</p> <p>RR 2A Distribution of Rights Statement to Members and Practitioners The organization distributes its member rights and responsibilities statement to members and participating practitioners.</p>
<p>42 CFR 438.224 Confidentiality</p>	<p><i>CRA §2.27.2, 2.27.2.8, .13, .15-.17, .22 and .24 (E/W, Middle and TCS);</i></p>	<p>RR 6A Adopting Written Policies</p>
	<p>In accordance with HIPAA regulations, the CONTRACTOR shall, at a minimum: Make available to TENNCARE enrollees the right to</p>	<p>The organization adopts written PHI policies and procedures that address:</p> <ol style="list-style-type: none"> 1. Information included in notification of privacy practices

Federal Requirements	2010 State Standards	2010 NCQA Standards
	<p>amend their PHI data in accordance with the federal HIPAA regulations. The CONTRACTOR shall also send information to enrollees educating them of their rights and necessary steps in this regard; Create and adopt policies and procedures to periodically audit adherence to all HIPAA regulations, and for which CONTRACTOR acknowledges and promises to perform, including but not limited to, the following obligations and actions: Implement all appropriate administrative, technical and physical safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this Agreement and, including but not limited to, confidentiality requirements in 45 CFR Parts 160 and 164; Set up appropriate mechanisms to limit use or disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure; Create and implement policies and procedures to address present and future HIPAA regulation requirements as needed to include: use and disclosure of data; de-identification of data; minimum necessity access; accounting of disclosures; patients rights to amend, access, request restrictions; and right to file a complaint; Adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by CONTRACTOR employees and other persons performing work for the CONTRACTOR to have only minimum necessary access to personally identifiable data within their organization; Be responsible for informing its enrollees of their privacy rights in the manner specified under the regulations.</p>	<ol style="list-style-type: none"> 2. Access to PHI 3. The process for members to request restrictions on use and disclosure of PHI 4. The process for members to request amendments to PHI 5. The process for members to request an accounting of disclosures of PHI 6. Internal protection of oral, written and electronic information across the organization
	<p><i>CRA § 2.27.2 and 2.27.2.8 (E/W, Middle and TCS)</i></p>	<p>RR 6C Authorization</p>

Federal Requirements	2010 State Standards	2010 NCQA Standards
	<p>In accordance with HIPAA regulations, the CONTRACTOR shall, at a minimum: Make available to TENNCARE enrollees the right to amend their PHI data in accordance with the federal HIPAA regulations. The CONTRACTOR shall also send information to enrollees educating them of their rights and necessary steps in this regard.</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, 2.27.2.17 and .18 (E/W, Middle and TCS)</i></p> <p>In accordance with HIPAA regulations, the CONTRACTOR shall, at a minimum: Create and implement policies and procedures to address present and future HIPAA regulation requirements as needed to include: use and disclosure of data; de-identification of data; minimum necessity access; accounting of disclosures; patients rights to amend, access, request restrictions; and right to file a complaint; Provide an appropriate level of training to its staff and enrollees regarding HIPAA related policies, procedures, enrollee rights and penalties prior to the HIPAA implementation deadlines and at appropriate intervals thereafter.</p>	<p>RR 6D Communication of PHI Use and Disclosure</p> <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"> 1. The organization's routine use and disclosure of PHI 2. Use of authorizations 3. Access to PHI 4. Internal protection of oral, written and electronic PHI across the organization 5. Protection of information disclosed to plan sponsors or to employers
<p>42 CFR 438.230 Subcontractual Relationships and Delegation</p>	<p><i>CRA § 2.26.1. and 2.26.1.1 (E/W, Middle and TCS)</i></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</p>	<p>CR (Credentialing)12, RR (Rights and Responsibilities) 8, UM (Utilization Management)15, and/or QI (Quality Improvement)13 D Predelegation Evaluation</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>

Federal Requirements	2010 State Standards	2010 NCQA Standards
	delegated.	
	<i>CRA § 2.26.1.2 (E/W, Middle and TCS)</i>	CR (Credentialing)12, RR (Rights and Responsibilities) 8, UM (Utilization Management)15, and/or QI (Quality Improvement)13 A Written Delegation Agreement
	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 inadequate.	There is a written delegation document: 1. Is mutually agreed upon 2. Describes the responsibilities of the organization and the delegated entity 3. Describes the delegated activities 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 (E/W, Middle and TCS)</i>	CR (Credentialing)12, RR (Rights and Responsibilities) 8, UM (Utilization Management)15, and/or QI (Quality Improvement)13 E Annual Evaluation
	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.
	<i>CRA § 2.26.1.4 (E/W, Middle and TCS)</i>	CR (Credentialing)12, RR (Rights and Responsibilities) 8, UM (Utilization Management)15, and/or QI (Quality Improvement)13 G Opportunities for Improvement
	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	2010 State Standards	2010 NCQA Standards
<p>42 CFR 438.236 Practice Guidelines</p>	<p><i>CRA § 2.8.1.2 (E/W, Middle and TCS)</i></p> <p>Each DM program shall utilize evidence-based clinical practice guidelines (hereafter referred to as the guidelines) that have been formally adopted by the CONTRACTOR’s Quality Management/Quality Improvement (QM/QI) committee or other clinical committee and patient empowerment strategies to support the provider-patient relationship and the plan of care...The guidelines shall include a requirement to conduct a mental health and substance abuse screening. The DM programs for bipolar disorder, major depression, and schizophrenia shall include the use of the evidence-based practice for co-occurring disorders.</p>	<p>QI 9A Factor 2 Adoption and Distribution of Guidelines</p> <p>The organization ensures that practitioners are using relevant clinical practice guidelines by:</p> <p>2. Establishing the clinical basis for the guidelines</p>
	<p><i>CRA § 2.15.4 (E/W, Middle and TCS)</i></p> <p>The CONTRACTOR shall utilize evidence-based clinical practice guidelines in its disease management programs. The guidelines shall be reviewed and revised at least every two (2) years or whenever the guidelines change.</p>	<p>QI 9A Factor 3 Adoption and Distribution of Guidelines</p> <p>The organization ensures that practitioners are using relevant clinical practice guidelines by:</p> <p>3. Updating the guidelines at least every two years</p>
	<p><i>CRA § 2.8.6 (E/W, Middle and TCS)</i></p> <p>As part of the DM programs, the CONTRACTOR shall educate providers regarding the guidelines and shall distribute the guidelines to providers who are likely to treat enrollees with the DM conditions. This includes, but is not limited to, PCPs and specialists involved in treating that particular condition. The CONTRACTOR shall also provide each PCP with a list of their patients enrolled in each DM program upon the member’s initial enrollment and at least annually thereafter. The CONTRACTOR shall provide specific information to the provider concerning how the program(s) works. The DM’s provider education shall be designed to increase</p>	<p>QI 9A Factor 4 Adoption and Distribution of Guidelines</p> <p>The organization ensures that practitioners are using relevant clinical practice guidelines by:</p> <p>4. Distributing the guidelines to the appropriate practitioners.</p>

Federal Requirements	2010 State Standards	2010 NCQA Standards
	the providers' adherence to the guidelines in order to improve the members' conditions.	
42 CFR 438.240(a) Program	<p><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></p> <p>The CONTRACTOR shall have a written Quality Management/Quality Improvement (QM/QI) program that clearly defines its quality improvement structures and processes and assigns responsibility to appropriate individuals. This document shall include a separate section on CHOICES care coordination and must include all of the elements listed below. This QM/QI program shall use as a guideline the current NCQA Standards and Guidelines for the Accreditation of MCOs and shall include the CONTRACTOR's plan for improving patient safety. This means at a minimum that the QM/QI program shall:</p> <p>Address physical health, behavioral health, and long-term care services;</p> <p>Be accountable to the CONTRACTOR's board of directors and executive management team;</p> <p>Have substantial involvement of a designated physician and designated behavioral health practitioner;</p> <p>Have a QM/QI committee that oversees the QM/QI functions;</p> <p>Have an annual work plan;</p> <p>Have resources – staffing, data sources and analytical resources – devoted to it.</p> <p>As part of the QM/QI program, the CONTRACTOR shall collect information on providers' actions to improve patient safety and make performance data available to providers and members.</p> <p>The CONTRACTOR shall have a QM/QI committee which shall include medical, behavioral health, and long-term care staff and contract providers (including medical, behavioral health, and long-term care</p>	<p>QI 1A Quality Improvement Program Structure</p> <p>The organization's QI program description includes the following.</p> <ol style="list-style-type: none"> 1. A written description of the QI program structure 2. Behavioral healthcare aspects of the program 3. Patient safety is specifically addressed in the program description 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

Federal Requirements	2010 State Standards	2010 NCQA Standards
	<p>providers). This committee shall analyze and evaluate the results of QM/QI activities, recommend policy decisions, ensure that providers are involved in the QM/QI program, institute needed action, and ensure that appropriate follow-up occurs. This committee shall also review and approve the QM/QI program description and associated work plan prior to submission to TENNCARE...</p>	
	<p><i>CRA § 2.15.2.1 (E/W, Middle and TCS)</i></p>	<p>QI 2A QI committee Responsibilities</p>
	<p>The CONTRACTOR shall have a QM/QI committee which shall include medical, behavioral health, and long-term care staff and contract providers (including medical, behavioral health, and long-term care providers). This committee shall analyze and evaluate the results of QM/QI activities, recommend policy decisions, ensure that providers are involved in the QM/QI program, institute needed action, and ensure that appropriate follow-up occurs. This committee shall also review and approve the QM/QI program description and associated work plan prior to submission to TENNCARE...</p>	<ol style="list-style-type: none"> 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
	<p><i>CRA § 2.15.2.2 (E/W, Middle and TCS)</i></p>	<p>QI 2B QI committee Minutes</p>
	<p>The QM/QI committee shall keep written minutes of all meetings. A copy of the signed and dated written minutes for each meeting shall be available on-file after the completion of the following committee meeting in which the minutes are approved and shall be available for review upon request and during the annual on-site EQRO review and/or NCQA accreditation review.</p>	<p>QI committee meeting minutes reflect all committee decisions and actions, and are signed and dated.</p>
	<p><i>CRA § 2.15.1.2 (E/W, Middle and TCS)</i></p>	<p>QI 2C Informing Practitioners and Members</p>
	<p>The CONTRACTOR shall make all information about its QM/QI program available to providers and members.</p>	<p>The organization annually makes information about its QI program available to the following groups.</p> <ol style="list-style-type: none"> 1. Members

Federal Requirements	2010 State Standards	2010 NCQA Standards
		2. Practitioners
	<i>CRA §2.15.1.1.7 (E/W, Middle and TCS)</i>	QI 1B Annual Evaluation
	<p>...The QM/QI program shall: Be evaluated annually and updated as appropriate.</p>	<p>There is an annual written evaluation of the QI program that includes the following information.</p> <ol style="list-style-type: none"> 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis of the results of QI initiatives, including barrier analysis 4. Evaluation of the overall effectiveness of the QI program, including progress toward influencing networkwide safe clinical practices

ⁱ Based on the 2010 NCQA Standards and Guidelines for the Accreditation of Health Plans and the Contractor Risk Agreements dated March 1, 2010. The “CONTRACTOR” refers to the Managed Care Organization who has entered into agreement with the Bureau of TennCare.