Tennessee External Quality Review Organization (EQRO)

March 2022

2021 Annual

EQRO Technical Report

TN Division of TennCare

Qsource

Table of Contents

List of Figures

List of Tables

List of Tables

Acknowledgements, Acronyms, and Initialisms[1]

AG ..... Amerigroup Tennessee, Amerigroup, a wholly owned subsidiary of Anthem, Inc.

AGE/AGM/AGW ..... Amerigroup referenced by operational region: East/Middle/West

AMM ..... Antidepressant Medication Management (HEDIS measure)

ANA ..... Annual Provider Network Adequacy and Benefit Delivery Review

Anthem ..... a registered trademark of Anthem Insurance Companies, Inc.

AON ..... Area of Noncompliance

AQS ..... Annual Quality Survey

ASH ..... Abortion, Sterilization, and Hysterectomy

BC ..... BlueCare Tennessee℠ and BlueCare, independent Licensees of the BlueCross BlueShield Association

BCE/BCM/BCW ..... BlueCare Tennessee referenced by operational region: East/Middle/West

BE-SMART ..... Buprenorphine Enhanced and Supportive Medication-Assisted Recovery and Treatment

BH ..... Behavioral Health

BlueCross®, BlueShield® ..... registered marks of the BlueCross BlueShield Association

C ..... Clinical or Critical (PIPs)

CAHPS® ..... Consumer Assessment of Healthcare Providers and Systems, a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

CDC ..... Comprehensive Diabetes Care (HEDIS measure)

CFR ..... *Code of Federal Regulations*

CHIP ..... Children's Health Insurance Program

CHOICES ..... a program providing long-term care benefits to members meeting CHOICES program criteria

CIS ..... Childhood Immunization Status (HEDIS measure)

CMS ..... Centers for Medicare & Medicaid Services

COB-AD ..... Concurrent Use of Opioids and Benzodiazepines (Adult Core Set Measure)

CRA ..... Contractor Risk Agreement

CY ..... Calendar Year

D-SNPs ..... Dual-Eligible Special Needs Plans

DBM/DBMC ..... Dental Benefits Manager/DBM Contract

DQ ..... DentaQuest of Tennessee, LLC

ECF ..... Employment and Community First

ED ..... Emergency Department

EPSDT ..... Early and Periodic Screening, Diagnostic, and Treatment

EQR/EQRO ..... External Quality Review/EQR Organization

FUH ..... Follow-Up After Hospitalization for Mental Illness (HEDIS measure)

FY ..... Fiscal Year

GDP ..... General Dental Practitioner

HCBS ..... Home and Community-Based Services

HD ..... HEDIS Determination

HDO ..... Use of Opioids at High Dosages (HEDIS measure)

HEDIS® ..... Healthcare Effectiveness Data and Information Set, a registered trademark of NCQA

HIPAA ..... *Health Insurance Portability and Accountability Act*

HPA ..... Health Plan Administrator

HSAG ..... Health Services Advisory Group, Inc.

[1] *Other company and product names may be trademarks of the respective companies with which they are associated. The mention of such companies and product names is with due recognition and without intent to misappropriate such names or marks.*

I/DD ..... Intellectual/Developmental Disabilities
ID ..... Identification
IMA ..... Immunizations for Adolescents (HEDIS measure)
IS ..... Information System(s)
ISCAT ..... Information Systems Capabilities Assessment Tool
LOC ..... Level of Care
LTSS ..... Long-Term Services and Supports
LTSS-SCP ..... LTSS Shared Care Plan (HEDIS measure)
MCC ..... Managed Care Contractor
MCO ..... Managed Care Organization
MD ..... Doctor of Medicine
MRR ..... Medical Record Review
MY ..... Measurement Year
NA ..... Not Applicable
NC ..... Non-Clinical
NCQA ..... National Committee for Quality Assurance
NCQA HEDIS Compliance Audit™ ..... a trademark of NCQA
NICU ..... Neonatal Intensive Care Unit
NR ..... Not Reported
OB/GYN ..... Obstetrician/Gynecologist
ORM ..... Office Reference Manual
ORx ..... OptumRx
OUD-AD ..... Use of Pharmacotherapy for Opioid Use Disorder (Adult Core Measure)
P ..... Partial
P&P ..... Policy and Procedure
PA ..... Performance Activity
PBM ..... Pharmacy Benefits Manager
PCP ..... Primary Care Provider/Practitioner
PCR ..... Plan All-Cause Readmissions (HEDIS measure)
PDV ..... Provider Data Validation
PIP ..... Performance Improvement Project
PMV ..... Performance Measure Validation
PSS ..... Provider Satisfaction Survey
QAPI ..... Quality Assurance and Performance Improvement
QI/QIP/QIPD ..... Quality Improvement/QI Program/QIP Description
QM/QMP ..... Quality Monitoring/QM Program
QP ..... Quality Process
Qsource® ..... a registered trademark
R ..... Reportable
R1/R1/R3/R4 ..... Remeasurement Year 1, 2, 3, 4
Roadmap ..... Record of Administrative Data Management and Processes
SAA ..... Adherence to Antipsychotic Medications for Individuals with Schizophrenia (HEDIS measure)
SCP ..... Specialty Care Provider
SDF ..... Silver Diamine Fluoride
SSD ..... Diabetes and Cardiovascular Disease Screening and Monitoring for People With Schizophrenia or Bipolar Disorder (HEDIS measure)
TCA ..... Tennessee Code Annotated
TCS ..... TennCare*Select*, administered by BlueCare Tennessee
TDCI ..... Tennessee Department of Commerce and Insurance
TennCare ..... TN Division of TennCare
TN ..... Tennessee
TSA ..... TennCare*Select* Agreement
UHC ..... UnitedHealthcare Community Plan
UHCE/UHCM/UHCW ..... UHC referenced by operational region: East/Middle/West
UnitedHealthcare® ..... a registered mark of UnitedHealth Group, Inc.
UM ..... Utilization Management
W30 ..... Well-Child Visits in the First 30 Months of Life (HEDIS measure)
WCV ..... Child and Adolescent Well-Care Visits (HEDIS measure)

Executive Summary

Overview

Qsource produced this *2021 Annual EQRO Technical Report* to summarize the quality, timeliness, and accessibility of care furnished by the managed care contractors (MCCs) of the State of Tennessee Division of TennCare (TennCare) to the members of the state's Medicaid program. Results were determined by aggregating and analyzing data obtained through the three federally mandated external quality review (EQR) activities that Qsource conducted as the EQR organization (EQRO) for TennCare:

- Monitoring access, timeliness, and quality of care by monitoring compliance with federal and state standards through the Annual Provider Network Adequacy and Benefit Delivery (ANA) Review and the Annual Quality Survey (AQS)
- Monitoring quality of care by validating performance measures (PMV)
- Monitoring quality of care by validating performance improvement projects (PIPs)

These activities were conducted in accordance with the CMS EQR Protocols released in October 2019, which were current during 2020, the measurement year (MY) under review in this report. Qsource's EQR assessment tools review compliance with the following 11 standards of Title 42 *Code of Federal Regulations* (CFR) 438, Subparts D and E:

1. 42 CFR 438.206: Availability of services
2. 42 CFR 438.207: Assurances of adequate capacity and services
3. 42 CFR 438.208: Coordination and continuity of care
4. 42 CFR 438.210: Coverage and authorization of services
5. 42 CFR 438.214: Provider selection
6. 42 CFR 438.224: Confidentiality
7. 42 CFR 438.228: Grievance and appeal systems
8. 42 CFR 438.230: Subcontractual relationships and delegation
9. 42 CFR 438.236: Practice guidelines
10. 42 CFR 438.242: Health information systems
11. Quality assessment and performance improvement (QAPI) standards

For a crosswalk demonstrating how Qsource's assessment tools reflect these required standards, see Appendix A.

During MY2020, TennCare's MCCs included managed care organizations (MCOs) operating in Tennessee's East, Middle, and West Grand Regions; a statewide MCO available to certain TennCare members under age 21 years enrolled by the State; a statewide dental benefits manager (DBM); and a statewide

pharmacy benefits manager (PBM). While TennCare also contracts with a health plan administrator (HPA) and DBM for the CoverKids Children's Health Insurance Program (CHIP), and with nine Dual-Eligible Special Needs Plans (D-SNPs) for Medicare cost-sharing, EQRO reporting for both populations is separate from the TennCare-only population and, therefore, not included in this report.

TennCare annually identifies goals and objectives in a State *Quality Assessment and Performance Improvement Strategy* (Quality Strategy), to provide guidance for the Medicaid program. Qsource meets all the qualifications and standards of independence for EQROs set forth in 42 CFR §438.354, including demonstrated expertise with Medicaid program assessment and managed care policies, processes, and data systems. The Centers for Medicare & Medicaid Services (CMS) supplemented the EQRO reporting parameters of 42 CFR §438.364 in providing guidelines for this report, which includes the following sections:

- Overview of EQRO Activities
- ANA Review, AQS, PMV, and PIP Validation (each including subsections on Assessment Background, Technical Method of Data Collection and Analysis, Description of Data Obtained, and Comparative Findings)
- Conclusions, including any identified performance strengths and recommendations for improvement

Assessments and Results

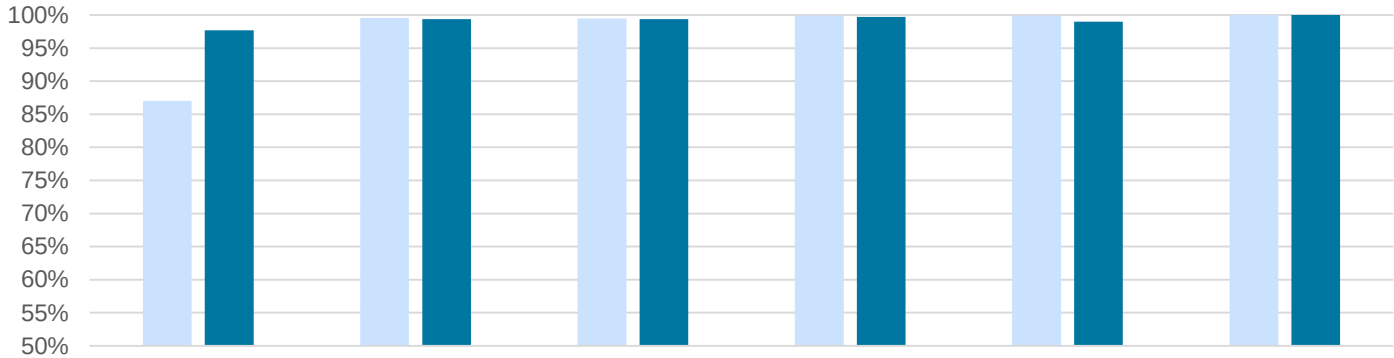
Results from Qsource's 2021 EQR activities show that TennCare's plans are committed to delivering timely, accessible, and high-quality care to members. Findings for each activity are summarized in this section.

The TennCare plans are: Amerigroup (**AG**), referenced by operational region as **AGE** (East), **AGM** (Middle), and **AGW** (West); BlueCare (**BC**), referenced by region as **BCE**, **BCM**, and **BCW**, which also administers the statewide TennCare*Select* (**TCS**); UnitedHealthcare (**UHC**), referenced by region as **UHCE**, **UHCM**, and **UHCW**; DentaQuest (**DQ**), the statewide DBM; and **OptumRx** (**ORx**), the statewide PBM.

Access and Timeliness: ANA Review

Figure 1 shows each MCC's 2021 ANA Review scores. Network Adequacy includes an assessment of the number and type of providers in each MCC's provider network and the proximity of members to these providers. Benefit Delivery is an evaluation of each MCC's delivery of covered benefits (via handbooks, contracts, and policies) to its members and providers. For both overall Network Adequacy and Benefit Delivery scores, all plans earned 99.0% or better with one exception, **AG**, which achieved 87.0% overall for Network Adequacy and 97.7% overall for Benefit Delivery.

Figure 1. 2021 ANA Review Results: Overall Network Adequacy and Benefit Delivery Scores



	AG	BC	TCS	UHC	DQ	ORx
Network Adequacy	87.0%	99.6%	99.5%	>99.9%	>99.9%	100%
Benefit Delivery	97.7%	99.4%	99.4%	99.7%	99.0%	100%

Individual plan results and available trending are presented in the ANA Review section of this report.

Quality, Access, and Timeliness: AQS

The AQS assessed plans for compliance with statewide quality process (QP) standards and operational performance activities (PAs) based on contractual, regulatory, legislative, and judicial requirements. According to CMS Protocol, in order to avoid duplication, elements that were met through a national accrediting entity were deemed. All plans' credentialing and recredentialing policies and procedures (P&Ps) were assessed during the 2021 ANA. Those results, as well as results for CHOICES credentialing and recredentialing file reviews, were included in detail in the *2021 AQS Technical Papers* and *2021 AQS Summary Report* and are included in the AQS section of this report.

As shown in Table 1, 2021 AQS compliance scores were high overall. QP standards are reported as a single statewide score for each MCC. **BC** and **TCS** achieved compliance scores of 100% for all applicable QP standards, while **AG** and **UHC** each fell short of 100% on two of eight standards; **DQ** earned less than 100% on one of its 15 standards, while **ORx** earned less than 100% on one of its eight standards. For the CHOICES credentialing and recredentialing file reviews, all applicable MCOs earned 100% for both quantity and quality ratings except AG (credentialing quantity) and UHC (credentialing quantity and recredentialing quality). PA file review scores are reported by region. During the 2021 AQS, MCO operational regions achieved 100% compliance on all applicable PA file reviews except **AGE**, **AGW**, **UHCE**, **UHCM**, and **UHCW. DQ** earned 100% for all three applicable PAs. *Note: **ORx** is only assessed for QP standards.*

Table 1. 2021 AQS Summary Results						
	AG	**BC**	**TCS**	**UHC**	**DQ**	**ORx**
QP Standards Range	91.3–100%	100%	100%	97.2–100%	98.0–100%	89.2–100%
CHOICES Credentialing/ Recredentialing Range	90.0–100%	100%		90.0–100%		
PA File Reviews Range	AGE: 95.0–100% AGM: 100% AGW: 90.0–100%	BCE: 100% BCM: 100% BCW: 100%	100%	UHCE: 95.0–100% UHCM: 95.0–100% UHCW: 94.9–100%	100%	

Note: Gray cells designate that a measure was not applicable (NA).

Individual MCC results and available trending are presented in the AQS section of this report.

Quality Care: PMV

TennCare requires MCOs to earn National Committee for Quality Assurance (NCQA) accreditation, but this mandate is not applicable to the PBM or DBM. Therefore, the PMV is conducted using NCQA protocols for MCOs and using CMS's *Core Set of Adult Health Care Quality Measures for Medicaid* (Adult Core Set) technical specifications for the PBM. For the DBM, Qsource reviews the Information Systems Capabilities Assessment Tool (ISCAT) that provides the DBM's information and data processing systems and reporting procedures. Accordingly, this report discusses the validations for the MCOs, PBM, and DBM separately.

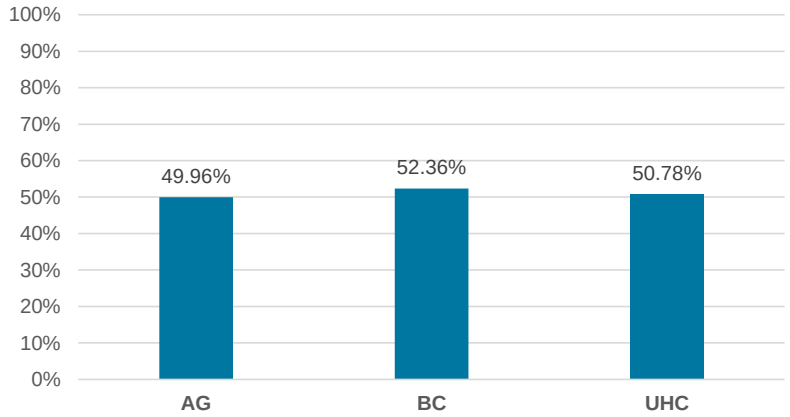
To verify MCC reporting accuracy and compliance with reporting standards, TennCare annually selects two measures (two for MCOs and two for the PBM) for the EQRO to validate. All TennCare MCOs report a full set of Healthcare Effectiveness Data and Information Set (HEDIS) measures as part of NCQA accreditation, while the PBM's measures were selected from the Adult Core Set. The DBM is not required to report performance measures.

MCOs

For the 2021 validations, each MCO passed the audit, was determined to be in full compliance with all standards, and received a Reportable (*R*) designation for the two audited measures: Child and Adolescent Well-Care Visits (WCV) and Well-Child Visits in the First 30 Months of Life (W30). PMV scores are statewide and not reported by operational region. **TCS**, administered by **BC**, was evaluated as one rate with the statewide **BC** data. Figure 2 shows the HEDIS MY2020 rates by MCO for WCV: Total for all three age cohorts, and Figure 3 shows the HEDIS MY2020 rates for W30 by MCO.

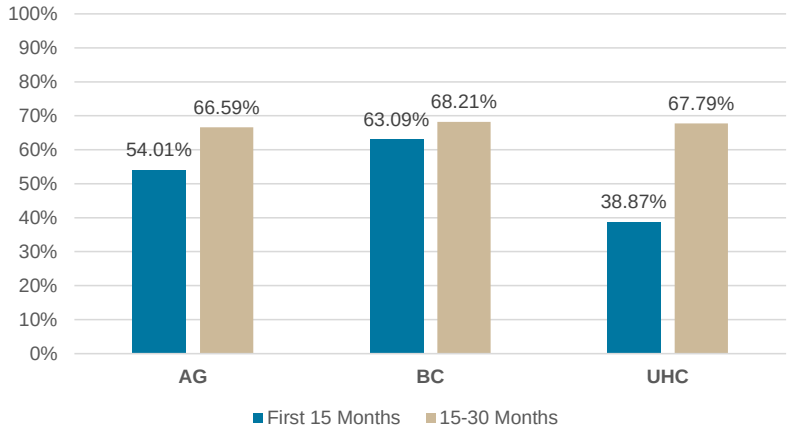
Individual MCO, PBM, and DBM validation results are presented in the PMV section of this report.

Figure 2. HEDIS MY2020 Rates for WCV: Totals



Note: Revised and renamed measure for HEDIS MY2020; trending is not possible.

Figure 3. HEDIS MY2020 MCO Rates for W30



Note: Revised and renamed measure for HEDIS MY2020; trending is not possible.

PBM

ORx was fully compliant with Qsource's claims data system findings, eligibility data system findings, and data integration findings. Based on all validation activities, Qsource determined the two **ORx** measures (Concurrent Use of Opioids and Benzodiazepines [COB-AD] and Use of Pharmacotherapy for Opioid Use Disorder [OUD-AD]) met the Adult Core Set technical specifications, and no issues were identified.

DBM

DQ was fully compliant with Qsource's claims data system findings, eligibility data system findings, and data integration findings.

Quality Care: PIP Validation

Devised by MCCs and approved by TennCare, PIPs measure the effectiveness of quality improvement (QI) interventions in improving processes, healthcare, and QI sustainability. For the year under review, MCCs were contractually required to conduct and report methodologically sound PIPs in accordance with CMS protocol, and to choose topics that reflect Medicaid enrollment demographics and prevalence and potential consequences of disease.

The TennCare Quality Strategy and MCC contracts specify that the DBM and PBM both annually submit one non-clinical and one clinical PIP, and that MCOs annually submit at least three non-clinical and two clinical PIPs, along with a PIP in an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) topic if the MCO has an overall rate below 80% on the State's CMS-416 report. One of the MCOs' non-clinical PIPs must be in long-term services and supports (LTSS), and the clinical PIPs must include

one in behavioral health (relevant to population health programs for bipolar disorder, major depression, or schizophrenia) and one in child or perinatal health. Any PIPs conducted in more than one MCO region must be submitted with region-specific data and information, including improvement strategies, and statewide PIPs are considered valid for each region, if applicable. Since 2015, TennCare has elected to have Qsource validate all PIPs that were underway during the 12 months preceding review. All CRA specifications were met this year in the 58 PIPs conducted by TennCare's plans and submitted for 2021 PIP validation.

This year's PIPs covered 26 study topics (with several shared by more than one MCC), and were at different stages of progress during the review year, from Baseline (initial year) to Remeasurement Year 4. Of the 58 PIPs, all earned a validation status of Met (**Table 2**), and 31 of those also earned overall element scores of 100%. These results reflect Qsource's confidence in the MCCs' topic selections, study designs, and findings, and show that TennCare's MCCs share a commitment to improving the quality of and access to care that members receive.

Table 2. 2021 PIP Validation Statuses

MCC	PIPs Met/Submitted	MCC	PIPs Met/Submitted
AGE	5/5	**TCS**	6/6
AGM	4/4	**UHCE**	5/5
AGW	5/5	**UHCM**	5/5
BCE	6/6	**UHCW**	6/6
BCM	6/6	**DQ**	2/2
BCW	6/6	**ORx**	2/2

Individual MCC results are presented in the PIP Validation section of this report.

Overview

This section provides a brief history of TennCare, its Quality Strategy, the guidelines for this report, and descriptions and objectives of the EQR activities conducted in 2021.

Background

By establishing TennCare on January 1, 1994, Tennessee became the first state in the nation to implement a comprehensive managed care model for Medicaid. The program was granted a five-year §1115 demonstration waiver by the Health Care Financing Administration, now known as CMS. The waiver has been continuously extended and in effect since the original approval.

The model was an attempt to control the escalating costs of Medicaid while continuing to provide quality care for its members. TennCare's revised model also allowed for expanded coverage to include uninsured/uninsurable individuals who were not previously eligible for Medicaid. To achieve these goals, MCCs were selected to provide healthcare services to TennCare members.

In 1996, behavioral health organizations were brought into the managed care system to deliver mental health and substance-abuse treatment services. Similarly, children under the age of 21 years began receiving dental services through a DBM in 2002. Drug benefits for members who were eligible for both TennCare and Medicare were separated in 2000 and for all remaining members in 2003, when a PBM was contracted to manage the drug program.

In 2004, in the face of projections that TennCare's growth would soon make it impossible for the state to meet its obligations in other critical areas, a TennCare Reform package was developed to accomplish goals such as "rightsizing" program enrollment and reducing the dramatic growth in pharmacy spending. With approval from CMS, the state began implementing these modifications in 2005. Additionally, the entire TennCare program shifted in July 2002 from a full-risk to an administrative services-only model during a period of financial instability for some of its MCOs. Under this model, the MCOs received an administrative fee for managing programs, while TennCare was responsible for the medical costs associated with each member.

Since enacting reform measures in early 2005, the TennCare program has stabilized, allowing for a return to the full-risk model under which MCOs are paid a per-member, per-month capitation rate for delivering care. In August 2006, two nationally recognized MCOs with experience in Medicaid managed care were awarded bids under this model, which was also marked by a reintegration of physical and behavioral health services and an enhanced focus on disease management. These MCOs began serving members in the Middle Grand Region on April 1, 2007. West Grand Region MCOs returned to the full-risk, integrated model effective November 1, 2008. East Grand Region MCOs also returned to this model on January 1, 2009, marking integration by all MCOs and eliminating

the need for behavioral health organizations to continue serving TennCare members.

By August 2, 2010, all MCOs began to manage long-term care service delivery for their members as part of the CHOICES Home- and Community-Based Services (HCBS) program. The *Long-Term Care Community Choices Act*, passed by the Tennessee legislature in May 2008, paved the way for this integration while shifting the focus from institutional to home and community-based services. CHOICES HCBS Group 1 and CHOICES HCBS Group 2 were rolled out first, and CHOICES HCBS Group 3 began July 1, 2012. Implementation of the CHOICES program enabled MCOs to be responsible for coordination of all medical, behavioral and long-term supports and services (LTSS) for members, with the exception of pharmacy and dental services. There are now two CHOICES programs in Tennessee: CHOICES HCBS and Employment and Community First (ECF) CHOICES.

On January 1, 2015, new contracts took effect between the State and its existing MCOs—**AG**, **BC**, and **UHC**—with full statewide implementation completed by the end of CY2015. This expanded coverage for all three MCOs and helped ensure quality and accessibility across the state through three covering plans, a PBM, and a DBM.

Effective on July 5, 2019, the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) is the first update to Medicaid and CHIP managed care regulations in over a decade and includes the following goals:

- Support TennCare efforts to advance delivery system reform and through flexible value-based purchasing models and provider reimbursement requirements in the managed care contract.
- Modernize and improve the quality of care through network adequacy standards, resources with accessible and consistent content, a quality rating system, and expanded quality strategies.
- Strengthen the beneficiary experience of care through enrollments and supports, including managed long-term services and supports.
- Improve accountability and transparency through changes in screening processes, encounter data management, and treatment of overpayments, as well as implementation of procedures to prevent fraud, waste, and abuse.
- Align key Medicaid and CHIP managed care requirements with other health coverage programs to smooth beneficiary coverage transitions and ease administrative burdens tied to participation across publicly-funded programs and the commercial market. Requirements include the medical loss ratio and appeals and grievances management.

State Quality Strategy Goals and Evaluation

TennCare's Vision and Mission Statements, Core Values, and goals align with the three aims of the National Quality Strategy: better care, healthy people/healthy communities, and affordable care.

TennCare's Vision and Mission Statements serve as a guide for ensuring quality remains a top priority by providing a strong foundation for TennCare and the services it provides the State of Tennessee:

- **Vision Statement**: "A healthier Tennessee."
- **Mission Statement**: "Improving lives through high-quality cost-effective care."

TennCare also strives to conform to a set of Core Values consistent with its Vision and Mission Statements. These Core Values strongly enhance the foundation already in place:

- **C**ommitment: Ensuring that Tennessee taxpayers receive values for their tax dollars
- **A**gility: Be nimble when situations require change
- **R**espect: Treat everyone as we would like to be treated
- **I**ntegrity: Be truthful and accurate
- **N**ew Approaches: Identify innovative solutions
- **G**reat customer service: Exceed expectations

Using its Vision and Mission Statements and Core Values, TennCare developed four primary goals. These goals work together and help shape TennCare's approach to improving the quality of healthcare for its members:

1. Assure appropriate access to care
2. Provide high-quality, cost-effective care
3. Assure satisfaction with services
4. Improve healthcare

Additional Quality Strategy objectives, assessed through LTSS measures, have been established based on the CHOICES program, which was implemented in 2010. As the name suggests, CHOICES is designed to provide adults who are elderly or have physical disabilities with viable alternatives to institutional care. Quality assurance for these services focuses on the following:

- Levels of care
- Service plans
- Qualified providers
- Health and welfare
- Administrative authority
- Participant rights

To fulfill the requirements outlined in 42 CFR 438.340(c)(2)(i), 438.340(c)(2)(ii), and 457.1240(e), TennCare has elected to have Qsource evaluate the effectiveness of its Quality Strategy via a separate report that measures progress toward the strategy's primary goals and objectives. The *2020 TennCare Quality Strategy Evaluation Summary*, published in 2021 and reviewing the most recent (2020) update of the Quality Strategy, used a variety of data sources to measure effectiveness, including statewide average HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) rates; patient-centered medical home (PCMH) data provided by the NCQA; and TennCare enrollment and claims data.

The 2020 evaluation found that, of the 11 objectives that make up the Quality Strategy's physical and behavioral health goals,

six met or exceeded the goals set forth for 2020, one was partially met, and data for one objective were unavailable due to the COVID-19 pandemic. **Table 3** lists the three objectives and one partial objective that did not fully achieve the 2020 aims, along with EQRO suggestions for the State.

Table 3. 2020 Quality Strategy Evaluation Summary

Quality Strategy Objective	EQR Finding	Statewide Performance MY2019	Statewide Performance Target	EQRO Suggestions for the State
Objective 1.1: The CMS-416 EPSDT screening rate will show incremental improvement through 2020 and beyond, bringing the statewide rate to the CMS standard of 80% in the coming years. 2020 Goal: Continued goal of reaching the 80% benchmark for the statewide rate, with a focus on seeing at least 5% improvement in counties where the rates continue to linger in the 60% range.	The statewide EPSDT screening rate fell slightly short of the 80% goal. Of the 16 counties with screening rates between 60% and 69%, only five improved by 5% or more; however, a total of seven brought their screening rates to 70% or higher.	79%	80%	As raising EPSDT screening rates have presented an ongoing challenge and focus for the MCOs, TennCare could monitor and evaluate successful MCO interventions and require that MCOs with the lowest screening rates adopt and monitor them.
Objective 2.1: By 2019, statewide HEDIS rates for timeliness of prenatal care, frequency of ongoing prenatal care (≥81% of expected visits), and postpartum care will improve to the national medians.	The Timeliness of Prenatal Care rate for the PPC measure fell slightly short of the target. The other PPC rate exceeded the goal. However, while both rates are improvements over previous years, NCQA indicated a break in trending for PPC due to changes in measure specifications for HEDIS 2020.	83.68%	83.76%	TennCare could consider revising the goals for the PPC measure due to NCQA's changes in measure specifications for HEDIS 2020.

Table 3. 2020 Quality Strategy Evaluation Summary				
Quality Strategy Objective	**EQR Finding**	**Statewide Performance MY2019**	**Statewide Performance Target**	**EQRO Suggestions for the State**
Objective 2.4: By 2019, statewide HEDIS rates for the child and adolescent immunization measures will improve to the national medians.	Although the statewide rates for these HEDIS MY2019 measures fell slightly short of the goals, trending with previous years reveals steady improvements in all three rates.	CIS—MMR: 88.90% IMA—Combination 1: 78.02% CIS—Influenza: 44.68%	CIS—MMR: 90.1% IMA—Combination 1: 79.19% CIS—Influenza: 46.91%	TennCare should continue monitoring results for the CIS and IMA measures, as well as the population health measures for Objective 4.2, and determine if any goals may need to be adjusted given new circumstances due to COVID-19. Potential opportunities include identifying alternative settings and sites for vaccine administration or routine care for those avoiding healthcare settings during the pandemic.
Objective 4.2: TennCare members will show improvement across the 3 Population Health outcome measures:	The statewide rates for these population health outcome measures, in which lower rates indicate better performance, did not meet the goals. However, trending shows steady improvement in the ED visit rate over the previous three years.	ED visits per 1000 members—593 30-day readmissions per 100 members—13.6 ESRD per 100 members with diabetes—7.8	ED visits per 1000 members—582 30-day readmissions per 100 members—10.7 ESRD per 100 members with diabetes—7.0	

In addition to these findings, several objectives significantly exceeded the targets, and trending with previous years revealed that many measures have steadily improved over time. Overall, the Quality Strategy represents an effective tool for measuring and improving the quality of TennCare's managed care services.

The CAHPS program (analyzed by the EQRO with the HEDIS) and *The Impact of TennCare: A Survey of Recipients* (a member satisfaction survey administered by the University of Tennessee) are used to measure member satisfaction. TennCare receives Quarterly Point of Service Satisfaction Reports for the CHOICES HCBS and ECF CHOICES programs that provide member satisfaction data entered directly and recorded in electronic visit verification systems.

EQR Activity Descriptions and Objectives

Based on the 2019 CMS EQR Protocols, which were in effect for the entirety of MY2020, EQR requires three mandated activities and can include five optional activities. Each state may also assign other responsibilities to its designated EQRO, such as the provision of ongoing technical assistance. This section summarizes the activities that Qsource performed for TennCare in 2021.

EQR Mandatory Activities

As set forth in 42 CFR §438.358, three mandatory EQR activities must be conducted to assess the performance of the Medicaid plans:

- Monitoring access, timeliness, and quality of care by assessing compliance with federal and state standards through ANA review and AQS
- Monitoring quality of care via PMV
- Monitoring quality of care via PIP validation

Qsource is responsible for the production of this *2021 Annual EQRO Technical Report*, which compiles the results of these EQR activities. Qsource's efforts are a primary means of assessing the quality, timeliness, and accessibility of services provided by TennCare's MCCs. Health Services Advisory Group, Inc. (HSAG), Qsource's subcontractor, assisted in the completion of the ANA.

As mandated by *Tennessee Code Annotated* (TCA) §56-32-131 and at the direction of the Tennessee Department of Commerce and Insurance and TennCare, Qsource performs annual EQR activities to determine each MCC's and benefit manger's compliance with federally mandated activities:

- A brief description of the data collection, aggregation, and analyses for each of the EQR compliance activities
- A summary of findings from each review (ANA review, AQS, PMV, and PIP validation)
- Comparative information and assessments of the degree to which benefit managers have addressed prior year EQRO recommendations for QI
- A summary of strengths and opportunities demonstrated by each MCC in providing healthcare services to TennCare members
- Recommendations for improving the quality of these services

The mandated EQR activity audit periods for TennCare MCCs are summarized in **Table 4** for the measurement year of January–December 2020. Applicable trending results are presented in the individual activity sections of this report.

Table 4. 2021 Audit Periods for EQR Activities

Activity	Audit Period
ANA Review	February–March 2021
AQS	February–May 2021
PMV	March–August 2021
PIP Validation	July–October 2021

The following reports were generated for each of the reviews:

- *2021 ANA Reports* for individual plans
- *2021 AQS Technical Papers* for individual plans
- *2021 AQS Summary Report* for all plans
- *2021 Annual PMV Reports* for individual plans
- *2021 Annual PIP Validation Technical Papers* for individual PIP topics, by plan
- *2021 Annual PIP Validation Summary Report* for all plans

This *2021 Annual EQRO Technical Report* is based on detailed findings that can be examined in the individual and summary reports. Each EQR activity's brief descriptions and objectives are described in the following paragraphs of this section.

ANA

Per 42 CFR §438.206 and their respective contracts, TennCare plans must ensure the following:

- That all covered benefits are available and provided to members;
- That an adequate number of qualified, skilled providers and healthcare facilities are employed or contracted, as defined by the MCO or DBM contract (DBMC); and
- That these providers/facilities have sufficient resources and the ability to guarantee members access to quality medical care for all covered benefits.

ANA reviews are designed to evaluate both the adequacy of each MCC's provider network and the completeness of its member and provider communication regarding TennCare-covered services during the review year. The multiple measures used to assess each are listed in the ANA section of this report.

AQS

The AQS is bound by the same mandates as ANA reviews. AQS requirements are further defined by (1) 42 CFR §434 and 438; (2) each MCC's contract with the state; and (3) additional quality standards established by the State. While the *Grier Revised Consent Decree* and *John B. Consent Decree* have been vacated, the state remains dedicated to continued review of appeals and EPSDT services.

Qsource evaluated MCC compliance using customized QP Standard and PA File Review Tools. These tools provide required data and meaningful information that TennCare and the MCCs can use to

- compare the quality of service and healthcare that MCCs provide to their members, including physical–behavioral integration, where applicable;
- identify, implement, and monitor system interventions to improve quality;
- evaluate performance processes; and
- plan/initiate activities to sustain and enhance current performance processes.

Required data were also obtained through NCQA accreditation, which had been earned by all TennCare MCOs by the end of CY2009. The multiple measures used to assess each are listed in the AQS section of this report.

PMV

To evaluate performance levels, TennCare selected a process for an objective, comparative review of quality-of-care outcomes and performance measures. Its primary aims were to evaluate the accuracy of MCO-reported measures and to determine whether those measures were calculated according to required technical specifications. To satisfy CMS protocol for MCOs and to meet the requirements set forth in 42 CFR §438.358 (b)(1)(ii), TennCare identified for validation the following two HEDIS measures,

defined by the NCQA and validated through an NCQA HEDIS Compliance Audit: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) and Pharmacotherapy for Opioid Use Disorder (POD). Trending and comparisons among MCOs are available in the PMV section of this report.

PIP Validation

The primary objective of the EQRO's PIP validation is to determine the compliance of each MCC with the requirements set forth in 42 CFR §438.330(d)(2). MCCs must conduct PIPs that are designed to achieve, through ongoing measurements and interventions, significant and sustained improvement in clinical and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. PIP study topics must reflect Medicaid enrollment in terms of demographic characteristics and, if applicable, in terms of the prevalence and potential consequences (risks) of disease. Each PIP must be completed in a reasonable timeframe to allow PIP success-related data in the aggregate to produce new information on quality of care every year.

The 2021 PIP validation process evaluated 58 PIPs spread across 9 regional MCOs, one statewide MCO, one DBM, and one PBM. Validation was performed only for ongoing and baseline PIPs that were already underway during the 12 months preceding review. The validation process included a review of each PIP's design and approach, an evaluation of each PIP's compliance with the analysis plan, and an assessment of the effectiveness of plan interventions. The results of the validation process can be found in the PIP section.

Additional Contractual Activities

In addition to those EQR activities mentioned, Qsource provides TennCare and MCCs with technical assistance—an EQR-related activity also defined by 42 CFR §438.358. In this capacity, Qsource maintains ongoing, collaborative communication with TennCare and supports the MCCs and benefit managers in their EQR activities. Further examples of Qsource technical assistance include the following areas of expertise: (a) Medicaid legislation, (b) MCC accreditation standards and guidelines as outlined by NCQA, and (c) continuous QI. Qsource also participates in MCC collaborative workgroups, conducts PIP training for MCC staff, and assists the TennCare Quality Oversight with its strategic planning sessions and Quality Strategy development.

Qsource performs additional activities as part of its EQRO contract with TennCare. These include the following 2021 deliverables:

- *Annual Abortion, Sterilization, and Hysterectomy (ASH) Audit Report*
- *Annual CHOICES Report: Group Enrollment Trend*
- *Annual EPSDT Summary Report*
- *Annual HEDIS/CAHPS Report: Comparative Analysis of Audited Results from TennCare Managed Care Organizations*
- *Annual HEDIS D-SNPs Report*
- *Annual Impact Analysis Report*

- *Medication-Assisted Treatment (MAT) Provider Network Survey*
- *Quarterly Provider Data Validation (PDV) Report*
- Additional ad hoc reports as requested by TennCare

Qsource also conducts meetings with TennCare and representatives of the plans three times a year. The three 2021 meetings featured presentations from experts on disease management strategies; a nurse-family partnership program for low-income mothers; using the chronic disease management model to prevent and treat early childhood caries; enabling technologies for those with disabilities; oral healthcare coordination; integrated addiction care; opioid use disorder disparities in pregnant people; and reducing childhood obesity through physical activity. Qsource posts highlights online within a month of each health plan meeting, which were held on February 9, June 22, and September 15, 2021. (*Note: Due to the COVID-19 pandemic, all meetings were held as live webinars in 2021.)*

Technical Report Guidelines

To assist both EQROs and state agencies, CMS supplemented the requirements of 42 CFR §438.364 and provided guidelines for this *2021 Annual EQRO Technical Report*, which—in addition to the Executive Summary and this Overview—includes the following sections:

- ANA Review
- AQS
- PMV
- PIP Validation
- Summary and Conclusions

State Utilization of the EQRO Technical Report

The *Annual EQRO Technical Report* provides TennCare with unbiased data for the MCCs and benefit managers. As mandated by 42 CFR § 438.364, these data make it possible to benchmark performance statewide and nationally. The data also depict the healthcare landscape for the state's Medicaid population, which assists TennCare in its collaborations with other state agencies to address common health issues—particularly those that are prevalent, chronic, and preventable. TennCare can use these data to measure progress toward goals and objectives of TennCare's Quality Strategy, identify areas where targeted QI interventions could be beneficial, and determine if new or restated goals are needed. Multiyear trending, a critical component for State assessment, is offered where possible and will continue to be evaluated annually.

State Quality Initiatives

Each year TennCare assesses the effectiveness of its Quality Strategy and updates it to include any significant changes since the previous year's strategy regarding program structure, benefits and MCC changes. Updated evaluation data, interventions, and activities are also considered.

TennCare has implemented several initiatives to support both QI among its contractors and the goals of its Quality Strategy. These include the implementation of the Care Coordination Tool, which will perform a number of tasks, including producing risk scores, prioritizing patients and activities based on those scores, tracking gaps in care, and allowing members to view prescription fill information. The implementation of a Clinical Knowledge Module will standardize the clinical information loaded from the admission, discharge information, and transfer information feeds. As use of this module increases, it will allow for the development of a clinical database that will address gaps in care and help reduce hospital admissions.

Through its Quality Apps project, the State the state will have the ability to collect clinical quality data that cannot be acquired from processed medical billing claims. Ultimately, these Quality Apps will provide payers, beginning with the State's Medicaid participating MCOs, with the necessary information to reimburse providers for high quality health outcomes.

TennCare's 2019 Update to State Quality Strategy helped determine the parameters of state Medicaid initiatives, of which Population Health, Pay-for-Performance, and PIP Validation were chosen for inclusion in this report due to the programs' relevance to EQR activities. These represent only a small fraction of TennCare's total efforts.

Population Health

By July 1, 2013, TennCare required each MCC to replace the disease/health management model with operationalized population health programs. By 2014, all MCCs had transitioned from disease management to population health and all TennCare members had been stratified into three population health levels. TennCare's Quality Strategy measures improvement via four population health outcome measures: emergency department (ED) visits, readmissions, neonatal intensive care unit (NICU) babies, and end-stage renal disease.

Unlike disease management, which addresses only those members with existing health conditions, population health is a more comprehensive approach that requires intensive care management for high-risk members and more personalized health management for those at lower risk levels. Population health programs are designed to help members self-manage their conditions and risk factors. TennCare emphasizes improving members' self-management of two specific conditions, pregnancy and diabetes. Statewide collaborative working groups have been established with each MCC. To support those efforts, TennCare requires MCCs to offer the following population health programs:

- Wellness
- Low- to Moderate-Risk Maternity
- "Opt Out" Health Risk Management
- Care Coordination

- "Opt In" Chronic Care Management
- "Opt In" High-Risk Maternity
- "Opt In" Complex Case Management

As part of the evaluation process, all MCOs were required to conduct rapid cycle improvement projects. Some of the successful projects included changing or improving member behavior regarding ED utilization and ensuring newly diagnosed diabetic members receive needed supplies in a timely manner.

Pay-for-Performance

The pay-for-performance initiative has been in place since 2006. The required reporting of HEDIS measures has allowed TennCare to establish performance incentives for those MCOs that meet defined benchmarks. Pay-for-performance quality incentive payments are offered to MCOs that demonstrate significant improvement from the previous reporting period for specified measures in which MCOs scored below the 25th percentile for the National Medicaid Average.

PIP Validation

In addition to the CMS requirements of two PIPs for each plan, TennCare requires MCOs to conduct at least two clinical and three non-clinical PIPs. The DBM and PBM must conduct at least one clinical and one non-clinical PIP. For the MCOs, the two clinical PIPs must include one in the area of behavioral health that is relevant to one of the population health programs for bipolar disorder, major depression, or schizophrenia. The other must be in the area of either child health or perinatal (prenatal/postpartum) health. Furthermore, one of the three non-clinical PIPs is required to be in the area of LTSS. Beginning in 2017, a PIP in the area of EPSDT was also required if the MCO's CMS-416 report rates were lower than 80%. All these specifications were met per CRA requirements in 2021.

Annual Network Adequacy and Benefit Delivery (ANA) Review

Assessment Background

For the ANA reviews, directed by the Tennessee Department of Commerce and Insurance (TDCI) and TennCare, Qsource evaluated each TennCare plan to determine if it had a provider network adequate to ensure the effective and efficient delivery of healthcare to members, pursuant to *TCA* §56-32-131. The ANA reviews were conducted in February–March of 2021.

Technical Methods of Data Collection and Analysis

ANA reviews include a desk audit of documents, an onsite review, administrative data analyses, and measure scoring. Each evaluation area's metric contributes to performance scores via a rating system for an overall Network Adequacy and an overall Benefits Delivery score.

For Network Adequacy, quantitative analyses were conducted of provider files supplied by the plans and downloaded from TennCare. Once extracted from source files, provider and member data were cleaned and imported into SAS for preliminary review. Quest Analytics Suite software was used to further clean and geocode data, including standardizing addresses to United States Postal Service specifications to ensure consistent and accurate assessment of network access by members. Member complaints related to access and availability provided by the plans and TDCI were analyzed to determine a ratio per total members, and CHOICES HCBS and ECF CHOICES data were reviewed by county.

Benefits delivery evaluation was based on desk review of documentation including member handbooks and provider manuals. All credentialing/recredentialing findings and results were incorporated by Qsource into AQS technical papers at TennCare's request. Details on the ANA review process and results can be found in each MCC's *2021 Annual Network Adequacy Report*. ANA assessment tool templates can be found in Appendix B of this report.

Description of Data Obtained

The 2021 ANA measurement period was January 1 to December 31, 2020, and focused on the following data sources:

- The distribution, availability, and assignment of providers to TennCare members
- Provider appointment availability and plan P&Ps
- Provider Manual and Member Handbook
- Sample of provider contracts
- Plan staff interviews, as needed, regarding availability and accessibility of providers to members
- Plan credentialing/recredentialing P&Ps and a sample of CHOICES credentialing/recredentialing files

Comparative Findings

Network Adequacy

All plans achieved high compliance scores for overall Network Adequacy in 2021, with most plans earning 99.0% compliance or better. **Table 5**, **Table 6**, and Table 7 present high-level summaries of the Network Adequacy scores for MCOs, the DBM, and the PBM, respectively.

Table 5. 2021 ANA Network Adequacy Scores: MCO Access/Availability

Measure	AG	BC	TCS	UHC
Primary Care Provider (PCP) Average	99.9%	100%	100%	>99.9%
Specialty Care Provider (SCP) Average	97.1%	97.1%	97.1%	100%
Behavioral Health (BH) Provider Average	100%	>99.9%	>99.9%	>99.9%
Opioid Use Disorder Treatment Providers	0.0%	100%	100%	100%
General Optometry and Hospitals Avg.	99.8%	99.9%	>99.9%	>99.9%
Special Programs Average	100%	100%	100%	100%
CHOICES HCBS Providers Average	100%	>99.9%		>99.9%
ECF CHOICES Providers Average	99.4%	100%		100%
Overall Network Adequacy Score	**87.0%**	**99.6%**	**99.5%**	**>99.9%**

Note: Cells in gray are NA. The value >99.9% was used to distinguish the performance of plans for which at least one member was outside the expected access standard. The overall score, however, is aggregated based on the value rounded to the whole integer. In this case, the value was 100%.

Table 6. 2021 ANA Network Adequacy Scores: DBM Access/Availability

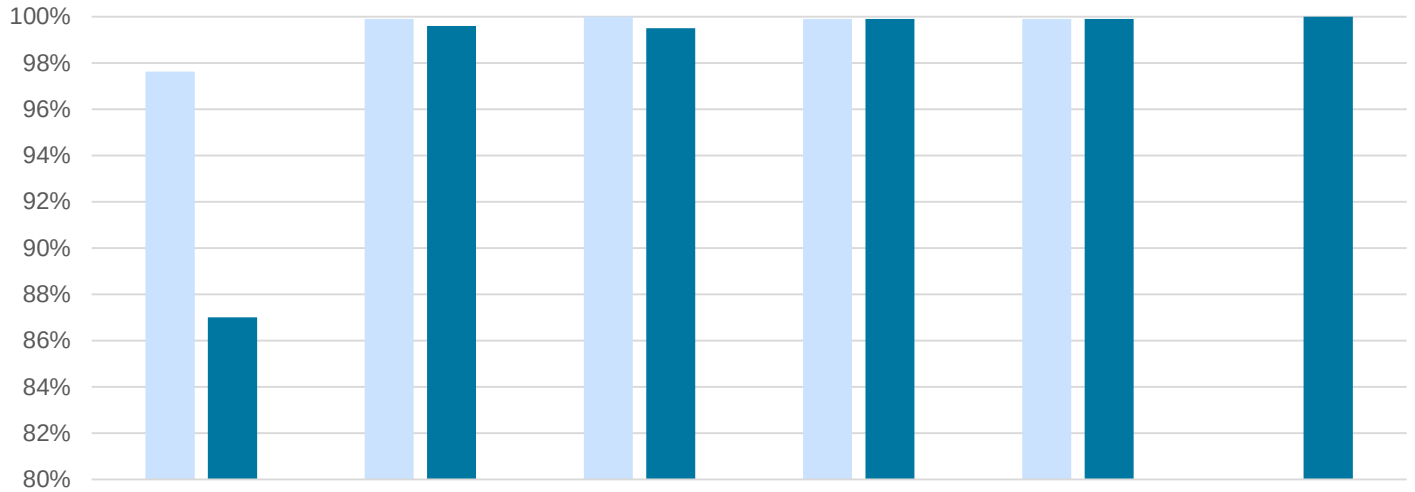
Measure	Standard (max)	Members < 21 Years	ECF CHOICES
General Dental Provider (GDP) Ratio	2,500:1	100%	
GDP Distance	≤30 miles or ≤45 minutes	100%	
Oral Surgery Distance	≤60 miles or ≤60 minutes	100%	
Orthodontic Services Distance	≤60 miles or ≤60 minutes	100%	
Pediatric Dental Services Distance	≤70 miles or ≤70 minutes	100%	
Dental Provider Distance (ECF CHOICES)*	Two: ≤30 miles or ≤45 mins./ ≤60 or ≤60		>99.9%**
Overall Network Adequacy Results: >99.9%			

Note: Cells in gray are NA.
** The distance requirement is one provider within 30 miles travel distance or 45 minutes travel time for 75% of the members, and 60 miles travel distance or 60 minutes travel time for all ECF CHOICES members. The ECF CHOICES distance requirements were calculated using all ECF members selecting dental benefits.*
***The overall score is based on the combination of scores for Standard 1 (75% of members within 30 miles travel distance or <45 minutes travel time) and Standard 2 (100% of members within 60 miles travel distance or 60 minutes travel time). However, because Standard 1 is based on 75% of the non-dual members, the Standard 1 score is adjusted, or weighted, to the total population. This adjusted score is then combined with the Standard 2 score to obtain the overall score.*

Table 7. 2021 ANA Network Adequacy Scores: PBM Access/Availability		
Measure	**Standard (max)**	**ORx**
Urban areas	3 miles and 15 minutes	100%
Suburban areas	10 miles and 20 minutes	100%
Rural areas	25 miles and 30 minutes	100%
Overall Network Adequacy Results: 100%		

Compared to the previous ANA review, several plans showed a slight decline in overall Network Adequacy scores in 2021. **DQ** maintained the same >99.9% score as in 2020, and **UHC**'s changed minimally from 99.9% to >99.9%. However, **AG**'s score declined more than 10 percentage points from 97.6% to 87.0%, while **BC**'s score declined by 0.3 points and **TCS**'s by 0.5. In its first year of the ANA review, **ORx** achieved 100% compliance with the Network Adequacy portion of the review. (See **Figure 4**.)

Figure 4. 2020–2021 Overall Network Adequacy Scores



	AG	BC	TCS	UHC	DQ	ORx
2020	97.6%*	99.9%*	100%	99.9%*	>99.9%	
2021	87.0%	99.6%	99.5%	>99.9%	>99.9%	100%

** Because ANA results were previously reported by operational region, 2020 statewide scores represent an aggregated average of three regional scores for AG, BC, and UHC.*
Note: 2021 was the first year of the ANA review for ORx.

Benefit Delivery

The information in **Table 8** was obtained from reviews of the six areas used to determine the effectiveness of the plans' delivery of covered benefits. TennCare plans earned high compliance scores for overall Benefit Delivery in 2021, ranging from a low of 97.7% (**AG**) to a high of 100% (**ORx**).

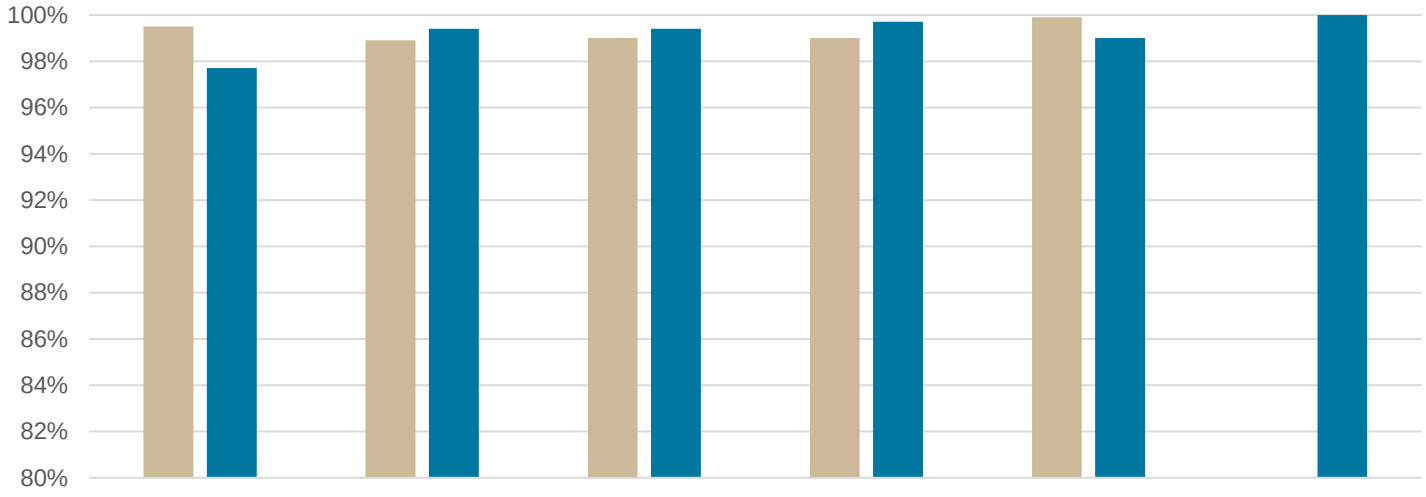
Table 8. 2021 ANA Benefit Delivery Scores: Plan Averages

AG	BC	TCS	UHC	DQ	ORx
Covered Benefits—Member Handbook					
100%	100%	100%	100%	100%	
Covered Benefits—Provider Manual					
98.5%	100%	100%	98.5%	100%	
Appointment Availability—Policies and Procedures					
97.7%	96.6%	96.6%	100%	93.8%	100%
Appointment Availability—Complaints					
>99.9%	>99.9%	>99.9%	>99.9%	>99.9%	100%
MCO Provider Contracts—Quantity					
95.0%	100%	100%	100%	100%	
MCO Provider Contracts—Quality					
95.0%	100%	100%	100%	100%	
Overall Benefit Delivery Results					
97.7%	**99.4%**	**99.4%**	**99.7%**	**99.0%**	**100%**

Note: The value >99.9% was used to distinguish the performance of plans for which at least one member was outside the expected access standard. The overall score, however, is aggregated based on the value rounded to the whole integer. In this case, the value was 100%.

As shown in **Figure 5**, several plans raised their compliance percentages from 2020, with **UHC** showing the most improvement (+0.7 percentage points) and **AG** the highest decline (-1.8 percentage points). In its first year of the ANA review, **ORx** achieved 100% compliance with the Benefit Delivery portion of the review.

Figure 5. 2020–2021 Overall Benefit Delivery Scores



	AG	BC	TCS	UHC	DQ	ORx
2020	99.5%*	98.9%*	99.0%	99.0%*	>99.9%	
2021	97.7%	99.4%	99.4%	99.7%	99.0%	100%

** Because ANA results were previously reported by operational region, 2020 statewide scores represent an aggregated average of three regional scores for AG, BC, and UHC.*
Note: 2021 was the first year of the ANA review for ORx.

Conclusions

Strengths are noted during the ANA review when a plan demonstrates particular proficiency in a given assessment element or plan activity, and are identified regardless of compliance score. Weaknesses, also termed areas of noncompliance (AONs), are identified when a plan achieves less than 100% compliance with an assessment element. **Table 9** lists the strengths and weaknesses for improvement identified for each of the TennCare Medicaid plans during the 2021 ANA review. All strengths and AONs for the ANA review are related to **Access** and **Timeliness** of care.

Table 9. 2021 ANA Review Strengths and AONs

AG	
Strengths	
In 2020, in recognition of the challenges arising from the coronavirus disease 2019 (COVID-19) pandemic, **AG** developed a Virtual Site Visit process to ensure that **AG** maintained the critical long-term services and supports (LTSS) credentialing and recredentialing requirements. **AG** obtained TennCare feedback and approval to ensure this virtual process would meet expectations. **AG** offered highlights of this process to MCO partners with the goal of sharing best practices and further reducing provider abrasion through an aligned approach. This approach prevented any unnecessary outreach to providers and staff members while they were focused on providing ongoing services to the people they support.	
AONs	
Network Adequacy	**AG** achieved a score of 100% in 82 of 88 Network Adequacy measures. For performance improvement, **AG** should ♦ ensure that the provider files sent for the ANA review contain opioid use treatment disorder providers contracted to treat with buprenorphine since the 4th Quarter 2020 geographical access report generated by TennCare confirmed that AG did have those providers on its network. ♦ address the shortage of OB/GYN providers. ♦ address the shortage of optometry providers. ♦ address the shortage of hospitals contracted to provide services to members. ♦ address the shortage of specialized consultation and training providers in Bledsoe, Claiborne, Grainger, Grundy, Hamblen, Hancock, Jefferson, Monroe, Sequatchie, and Sevier counties.
Benefit Delivery	For performance improvement in Benefit Delivery, **AG** should ♦ ensure that plan documents include the requirement to monitor the ratio of members to providers including opioid use disorder providers contracted to treat with methadone. ♦ ensure that every provider contract is signed and dated prior to the provider furnishing services to the TennCare population. ♦ ensure that providers are informed of all available medically necessary employment services/supports for ECF CHOICES members in Groups 4, 5, 6, 7, and 8.

Table 9. 2021 ANA Review Strengths and AONs	
BC	
Strengths	
In 2020, **BC** began using CareTN, a cloud-based digital care management platform that delivers a mobile, interactive, individualized care program to members via smartphone or tablet; furnishes real-time progress and clinical alerts for care managers; and enables easy two-way communication. Each program is targeted toward a specific condition or topics using population data to determine beneficial programs. Members receive educational articles, encouragement, and surveys, and member responses feed into a dashboard used by the care team to deliver care. By increasing interaction and engagement with members, **BC** is able to gather insights from member responses to address social determinants of health, connect members with their providers, schedule appointments and transportation, and escalate clinical concerns to the appropriate care team member with real-time insights. Members gain increased access to health plan services and are encouraged to access and engage with **BC**'s network of high-quality providers.	
AONs	
Network Adequacy	**BC** achieved a score of 100% in 83 of 88 Network Adequacy measures. For performance improvement, **BC** should ♦ ensure that the provider files sent for the ANA review contain opioid use treatment disorder providers contracted to treat with methadone since **BC** furnished other documentation to confirm that its network did include those providers. ♦ address the shortage of dermatology providers contracted to provide services to members. ♦ address the shortage of hospitals contracted to provide services to members. ♦ address the shortage of substance abuse—inpatient facility services providers. ♦ address the shortage of adult day care providers.
Benefit Delivery	For performance improvement in Benefit Delivery, **BC** should ♦ ensure that the correct standards for optometry (i.e., ≤30 miles travel distance and ≤45 minutes travel time, except in rural areas where community standards and documentation apply) are listed in all plan documents, and ♦ ensure that suburban/rural geographic access standards for PCPs and PCP extenders are listed correctly in the Provider Administration Manual (PAM). Suburban/rural requirements include ≤30 miles and ≤45 minutes travel for all members.
TCS	
Strengths	
As **TCS** is administered by **BC**, its Strengths are the same.	
AONs	
Network Adequacy	**TCS** achieved a score of 100% in 54 of 58 Network Adequacy measures. For performance improvement, **TCS** should ♦ ensure that the provider files sent for the ANA review contain opioid use disorder treatment providers (contracted to treat with methadone) since **TCS** furnished other documentation to confirm that its network did include those providers. ♦ address the shortage of dermatology providers contracted to provide services to members. ♦ address the shortage of hospitals contracted to provide services to members. ♦ address the shortage of substance abuse—inpatient facility services providers.

Table 9. 2021 ANA Review Strengths and AONs	
Benefit Delivery	For performance improvement in Benefit Delivery, **TCS** should ♦ ensure that the correct standards for optometry (i.e., ≤30 miles travel distance and ≤45 minutes travel time, except in rural areas where community standards and documentation apply) are listed in all plan documents. ♦ ensure that suburban/rural geographic access standards for PCPs and PCP extenders are listed correctly in the Provider Administration Manual (PAM). Suburban/rural requirements include ≤30 miles and ≤45 minutes travel for all members.
UHC	
Strengths	
In 2020, **UHC** developed TrustPoint, a treatment model that integrates dialysis services with inpatient psychiatric care. Integrating physical, psychiatric, and BH services for individuals with complex medical needs improves care and reduces cost. **UHC** identified and worked closely with a provider in Middle Tennessee to develop the model. Previously, members receiving dialysis had to suspend that treatment when admitted to an inpatient psychiatric facility. With integrated contracting and service coordination, a member can continue dialysis treatment during an inpatient psychiatric stay.	
AONs	
Network Adequacy	**UHC** achieved a score of achieved a score of 100% in 84 of 88 Network Adequacy measures. For performance improvement, **UHC** should ♦ address the shortage of OB/GYN providers. ♦ address the shortage of hospitals contracted to provide services to members. ♦ address the shortage of substance abuse—outpatient treatment services providers. ♦ address the shortage of adult day care providers.
Benefit Delivery	For performance improvement in Benefit Delivery, **UHC** should ensure that providers are informed of assistive technology benefits for ECF CHOICES members in Groups 7 and 8.
DQ	
Strengths	
In response to the coronavirus disease 2019 (COVID-19) pandemic, **DQ** worked with and obtained approval from TennCare for the use of synchronous and asynchronous teledentistry for dentists providing certain services after an executive order forced dental offices to close, with the exception of emergency services. The availability and use of teledentistry ensured that members' dental care was not delayed, allowed for remote monitoring and management for chronic conditions, reduced waiting time to see a dentist, reduced travel time and cost, and helped prevent unnecessary exposure for the dental office staff and members. **DQ** also worked with TennCare to obtain approval to apply unused monies from decreased claims to increase the provider fee schedule rates. Increasing these rates allowed providers to offset some of the lost revenue from closures and additional personal protective equipment (PPE) costs. Preventive services were given the highest rate increase, 10%, to encourage providers to increase their use. **DQ's** efforts offered some relief of the burden that dental providers experienced resulting from increased PPE costs, as well as helped to prevent office closures that could lead to decreased access for members.	
AONs	
Network Adequacy	**DQ** achieved a score of >99.9% in the Dental Provider Distance for the ECF CHOICES members network adequacy evaluation area. For performance improvement, **DQ** should review the ECF CHOICES provider networks to ensure that providers are available to all members within the required time or distance standards.

Table 9. 2021 ANA Review Strengths and AONs	
Benefit Delivery	**DQ** should develop written P&Ps that address the following: ♦ Non-discrimination in the provision of services to members on the basis of economic status or payment source in addition to non-discrimination on the basis of race, color, sex, religion, national origin, age, handicap, and health. ♦ Non-discrimination in the selection and/or retention of providers that serve high-risk populations or specialize in conditions that require costly treatment.
ORx	
Strengths	
In March 2020, East and Middle Tennessee were impacted by tornadoes that destroyed entire communities. In response, **ORx** deployed timely system edits to ensure that members in Putnam, Davidson, and Wilson counties significantly affected by the tornadoes (i.e., members who lost medication and/or were displaced from their homes) were able to obtain medications. Members could obtain their medications from out-of-network providers; copayments were waived; refill too soon edits were suspended (excluding controlled substances); and lock-in pharmacy locations were applicable for overrides. Communication was distributed to providers via fax blasts and the **ORx** website. Soon after the edits were deployed, the coronavirus disease 2019 (COVID-19) pandemic occurred. In response, the system edits were expanded to include the entire state, not just the three counties impacted earlier by the tornadoes. **ORx**'s efforts helped decrease disruption in members' access to care and services. Because **ORx** scored 100% for both Network Adequacy and Benefit Delivery, there were no recommendations for improving access and timeliness of care.	

Annual Quality Survey (AQS)

Assessment Background

Qsource conducted the AQS pursuant to nationally recognized guidelines: (1) CMS's *EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations* (October 2019); (2) *NCQA 2018 Health Plan Accreditation Standards and Guidelines for Credentialing*; and (3) additional state and federal regulations. The 2021 AQS was conducted from February through May 2021. Throughout the process, Qsource provided technical assistance to TennCare and its MCCs, and maintained ongoing, collaborative communication.

Technical Method of Data Collection and Analysis

The AQS is typically conducted in three phases for each plan: pre-onsite, onsite, and post-onsite. For 2021, however, TennCare approved the replacement of the onsite surveys with virtual surveys due to the COVID-19 pandemic.

Qsource's qualified EQRO survey team consisted of clinicians with expertise in QI and a healthcare data analyst. Qsource developed evidence-based oversight tools in consultation with TennCare and by referencing the State contracts with the plans:

- *Statewide Contract with Amendment 12—July 1, 2020* (**AG**, **BC**, and **UHC**)
- *An Agreement for the Administration of TennCareSelect between the State of Tennessee, d.b.a. TennCare and Volunteer State Health Plan, Inc.* (Amendments 1–48)
  - *Contract #59802 Between the State of Tennessee, Department of Finance and Administration and DentaQuest USA Insurance Company, Inc.*
  - *Contract #61494 Between the State of Tennessee, Department of Finance and Administration. Division of TennCare and OptumRx, Inc.*

TennCare contributed in developing assessment tools and evaluating MCCs' planned improvements. AQS tools assess quality process (QP) standards for MCC policies and procedures (P&Ps), and performance activity (PA) file reviews for documentation in member files. Tool criteria, elements, and standards are updated annually—revised, added, and/or consolidated—with TennCare approval to reflect changes in contract references, better align with the State Quality Strategy, and facilitate data collection. Qsource provided the tools to the plans prior to the onsite/virtual surveys, giving each the opportunity to ask questions, submit requested documentation, and prepare for the survey.

Qsource's AQS tools review compliance with the 11 standards of 42 CFR 438, Subparts D and E, as shown in Table 10. For more information, please see Appendix A.

Table 10. 2021 AQS Tools to CFR Crosswalk

Subparts D and E Standards	AQS QP Standards and PAs	Subparts D and E Standards	AQS QP Standards and PAs
42 CFR 438.206: Availability of services	♦ MCO: Network: Contracting, Availability, Access, and Documentation ♦ MCO and DBM: Member Rights and Responsibilities ♦ MCO: Early & Periodic Screening, Diagnostic & Treatment (EPSDT) ♦ MCO and DBM: Non-Discrimination Compliance ♦ DBM: Standards for Facilities	42 CFR 438.228: Grievance and appeal systems	♦ MCO: QI Activities ♦ MCO and DBM: Member Rights and Responsibilities ♦ MCO: TennCare Medical Services Grievance and Appeal Process standard ♦ DBM: Utilization Review ♦ DBM: Coordination of QM Activity with Other Management Activity ♦ DBM: EPSDT ♦ DBM: Non-Discrimination Compliance ♦ Complaints and Appeals PAs
42 CFR 438.207: Assurances of adequate capacity and services	♦ MCO: QI Activities and Behavioral Health ♦ MCO and DBM: Member Rights and Responsibilities ♦ MCO and DBM: EPSDT	42 CFR 438.230: Subcontractual relationships and delegation	♦ MCO: Network: Contracting, Availability, Access, and Documentation ♦ MCO: QI Activities ♦ MCO and DBM: Non-Discrimination Compliance ♦ DBM: Systematic Process of Quality Assessment and Improvement ♦ DBM: Quality Monitoring Supervision
42 CFR 438.208: Coordination and continuity of care	♦ MCO: QI Activities ♦ MCO: Clinical Criteria for Utilization Management (UM) Decisions ♦ MCO and DBM: EPSDT ♦ DBM: Dental Records ♦ CHOICES Annual Level of Care Assessment and Transition of CHOICES Members Between MCOs PAs	42 CFR 438.236: Practice guidelines	♦ MCO: Clinical Criteria for UM Decisions ♦ DBM: Systematic Process of Quality Assessment and Improvement
42 CFR 438.210: Coverage and authorization of services	♦ MCO: QI Activities ♦ MCO: Clinical Criteria for Utilization Management (UM) Decisions ♦ MCO and DBM: Member Rights and Responsibilities ♦ MCO and DBM: EPSDT	42 CFR 438.242: Health information systems	♦ MCO: QI Activities ♦ DBM: Utilization Review

Table 10. 2021 AQS Tools to CFR Crosswalk			
Subparts D and E Standards	**AQS QP Standards and PAs**	**Subparts D and E Standards**	**AQS QP Standards and PAs**
	♦ DBM: Utilization Review ♦ UM Denials PA		
42 CFR 438.214: Provider selection	♦ MCO: Network: Contracting, Availability, Access, and Documentation ♦ MCO and DBM: Non-Discrimination Compliance ♦ MCO: Credentialing/ Recredentialing P&Ps standard ♦ DBM: Systematic Process of Quality Assessment and Improvement ♦ DBM: Coordination of QM Activity with Other Management Activity	QAPI standards	♦ MCO: QI Activities ♦ MCO: Non-Discrimination Compliance ♦ DBM: Written QMP Description ♦ DBM: Systematic Process of Quality Improvement ♦ DBM: Accountability to the Governing Body ♦ DBM: Active Quality Monitoring Program Committee ♦ DBM: Quality Monitoring Supervision ♦ DBM: Member Rights and Responsibilities
42 CFR 438.224: Confidentiality	♦ MCO: QI Activities ♦ MCO and DBM: Member Rights and Responsibilities ♦ MCO: Credentialing/Recredentialing P&Ps		

Qsource's surveyor team first documented preliminary desktop review findings in the survey tools. During the virtual visits, they completed the survey tools, conducted interviews with plan staff, and obtained additional documentation to determine compliance with contractual requirements, explore issues not fully addressed in pre-assessment review, and increase overall understanding of plan performance. Surveyors closed the virtual visits by summarizing initial findings and recommendations with the plans.

After the virtual visits, Qsource compiled and analyzed compliance scores and reported results; identified MCC strengths, suggestions, and areas of noncompliance (AONs); and determined improvements made in AONs since the last AQS. Qsource uses tested protocols and scoring methods to calculate MCC compliance, analyzing each element of a QP standard using weighted point values to determine performance. All file reviews have the same possible overall value.

Individual *2021 AQS Technical Papers* for each MCC were submitted as drafts within 30 days of each onsite/virtual survey completion and finalized, following TennCare and MCC feedback, within 60 days of the onsite/virtual survey. ANA review tools and findings for credentialing and recredentialing P&Ps and file reviews were incorporated into these reports. Only CHOICES (LTSS) providers' credentialing and recredentialing records were required to be reviewed for compliance, and were not conducted for **TCS** due to the MCO's small CHOICES population.

Participants, documents requested before the onsite visit, and completed AQS tools (with surveyor comments and notes) were included in the individual plan reports as a comprehensive record of assessment activity. Additional details are available in those individual reports as well as the compiled findings in the *2021 AQS Summary Report*. AQS assessment tool templates can be found in Appendix B of this report.

Description of Data Obtained

Table 11 presents the documentation that Qsource requested for desk review for the 2021 AQS. Additional documentation reviewed included committee meeting minutes, quality studies, reports, and medical and provider records/files as needed to assess plan compliance with QP standards and PAs.

Table 11. 2021 AQS Documentation Reviewed

All MCCs	MCOs only
♦ Member Handbooks in English and Spanish ♦ Provider Manual ♦ Quality Improvement Program (QIP) Description ♦ Provider and Member Newsletters ♦ Quarterly EPSDT reports ♦ Utilization Management (UM) Program Description ♦ UM Program Evaluation of 2019 Activities ♦ QIP Evaluation of 2019 Activities ♦ Policies that define the MCC's time standards for handling all denials, complaints, and appeals ♦ 2020 corrective action plans and related documentation, if applicable ♦ All additional policies, procedures, and other documentation needed to answer survey tool elements ♦ Resumes of UM staff	♦ Current Population Health Program Descriptions ♦ 2020 Population Health Satisfaction Surveys ♦ Provider and Member Satisfaction Surveys
DBM only	
♦ 2020 TennCare Kids Outreach Plan ♦ 2020 QIP Work Plan ♦ UM P&Ps ♦ Dental Service P&Ps	
PBM only	
♦ Sample of a Notice of Adverse Benefit Determination ♦ Provider and Subprovider Contracts ♦ Provider Training Materials ♦ Staff Compliance Training Documents ♦ Provider Network Directory	

Comparative Findings

Results for QP standards and CHOICES credentialing/recredentialing file reviews are reported as one statewide score for each MCO. As shown in **Table 12**, MCOs earned 100% compliance for the vast majority of QP standards and CHOICES credentialing/recredentialing file reviews in 2021. MCO compliance scores fell in two QP standards compared to 2020: Network: Contracting, Availability, Access, and Documentation, for which **AG** achieved 91.3%; and EPSDT, for which **UHC** earned 99.8%. **AG**'s and **UHC**'s compliance scores fell from 100% for the quantity rating of the CHOICES credentialing file review, while **UHC**'s score also declined for the quality rating of the CHOICES Recredentialing file review.

Table 12. 2020–2021 AQS Compliance: MCO QP Standard and Credentialing/Recredentialing Results

QP Standards		AG		BC		TCS		UHC	
		2020	2021	2020	2021	2020	2021	2020	2021
Network: Contracting, Availability, Access, & Documentation		97.1%	91.3%	100%	100%	100%	100%	97.1%	100%
QI Activities		100%	100%	100%	100%	100%	100%	100%	100%
Clinical Criteria for Utilization Management (UM) Decisions		100%	100%	100%	100%	100%	100%	100%	100%
Member Rights and Responsibilities		100%	100%	100%	100%	100%	100%	100%	100%
EPSDT		100%	100%	100%	100%	100%	100%	100%	99.8%
TennCare Medical Services Grievance and Appeal Process		100%	100%	100%	100%	100%	100%	100%	100%
Non-Discrimination Compliance		100%	100%	100%	100%	100%	100%	95.0%	100%
Credentialing/Recredentialing P&Ps		94.0%	97.2%	100%	100%	100%	100%	97.0%	97.2%
CHOICES Credentialing/Recredentialing File Reviews[1]									
CHOICES Credentialing Files[1]	Quantity[2]	100%	90.0%	100%	100%			100%	90.0%
	Quality[2]	100%	100%	100%	100%			100%	100%
CHOICES Recredentialing Files[1]	Quantity[2]	100%	100%	100%	100%			100%	100%
	Quality[2]	100%	100%	100%	100%			100%	98.1%

Scores in red indicate a decline for the 2021 review, while scores in green indicate increased or maintained scores compared to 2020. Cells in gray indicate that a measure was not assessed.

[1] *Not assessed for TCS due to its small number of CHOICES members.*

[2] *The quantity rating reflects the percentage of the sampled files available for review and the accuracy of the providers included in the sample; the quality rating reflects the accuracy and completeness of the credentialing documentation.*

PA file review scores are reported separately by operational region (**Table 13**). Once again, MCOs achieved 100% compliance with the majority of measures, falling short in four PAs: UM Denials, for which **AGW** and **UHCE** each achieved 97.5% (the same score **UHCE** earned last year); Appeals, for which **AGE** achieved 97.5%, **AGW** achieved 92.5%, **UHCM** achieved 95.0%, and **UHCW** achieved 94.9%; CHOICES Annual LOC Assessment, for which **AGE** earned 95.0%, **AGW** earned 90.0%, and **UHCE** and **UHCW** each earned 95.0%; and Transition of CHOICES Members Between MCOs, for which **UHCW** achieved 96.3%.

Table 13. 2020–2021 AQS Compliance: MCO PA File Review Results

PAs	AGE		AGM		AGW		BCE		BCM		BCW		TCS		UHCE		UHCM		UHCW	
	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021
UM Denials (ages 20 and younger)	100%	100%	100%	100%	100%	97.5%	100%	100%	100%	100%	100%	100%	100%	100%	97.5%	97.5%	100%	100%	100%	100%
Appeals	100%	97.5%	100%	100%	100%	92.5%	100%	100%	100%	100%	100%	100%	100%	100%	97.1%	100%	100%	95.0%	100%	94.9%
EPSDT Information System Tracking[1]	100%	100%	100%	100%	100%	100%		100%		100%		100%		100%	100%	100%	100%	100%	100%	100%
CHOICES Annual LOC Assessment[2]	100%	95.0%	100%	100%	100%	90.0%	100%	100%	100%	100%	100%	100%		100%	100%	95.0%	95.0%	100%	100%	95.0%
Transition of CHOICES Members Between MCOs[3]	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%	100%	100%	100%	100%	100%	96.3%

Scores in red indicate a decline for the 2021 review, while scores in green indicate increased or maintained scores compared to 2020. Cells in gray indicate that a measure was not assessed.

[1] *Not assessed in 2020 for BC and TCS to avoid burdening providers with additional tasks during the COVID-19 pandemic.*

[2] *Not assessed in 2020 for TCS due to its small number of CHOICES members.*

[3] *Not assessed in 2020 for TCS due to its small number of CHOICES members.*

As shown in **Table 14, DQ**'s performance in the 2021 AQS was similar to its 2020 performance. The DBM only fell short of 100% compliance in one measure, the EPSDT QP standard, for which it scored 98.0%, and raised its score for Appeals from 97.5% to 100%.

Table 14. 2020–2021 AQS Compliance: DBM Results

QP Standards	2020	2021	QP Standards	2020	2021
Written QMP Description	100%	100%	Utilization Review	100%	100%
Systematic Process of Quality Assessment & Improvement	100%	100%	Coordination of QM Activity w/ Other Management Activity	100%	100%
Accountability to the Governing Body	100%	100%	EPSDT	100%	98.0%
Active Quality Monitoring Program Committee	100%	100%	Non-Discrimination Compliance	100%	100%
Quality Monitoring Supervision	100%	100%	Credentialing/Recredentialing P&Ps	100%	100%
Adequate Resources	100%	100%	**PA File Reviews**	**2020**	**2021**
Provider Participation in the QMP	100%	100%	Appeals	97.5%	100%
Member Rights and Responsibilities	100%	100%	Complaints	100%	100%
Standards for Facilities	100%	100%	UM Denials (ages 20 years and younger)	100%	100%
Dental Records	100%	100%			

Scores in red indicate a decline for the 2021 review, while scores in green indicate increased or maintained scores compared to 2020.

Because the 2021 AQS was the first for the PBM, trending is not possible this year. **Table 15** displays ORx's scores. The PBM earned 100% compliance for all QP standards except Appeals and Grievances, for which it earned 89.2%. *Note: File reviews are not required for the PBM.*

Table 15. 2021 AQS Compliance: PBM Results

QP Standards	
Coordination and Continuity of Care	100%
Coverage and Authorization of Services	100%
Information Requirements	100%
Information Systems	100%
Quality Improvement	100%
Appeals and Grievances	89.2%
Non-Discrimination Compliance	100%
Credentialing/Recredentialing P&Ps	100%

Conclusions

Strengths and Weaknesses

Scoring for each evaluated QP standard and file review reflects each plan's degree of compliance with applicable contractual, State, and federal requirements. In addition, Qsource identifies strengths, suggestions, and AONs (weaknesses) to highlight areas in which a plan excels, areas in which it could improve, and areas in which it must improve to achieve compliance, respectively. The lack of an identified strength should not be considered a deficiency. AONs are identified when a plan achieves less than 100% compliance on any given QP standard element or file review, and may be accompanied by recommendations for policy, procedure, or process changes. Because the plans are not held accountable for addressing suggestions, suggestions are not included in this report.

As shown in **Table 16**, strengths were noted for two MCOs regarding their MAT provider dashboard and Buprenorphine Enhanced and Supportive Medication-Assisted Recovery and Treatment (BE-SMART) provider tracking system, and for another MCO for hosting creative outreach events during the pandemic. For improvement in AONs, several plans were instructed to ensure that CHOICES credentialing and recredentialing files are correct and complete; that UM denial requests are processed and notifications are sent timely; that appeal decision notifications are sent to members on time, appeals policies are corrected, and the TennCare-mandated letter for member appeal notifications is used; and that CHOICES LOC assessments are conducted and documented correctly. The table also labels each standard or file review according to the aspect of care it assesses: **Quality (Q), Access (A)**, and/or **Timeliness (T)**.

Table 16. 2021 AQS Strengths and AONs

AG		
AONs		
Network: Contracting, Availability, Access, and Documentation	**Element #10, Quarterly MAT Network Quality Metrics Reports**: **AG** should ensure that it distributes quarterly MAT Network Quality Metrics Reports to all contracted MAT providers on an NPI level within 120 calendar days of the end of each calendar year quarter.	**Q/A**
Credentialing/ Recredentialing P&Ps	**Element #22, Unlicensed BH Providers**: **AG** should ensure that individuals providing behavioral health treatment services who are not required to be licensed or certified, based on applicable State license rules and/or program standards, are appropriately educated, trained, qualified, and competent to perform their job responsibilities.	**Q**
CHOICES Credentialing (Quantity)	**AG** should ensure that the initial credentialing file sample includes only initial provider credentialing records. The issue was noted in one file.	**Q**
UM Denials	**AGW** should ensure that expedited requests are processed within 72 hours. The issue was noted in one file.	**T**
Appeals	**AGW** should ensure that member notifications are sent timely. The issue was noted in one file.	**T**

Table 16. 2021 AQS Strengths and AONs		
	AGE and **AGW** should ensure that the TennCare-mandated letter is used for member notifications, including the taglines. The issue was noted in one **AGE** file and two **AGW** files.	**T**
CHOICES LOC Assessment	**AGE** should ensure that the date of the LOC reassessment is documented in each member's file. The issue was noted in one file.	**Q**
	AGW should ensure that LOC assessment is conducted timely and all documentation is appropriately retained. The issue was noted in one file.	**Q/T**
No strengths were identified for AG in 2021.		
BC		
Strengths		
Network: Contracting, Availability, Access, and Documentation	**Element #10, Quarterly MAT Network Quality Metrics Reports**: **BC** created an interactive Tableau Dashboard for quarterly MAT Network Quality Metrics Reports for use by MAT providers.	**Q/A**
	Element #11: BE-SMART Network Program Description: **BC** maintained a very efficient system that tracked BE-SMART providers' attestations.	**Q/A**
No AONs were identified for BC in 2021.		
TCS		
Strengths		
Network: Contracting, Availability, Access, and Documentation	**Element #10, Quarterly MAT Network Quality Metrics Reports**: **TCS** created an interactive Tableau Dashboard for quarterly MAT Network Quality Metrics Reports for use by MAT providers.	**Q/A**
	Element #11: BE-SMART Network Program Description: **TCS** maintained a very efficient system to track BE-SMART providers' attestations.	**Q/A**
No AONs were identified for TCS in 2021.		
UHC		
Strengths		
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	**Element #21, Program Coordination**: **UHC** creatively and successfully engaged members despite the restrictions of the COVID-19 pandemic by partnering with the Nashville Diaper Connection to host several drive-up events offering childhood vaccinations and diapers.	**Q/A/T**
AONs		
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	**Element #2, Member Outreach Contacts**: **UHC** should ensure that all members receive a separate reminder for the Member Handbook to achieve the specified six outreach attempts per year.	**Q/A/T**
Credentialing/ Recredentialing P&Ps	**Element #12, Delegated Credentialing Reporting**: **UHC** should ensure that all annual reviews for delegated entities are presented to the appropriate committee for review and approval.	**Q/A**
CHOICES Credentialing (Quantity)	**UHC** should ensure that the initial credentialing file sample includes only initial provider credentialing records. The issue was noted in one file.	**Q/A**
CHOICES Recredentialing (Quality)	**UHC** should ensure that recredentialing provider records include a valid license or certification. The issue was noted in one file.	**Q/A**

Table 16. 2021 AQS Strengths and AONs		
UM Denials	**UHCE** should ensure that notifications about UM denial decisions are sent timely. The issue was noted in one file.	**T**
Appeals	**UHCM** and **UHCW** did not notify nor document any attempts to notify the member about the appeal decision. The MCO should ensure its appeals policy is corrected to accurately reflect the member notification process. The issue was noted in one file for both regions.	**T**
CHOICES Annual LOC Assessment	**UHCE** and **UHCW** should ensure that the LOC reassessment is conducted timely. The issue was noted in one file for both regions.	**Q/T**
Transition of CHOICES Members Between MCOs	**UHCW** should ensure that the face-to-face assessment for transitioning CHOICES members is conducted within 30 days. The issue was noted in one file.	**Q/T**
DQ		
AONs		
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	**Element #2, Re-Notification If No Services Used:** The DBM should ensure that dental appointment notices are distributed annually, meaning at least once every 12 months, to all members who did not receive dental services in the previous 12 months, as no notifications were sent during calendar year 2020.	**Q/A/T**
No strengths were identified for DQ in 2021.		
ORx		
Strengths		
Appeals and Grievances	**Element #4, Appeals Request Process:** The PBM provided the resolution of each appeal case to TennCare within one business day after receipt of the ORR for expedited cases, which are contractually due in three days.	**T**
AONs		
Appeals and Grievances	**Element #9, Information for Providers and Subcontractors**: The PBM's provider and subcontractor contracts should include information on member grievance rights. The PBM should also ensure that the provider training materials include information about member appeal and grievance rights. In addition, the PBM should ensure that its website includes information on member appeal and grievance rights in addition to the phone numbers.	**Q**

Improvements Since the 2020 AQS

Corrective action plans (CAPs) are designed to improve performance and give plans the opportunity to receive help with QI. TennCare may request CAPs at its discretion, but MCCs must submit a CAP for any QP standard element or file review scored less than 100% compliance, regardless of overall performance on the standard or activity. Qsource provided technical assistance to the MCCs completing CAPs, submitted CAP evaluations to TennCare for follow-up, and encouraged MCCs to monitor CAP activities throughout 2021 to ensure they fully met stated goals and to close compliance gaps within documented timelines. All CAPs submitted after last year's AQS met objectives, as shown in Table 17. *Note: **TCS** and **BC** were not required to submit a CAP last year, and 2021 was the first year **ORx** was required to complete the AQS.*

Table 17. 2021 AQS: Improvements Since the 2020 AQS	
2020 AON	**Improvements**
AG	
Network: Contracting, Availability, Access, and Documentation **Element #2, Notice of Provider Termination**: The MCO should ensure that it sends member notifications timely when a PCP ceases participation with the MCO.	The MCO addressed the AON by updating the Desktop Process: Provider Termination NDS Step by Step Desktop to ensure timely notification would be sent if a PCP ceases participation with the MCO. A focused audit was conducted for a period of nine week starting mid-June to ensure timely member notification letters were sent out. **These actions satisfied the 2020 CAP.**
Credentialing/Recredentialing P&Ps **Element #23, Credentialing Timeline**: The MCO should completely process credentialing applications within 30 calendar days of receipt of a completed credentialing application, including all necessary documentation, attachments, and a signed provider agreement.	The MCO updated plan documents concerning the requirement to completely process credentialing applications within 30 calendar days of receipt of a completed credentialing application. AG also established procedures to ensure that the practitioner signed a provider agreement and the information was entered into AG's claims system within the 30 calendar day period. AG also established reports and initiated inter-departmental meetings to ensure compliance with the 30-day requirements. **These actions satisfied the 2020 CAP**.
Element #24, Credentialing Timeline for Delegated Vendors: The MCO should ensure that it loads all providers submitted from the delegated credentialing agent into its provider files and claims processing system within 30 calendar days of receipt.	The MCO updated plan documents concerning the requirement to load all providers submitted from a delegated credentialing agent into its provider files and claims processing system within 30 calendar days of receipt the information. AG also established reports and initiated inter-departmental meetings to ensure compliance with the 30-day requirements. **These actions satisfied the 2020 CAP**.
UHC	
Network: Contracting, Availability, Access, and Documentation **Element #2, Notice of Provider Termination**: The MCO should ensure timely notifications are sent to members after provider termination.	The MCO implemented a comprehensive application to monitor all provider terminations and member notifications for CRA requirements compliance. **These actions satisfied the 2020 CAP.**
Non-Discrimination Compliance **Element #2: Display of Non-Discrimination Information:** The MCO should ensure that the required nondiscrimination information is posted in conspicuous places that are accessible to all employees.	The MCO posted the non-discrimination poster in the office. **This action satisfied the 2020 CAP.**
Credentialing/Recredentialing P&Ps **Element #12, Delegated Credentialing Reporting:** The MCO should ensure that all subcontracts with delegated entities are presented to the appropriate committee for review and approval prior to establishing an effective date for the contract.	The MCO retrained employees concerning the requirements to ensure that UHC sent delegation preassessments or annual assessments to the network management and quality improvement departments for presentation to the relevant committee to approve or deny the initiation or continuation of credentialing delegation. UHC also established quality checks by preparing and sending an Active Delegate Report to all Provider Affairs Subcommittee meetings. **These actions satisfied the 2020 CAP**.
UM Denials UHCE should ensure that timely notifications are sent regarding UM denials. The issue was noted in one file.	The MCO completed the process and provided the documentation that would ensure that timely notifications are sent regarding UM denials. **These actions satisfied the 2020 CAP.**

Table 17. 2021 AQS: Improvements Since the 2020 AQS	
2020 AON	**Improvements**
Appeals UHCE should ensure that timely member letters are sent regarding appeal resolutions. The issue was noted in one file.	The MCO completed the process that would ensure that timely notifications are sent. The MCO provided an email PDF file as documentation that the process changed and a PDF file that included an attendees list. Though the requirements are met, Qsource would suggest that the MCO retains a formal agenda, training, and attendee log. **These actions satisfied the 2020 CAP**.
CHOICES LOC Assessment UHCM should ensure that timely LOC assessments are conducted for each CHOICES member. The issue was noted in one file.	In order to ensure timely LOC assessments, the MCO completed a training with the Support Coordination Team and one-on-one coaching with Support Coordinators regarding the LOC reassessment process. The MCO provided the supporting documents to demonstrate progress in meeting the CAP, including the SOP and attendee log. **These actions satisfied the 2020 CAP**.
DQ	
Appeals One resolution letter was first sent to the incorrect member name; when the name was corrected in a second letter, it was sent outside the required timeframe. The DBM should ensure that resolution letters include the correct member name and are sent timely.	The DBM's Senior Client Partner stated that there were three staff members titled Complaints and Grievances Specialist II, and all underwent a training regarding ensuring correct member names on appeal member notification letters. Attestations of all three staff member attending the training were provided. The DBM also provided an email regarding a new complaints, grievances, and appeals system that would use Salesforce and would go live in 3Q 2021. It was noted that this new system would have automated features that would ensure compliance in the complaints, grievances, and appeals process. **These actions satisfied the 2020 CAP.**

State Best Practices

Although the AQS is only federally required to be completed every three years, TennCare has helped ensure quality care for Medicaid members by requiring a full AQS to be completed annually. TennCare reduces the burden of this requirement by mandating MCCs attain NCQA certification, which eliminates the need for EQR of criteria inherently met through the NCQA. Additionally, while several State consent decrees were vacated in prior years with Medicaid program QI efforts, TennCare has continued to ensure improvements achieved are sustained by incorporating associated EPSDT and appeals mandates in MCC contracts and criteria in the QP standard and PA tools. TennCare and Qsource's collaborative CAP process and follow-up evaluations and technical assistance help ensure that MCC planned improvements in response to the AQS were effective and sustainable.

Performance Measure Validation (PMV)

TennCare requires MCOs to earn NCQA accreditation, but this mandate is not applicable to the PBM or DBM. Therefore, the PMV is conducted using NCQA protocols for MCOs, using technical specifications for the CMS Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) for the PBM, and reviewing the ISCAT for the DBM. Accordingly, the validations for MCOs, the PBM, and the DBM are discussed separately in this section.

Assessment Background—MCOs

Qsource's PMV team consisted of both Certified HEDIS Compliance Auditors (CHCAs) and non-certified individuals selected for specified skills, including statistics, analysis, managed care operations, clinical expertise, performance measure reporting, IS assessments, and computer programming. Intended to measure achievement of TennCare's Quality and Performance goals and objectives and meet CMS requirements of *EQR Protocol 2: Validation of Performance Measures* (2020), the PMV draws findings from the *NCQA HEDIS Record of Administration, Data Management and Processes* (Roadmap) completed by the MCOs and an onsite visit by the Qsource team. Due to the COVID-19 pandemic in 2021, the onsite visits were replaced by virtual visits using online meeting software.

Technical Methods of Data Collection and Analysis

For MCOs, the PMV process includes an assessment of information systems (IS) capabilities, including the capture, transfer, and entry of data (e.g., medical services, enrollment, practitioner, and supplemental data). Medical services data are also assessed for sound coding methods. Validation included the following basic steps:

1. Virtual Review Activities: In addition to scheduling the virtual reviews and developing the agenda, the Qsource team prepared a data collection tool based on validation protocols and sent the HEDIS Roadmap packet to each MCO to facilitate its submission requirements. The team held conference calls with each MCO to follow up on any outstanding questions, and submitted a preliminary review to each MCO of its Roadmap and supporting documentation.

2. Virtual Reviews lasted one–two days and included an opening meeting, interviews with staff involved in performance measure reporting, a closing conference summarizing preliminary findings and recommendations and reviews of the following as related to performance measures:
   - System compliance, specifically the processing of claim, encounter, recipient, and provider data where applicable
   - Data integration and control procedures, including source code logic where applicable
   - How all data sources were combined and the method used to produce the analytical file for reporting

3. Validation Results: Based on all validation activities, results were determined for each performance measure following

NCQA's HEDIS Compliance Audit protocol and a report of preliminary findings was prepared for each MCO. Following the MCOs' completion of audit follow-up requests and any applicable corrective actions, final rates submitted by the MCOs were approved by the auditor. A final report for each MCO was concluded with HEDIS Compliance Audit measure designations that includes *Reportable (R)*, which indicates a reportable rate was submitted for the measure, and *Not Applicable (NA)*, which indicates the denominator was too small (less than 30) to report a valid rate. A complete list of designations was included in each *2021 PMV Report*. The NCQA standards tool template used for MCO PMV can be found in Appendix B of this report.

Description of Data Obtained

Per NCQA protocols, the following key types of data were collected and reviewed as part of the validation process:

- The Roadmap provided background information on MCO P&Ps and data in preparation for virtual PMV activities.
- When applicable, each MCO's Source Code (Programming Language) Performance Measures was reviewed for compliance with measure definitions if certified software was not used.
- Performance Measure Reports, prepared by each MCO, were reviewed, along with previous such reports, to assess trending patterns for any multiyear measures.
- Supportive Documentation included any additional information needed by the validation team to complete the PMV, including file layouts, system flow diagrams, system-log files, and data collection process descriptions.

For certified software, the vendor's certification report was reviewed to verify each HEDIS measure as certified by NCQA, and MCO oversight of the vendor was reviewed for accordance with NCQA's HEDIS Determination (HD) standards. Each MCO's information systems (IS), e.g., databases and software environment data collection procedures, supplemental databases, and abstraction, were reviewed to assess compliance with NCQA HEDIS standards to ensure reporting accurate and reliable rates and to identify aspects that could impact measure reporting. Noncompliance with the IS standards does not mean an MCO would not be able to report all measures.

For MY2020, TennCare MCOs were required to report a full set of HEDIS measures for NCQA-accreditation purposes, two of which were validated by Qsource in 2021— Child and Adolescent Well-Care Visits (WCV) and Well-Child Visits in the First 30 Months of Life (W30).

Because these measures used an administrative methodology, medical record review (MRR) was not applicable to the scope of the audit. The measure definitions from NCQA's *HEDIS Measurement Year 2020 & Measurement Year 2021 Volume 2: Technical Specifications for Health Plans* and other descriptions of the measure data obtained are presented in Table 18.

Table 18. 2021 PMV Audit Measures—MCOs			
Measure Name	**Measure Definitions**	**Measure Steward**	**Data Collection Method**
Child and Adolescent Well-Care Visits (WCV)	Reports the percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a primary care provider (PCP) or an OB/GYN practitioner during the measurement year. A total rate as well as three age stratifications are reported: ♦ 3–11 years ♦ 12–17 years ♦ 18-21 years	NCQA	Administrative
Well-Child Visits in the First 30 Months of Life (W30)	Reports the percentage of members who had a particular number of well-child visits with a PCP during the last 15 months. Two rates are reported: ♦ *First 15 Months*—Children who turned 15 months old during the measurement year: six or more well-child visits. ♦ *15 Months–30 Months*—Children who turned 30 months old during the measurement year: two or more well-child visits.	NCQA	Administrative

Comparative Findings—MCOs

AG, **BC**, and **UHC** were compliant with the HEDIS Information Systems Standards and HEDIS Determination Standards, and continue to use NCQA-certified software vendors for HEDIS measure production. The MCOs calculated results for MY2020 and reported them to TennCare as statewide rates for the PMV rather than rates by operational region, as reported for HEDIS auditing. MCO-specific results appear in **Table 19**.

Table 19. 2021 PMV Measure Rates—MCOs			
	AG	**BC**	**UHC**
Utilization Measures			
Child and Adolescent Well-Care Visits (WCV)††:			
3–11 Years	57.44%	59.86%	58.69%
12–17 Years	48.43%	51.69%	49.13%
18–21 Years	24.66%	27.55%	24.64%
Total	**49.96%**	**52.36%**	**50.78%**
Well-Child Visits in the First 30 Months of Life (W30)††:			
First 15 Months**	54.01%	63.09%	38.87%
15 Months–30 Months	66.59%	68.21%	67.79%

Note: BC results include the statewide TCS.

Findings and Conclusions—MCOs

All MCOs passed the 2021 annual PMV audit, were determined to be in full compliance with all HEDIS standards (IS and HD), and received an *R* designation for all audited measures. **AG**, **BC**, and **UHC** continue to use NCQA-certified software vendors for HEDIS measure production. All submitted measures were prepared according to the HEDIS Technical Specifications and presented fairly, in all material, the MCOs' performances with respect to these specifications. All supplemental databases used by MCOs were approved for HEDIS MY2020 reporting. None of the MCOs had a backlog in processing enrollment data during the measurement year.

Because all MCOs were in full compliance with both the 2020 and 2021 PMV, there were no deficiencies to report or improve for either year. Qsource did not identify particular strengths or best practices for any MCO during the 2021 PMV.

Assessment Background—PBM

To measure achievement of the goals and objectives detailed in TennCare's *Quality Assessment and Performance Improvement Strategy*, TennCare identified a set of performance measures to be calculated and reported by its PBM. These measure rates were derived from a number of sources, including claims data and enrollment data that were validated by Qsource. To satisfy the requirements of CMS's *Protocol 2* (October 2019), the validation activities for the PBM were conducted in accordance with the current CMS *Core Set of Adult Health Care Quality Measures for Medicaid* (Adult Core Set) technical specifications.

Technical Methods of Data Collection and Analysis

Validation for the PBM required the following key steps:

1. Pre-Onsite/Virtual Visit Activities: Qsource obtained the list of performance measures selected by TennCare for validation and technical specifications were secured from CMS Adult Core Set. Qsource customized the ISCAT for the TennCare program from Appendix V, Attachment A of *Protocol 2*. Qsource provided the ISCAT to the PBM, with a timetable for completion and instructions for submission. Qsource responded directly to ISCAT-related questions from the PBM during the pre-virtual-review phase. In addition to the ISCAT, Qsource requested source code for the performance measures. Qsource distributed an agenda for the virtual visit to the PBM with the ISCAT and source code request.

2. Virtual Reviews lasted one day for the PBM and included an opening meeting, interviews with staff involved in performance measure reporting, a closing conference summarizing preliminary findings and recommendations and reviews of the following as related to performance measures:
   - Claims System Review: The validation team reviewed information systems focusing on the processing of claims data.

- Enrollment Systems Review: The validation team reviewed information systems focusing on enrollment data and processing.
- Data Integration and Primary Source Review: The validation team discussed source code logic and reviewed the process for integrating all data sources to produce the analytic file for reporting of selected measures. The team also performed primary source review to further validate the output files and reviewed backup documentation on data integration. Finally, the review addressed data control and security procedures.

3. Validation Results: The validation team presented the PBM with preliminary findings based on review of the ISCAT and virtual sessions, along with a summary of documentation requirements for post-virtual-review activities.

Description of Data Obtained

Protocol 2 identifies the following key data sources reviewed as part of the validation process:

- ISCAT—Completed ISCAT received from the PBM was reviewed to ensure all sections were complete and all attachments were available. The validation team reviewed all ISCAT documents, noting issues or items needing follow-up.
- Source Code (Programming Language) for Performance Measures—For the performance measures, the validation team completed line-by-line code review and observation of program logic flow to ensure compliance with measure technical specifications. Areas of deviation were identified to evaluate the impact of the deviation on the measure and assess the degree of bias (if any).
- Performance Measure Reports—Qsource reviewed calculated rates for the current measurement period.
- Supportive Documentation—Qsource reviewed additional information to complete the validation process, including, but not limited to, policies and procedures (P&Ps), file layouts, system flow diagrams, system log files, and data collection process descriptions. Issues or areas needing clarification were flagged for follow-up.

For MY2020, Qsource validated the two PBM performance measures identified by TennCare: Concurrent Use of Opioids and Benzodiazepines (COB-AD) and Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD). These are defined in Table 20.

Table 20. 2021 PMV Audit Measures—PBM

Measure Name	Measure Definitions	Measure Steward	Data Collection Method
Concurrent Use of Opioids and Benzodiazepines (COB-AD)	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded. *Note: A lower rate indicates better performance.*	PQA	Administrative
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year. Five rates are reported: ♦ A total (overall) rate capturing any medications used in medication assisted treatment of opioid dependence and addiction ♦ Four separate rates representing the following types of FDA-approved drug products: ♦ Buprenorphine ♦ Oral naltrexone ♦ Long-acting, injectable naltrexone ♦ Methadone	CMS	Administrative

Findings and Conclusions—PBM

ORx was fully compliant with Qsource's claims data system findings, eligibility data system findings, and data integration findings. Based on all validation activities, Qsource determined the two **ORx** measures met the Adult Core Set technical specifications, and no issues were identified. **Table 21** displays the PBM's actual reported measure rates for the two audited measures, COB-AD and OUD-AD.

Table 21. 2021 PMV Measure Rates—PBM

Measure	Rate (%)
Concurrent Use of Opioids and Benzodiazepines-AD: 18-64 years*	79.1%
Use of Pharmacotherapy for Opioid Use Disorder-AD: 18-64 years	
Buprenorphine	91.0%
Oral naltrexone	3.5%
Long-acting, injectable naltrexone	10.1%
Methadone	0.2%
Total	**99.3%**

** A lower rate indicates better performance.*

Assessment Background—DBM

To measure achievement of the goals and objectives detailed in TennCare's Quality Assessment and Performance Improvement Strategy for the DBM, TennCare reviewed the ISCAT provided by **DQ**, including the following:

- Claims System Review: The validation team reviewed information systems focusing on the processing of claims data.
- Enrollment Systems Review: The validation team reviewed information systems focusing on enrollment data and processing.
- Data Integration and Primary Source Review: The validation team reviewed the process for integrating all data sources to produce the analytics files for reporting. Also, the review addressed data control and security procedures.

Description of Data Obtained—DBM

CMS's *Protocol 2* identifies the following key data sources reviewed as part of the validation process:

- ISCAT—Completed ISCAT received from the DBM was reviewed to ensure all sections were complete and all attachments were available. The validation team reviewed all ISCAT documents, noting issues or items needing follow-up.
- Supportive Documentation—Qsource reviewed additional information to complete the validation process, including, but not limited to, policies and procedures (P&Ps), file layouts, system flow diagrams, system log

files, and data collection process descriptions. Issues or areas needing clarification were flagged for follow-up.

Findings and Conclusions—DBM

General findings are described in this section.

Claims Data System Findings

DQ was fully compliant with the claims data system findings. **DQ** continued to use the Windward Structured Query Language Server for its dental claims processing. There were no significant system changes or upgrades made during the measurement year. **DQ** managed its service delivery through fee-for-service arrangements with no capitated agreements, which supported data completeness. The DBM accepted electronic data interchange files from its claims clearinghouse, applicable file upload to **DQ**'s file transfer protocol site, and via the provider portal. **DQ** continued to receive a high volume of electronic claims, at 95.0%. The DBM processed paper claims and translated them into a standardized format. **DQ** only used accepted standard dental procedure codes provided on standard claims forms. Thus, no mapping of non-standard codes was necessary. **DQ** had adequate processes for handling both electronic and paper claim submissions, with most claims being auto-adjudicated. All claims were captured and stored in the Windward system nightly. Rigorous audit practices were in place to ensure claims accuracy. New claims processors were audited at 100% with a minimum accuracy rate of 99.5%. All standards were met during the measurement year. The Windward system had adequate capture of the fields and data necessary for reporting performance measure data.

Eligibility Data System Findings

DQ was fully compliant with the eligibility data system findings. Daily, 834 files were received from TennCare with additions, changes, and terminations. Unique enrollee identification numbers were used to track enrollees across product lines, and detailed membership reports were exchanged between **DQ** and TennCare to ensure accuracy. Eligibility error reports were generated daily and resolved within 24 hours. DBM enrollment for TennCare members was 880,000 for MY2020 compared to 833,600 for MY2019, representing a 5.6% increase; for CoverKids members, enrollment was 33,800 for MY2020 compared to 36,200 for MY2019, representing a 6.6% decline. The Windward system captured and retained historical enrollment spans necessary for calculating continuous enrollment. **DQ** used the multiple IDs to track members across product lines.

Data Integration Findings

DQ was fully compliant with data integration. The warehouse was suitable for performance measure reporting. All the necessary data sources were captured and stored within the warehouse appropriately for measure calculation. The **DQ** team produced its own source code for measure production. Qsource validated the data integration process used by the DBM, which included a review of file consolidations or extracts, data integration documentation, source code, production activity logs, and linking mechanisms.

Performance Improvement Project (PIP) Validation

Assessment Background

The primary objective of PIP validation is to determine each PIP's compliance with the requirements set forth in the *Code of Federal Regulations* Title 42 § 438.330(d)(2), including:

- Measurement of performance using objective quality indicators
- Implementation of system interventions to achieve improvement in quality
- Evaluation of the effectiveness of the interventions
- Planning and initiation of activities to increase or sustain improvement

Qsource evaluates all PIPs conducted by MCCs. To evaluate PIPs, Qsource assembled a validation team of experienced clinical QI specialists, a healthcare data analyst, and a biostatistician with expertise in statistics, study design, and evaluation. For the 2021 PIP validation, 58 PIPs (26 unique topics) were conducted by nine regional MCOs, one statewide MCO, one DBM, and one PBM.

Technical Methods of Data Collection and Analysis

Each MCC is contractually required to annually submit PIP studies to TennCare as requested. Qsource developed a PIP Summary Form and a PIP Validation Tool to standardize the process by which each MCC provides PIP information to TennCare and how that information is assessed; the form and tool are in compliance with and aligned to the nine validation steps of CMS's *EQR Protocol 1: Validation of Performance Improvement Projects* (2019). Each MCC submitted multiple PIP studies and supplemental information using the PIP Summary Form in July–September 2021.

Each PIP validation assessed MCC performance on the nine steps from the CMS protocol and in the PIP Summary Form, and each step consisted of multiple elements essential to the successful completion of a valid PIP. The actual number of steps validated for each PIP varied depending on how far the PIP had progressed or whether the step was applicable to the PIP's methodology. For example, Step 4 was not validated when a study did not use sampling, used an administrative-only data collection methodology, or used HEDIS Technical Specifications for sampling.

The elements of each activity were scored as Met, Not Met, or Not Assessed. Overall element scores were calculated by dividing the number of evaluation elements Met by the number assessed; based on these scores, an overall PIP validation status was determined that indicated confidence in study results. (See Table 22.)

Table 22. Validation Status and Confidence Statements	
Overall Validation Status	
Met	70–100% of all assessed elements are Met
Not Met	Less than 70% of all assessed elements are Met
Confidence Statements	
High Confidence	90–100% of all assessed elements are Met
Moderate Confidence	80–89.99% of all assessed elements are Met
Low Confidence	70–79.99% of all assessed elements are Met
No Confidence	Less than 70% of all assessed elements are Met

Description of Data Obtained

PIP Summary Forms submitted by the MCCs included the necessary documentation detailing topic, population, and performance measure selection; data collection methodologies; data analysis plans; interventions; and an interpretation of all results, including potential threats to validity.

The 2021 PIP validation tool template can be found in Appendix B. Intervention strategies for each PIP in Remeasurement Year 1 or beyond, as written in unaltered language taken directly from MCC materials, can be found in Appendix C. More specific information on validation methodology is available in the individual, topic-and MCC-specific *2021 PIP Validation Technical Papers* as well as the *2021 PIP Validation Summary Report*.

Comparative Findings

TennCare plans achieved a Met validation status for all PIPs submitted in 2021. Of the 58 PIPs validated, 31 also earned overall element scores of 100%.

A summary of scores is presented in Table 23 by plan and PIP. Under Element Scores, the # Met/Assessed column shows the number of evaluation elements Met compared to the number of elements assessed, and the % column shows the overall element percentage score (the number of elements Met divided by the number of elements assessed). The Validation Status column identifies the overall validation status for each PIP. For PIPs conducted by more than one MCO region, scores and statuses listed in the table apply to each region. Also included are each PIP's measurement year (Baseline [B]; Remeasurement 1 [R1]; Remeasurement 2 [R2]; Remeasurement 3 [R3]; Remeasurement 4 [R4]) and classification as clinical (C) or non-clinical (NC).

Table 23. 2021 PIP Validation Results

PIP Study Title	PIP Year	C/NC	Element Scores		Overall PIP Validation Status
			# Met/ Assessed	%	
AGE, AGM, and AGW					
Improve Childhood Immunization Status (CIS) Combination 10 Rates—East, Middle, and West Regions	B	C	29/31	93.5%	**Met**
Increase Eye Exam Screening Rates for Members with Diabetes	B	NC	31/31	100%	**Met**
Improve EPSDT Screening Rates in the 18–20-Year-Old Age Group Statewide	R2	C	44/44	100%	**Met**
Increase Percentage of CHOICES Members Who Had LTSS Assessment with Nine Core Elements	R2	NC	42/43	97.7%	**Met**
AGE					
Improve East Grand Region Member Satisfaction with the Health Plan	R1	NC	40/41	97.6%	**Met**
AGW					
Improving Diabetic Screening Compliance for Members with Schizophrenia or Bipolar Disorder Using Antipsychotic Medication (SSD)	R1	C	43/44	97.7%	**Met**
BCE, BCM, and BCW					
LTSS Shared Care Plan with Primary Care Practitioner (LTSS-SCP)	B	NC	28/30	93.3%	**Met**
Improving Antidepressant Medication Management (AMM)	R1	C	44/44	100%	**Met**
Decrease the Use of Opioids in High Dosages (HDO)	R1	NC	43/44	97.7%	**Met**
Social Determinants of Health Data Collection Process	R1	NC	43/43	100%	**Met**
BCE, BCM, BCW, and TCS					
Improving Childhood and Adolescent Immunization Rates (CIS/IMA)	R1	C	41/44	93.2%	**Met**
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	R4	NC	40/41	97.6%	**Met**
TCS					
Improving Comprehensive Diabetes Care (Blood Pressure Control for SelectCommunity)	R1	NC	36/43	83.7%	**Met**
Decreasing Plan All-Cause Readmissions (PCR)	R1	NC	42/43	97.7%	**Met**
Follow-Up after Hospitalization for Mental Illness—7 Day (FUH)	R2	C	44/44	100%	**Met**
Social Determinants of Health Data Collection Process	R2	NC	43/43	100%	**Met**
UHCE, UHCM, and UHCW					
Increasing the Screening Rates of Child and Adolescent Well-Care Visits (WCV)	B	C	29/29	100%	**Met**
Increasing the Physical Health Provider Satisfaction Survey Engagement Rate	R1	NC	42/42	100%	**Met**
Care Coordination	R2	NC	48/48	100%	**Met**
Impact of Member and Provider Outreach on Immunization Rates for CIS Combo 10	R2	C	46/47	97.9%	**Met**
Transitions of CHOICES Individuals	R2	NC	43/43	100%	**Met**
UHCW					
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	R1	C	45/45	100%	**Met**

Table 23. 2021 PIP Validation Results					
PIP Study Title	PIP Year	C/NC	Element Scores		Overall PIP Validation Status
			# Met/ Assessed	%	
DQ					
Increasing Provider Use of Silver Diamine Fluoride (SDF) as a Preventive Measure	R3	C	44/44	100%	**Met**
Decreasing TennCare Enrollees Receiving Opioid Prescriptions	R3	NC	44/44	100%	**Met**
ORx					
Schizophrenia Medication Compliance Improvement Plan	B	C	27/27	100%	**Met**
Usage of Diagnosis Code Override by Providers for Preferred Atypical Antipsychotics	B	NC	27/27	100%	**Met**

Conclusions

Strengths and Weaknesses

To help improve PIP performance, Qsource identified strengths and/or AONs (weaknesses) (**Table 24**) regardless of validation status. The table also categorizes each PIP according to the aspect of care it addresses: **Quality (Q), Access (A)**, and/or **Timeliness (T)**. Qsource also identifies suggestions where a PIP validation step is fully compliant but a revision/update could further strengthen the PIP; however, because plans are not held accountable for addressing suggestions, they are not included in this report.

Table 24. 2021 PIP Validation Strengths and AONs		
AG		
Strengths		
Q/A/T	*Improve Childhood Immunization Status (CIS) Combination 10 Rates*	**Step 6. AGE/AGM/AGW**: The MCO had a very stringent policy for IRR that required a passing score of 100% for its abstractors to ensure data accuracy.
Q/A/T	*Improve EPSDT Screening Rates in the 18–20-Year-Old Age Group Statewide*	**Step 7. AGE/AGM/AGW**: The MCO reported the results of additional statistical significance testing between remeasurement years.
Q/A	*Increase Percentage of CHOICES Members Who Had LTSS Assessment with Nine Core Elements*	**Step 7. AGE/AGM/AGW**: The MCO reported the results of additional statistical significance testing between remeasurement years.
Q/A/T	*Improving Diabetic Screening Compliance for Members with Schizophrenia or Bipolar Disorder*	**Step 8. AGW**: The MCO demonstrated proficient use of the PDSA cycle in this PIP through multiple fishbone (barrier analysis) and driver diagrams, meeting minutes from a multidisciplinary workgroup detailing each step of the cycle, and narratives detailing the evaluation and adjustment of improvement strategies throughout the measurement year.

Table 24. 2021 PIP Validation Strengths and AONs		
AONs		
Q/A/T	*Improve Childhood Immunization Status (CIS) Combination 10 Rates*	**Step 2. AGE/AGM/AGW**: The MCO should ensure that the aim statement clearly specifies the PIP time period.
		Step 5. AGE/AGM/AGW: The MCO should correctly define the variable according to HEDIS Technical Specifications.
Q/A	*Increase Percentage of CHOICES Members Who Had LTSS Assessment with Nine Core Elements*	**Step 2. AGE/AGM/AGW**: The MCO should ensure that the aim statement clearly specifies the PIP time period.
Q/A/T	*Improving Diabetic Screening Compliance for Members with Schizophrenia or Bipolar Disorder*	**Step 2. AGW**: The MCO should clearly specify the time period being measured in the PIP aim statement.
Q	*Improve East Grand Region Member Satisfaction with the Health Plan*	**Step 2. AGE**: The MCO should ensure that the aim statement clearly specifies the PIP time period.
BC		
AONs		
Q	*Decrease the Use of Opioids in High Dosages (HDO)*	**Step 2. BCE/BCM/BCW**: The MCO should, at a minimum, identify the focus of the targeted interventions (e.g., providers or members) in the PIP aim statement.
Q	*LTSS Shared Care Plan with Primary Care Practitioner (LTSS-SCP)*	**Step 1. BCE/BCM/BCW**: The MCO should clearly describe how it considered input from members and/or providers when devising the PIP topic. A reason should be provided if this was not possible.
		Step 2. BCE/BCM/BCW: The MCO should, at a minimum, identify the focus of the targeted interventions (e.g., providers or members) in the PIP aim statement.
No strengths were identified in any BCE, BCM, or BCW PIPs in 2021.		
BC and TCS		
AONs		
Q/A/T	*Improving Childhood and Adolescent Immunization Rates (CIS/IMA)*	**Step 7. BCE/BCM/BCW and TCS**: The MCO should identify the change in the rate calculation for CIS Combination 10, which was "after exclusions" for Baseline and "before exclusions" for Remeasurement 1, and explain how it does or does not impact the comparability of results. The MCO should also identify threats to the validity of findings, such as the other vaccines in each combination being studied, and discuss their impact.
		Step 9. BCE/BCM/BCW and TCS: The MCO should identify the change made to the numerator calculations for CIS Combination 10 as it pertains to "before exclusions" or "after exclusions."
Q/A/T	*Early and Periodic Screening, Diagnostic and Treatment (EPSDT)*	**Step 2. BCE/BCM/BCW and TCS**: The MCO should ensure that the PIP population is specified in the PIP aim statement.
No strengths were identified for any combined BCE/BCM/BCW/TCS PIPs in 2021.		

Table 24. 2021 PIP Validation Strengths and AONs		
TCS		
Strengths		
Q/T	*Follow-Up After Hospitalization for Mental Illness (FUH)*	**Step 7. TCS**: The MCO reported the results of additional statistical significance testing between remeasurement years.
AONs		
Q	*Improving Comprehensive Diabetes Care (Blood Pressure Control for SelectCommunity)*	**Step 2. TCS**: The MCO should provide the general focus of the improvement strategies used in the PIP.
		Step 6. TCS: The MCO should ensure that the PIP design allows for consistent data collection over PIP time periods and adjust the goal accordingly.
		Step 7. TCS: The MCO should address the break in trending identified by NCQA for the CDC measure between MY2019 and MY2020, its influence on comparability of Baseline to Remeasurement 1 findings, and its threat to the validity.
		Step 9. TCS: When assessing for real improvement, the MCO should acknowledge that there was a change in methodology between measurement years. Due to this change, the MCO should not attribute the reported improvement in performance or the statistical evidence of observed improvement to the improvement strategies.
Q	*Plan All-Cause Readmissions*	**Step 2. TCS**: The MCO should provide the focus of targeted interventions (e.g., providers, members).
UHC		
AONs		
Q/A/T	*Impact of Member and Provider Outreach on Immunization Rates for CIS Combo 10*	**Step 6. UHCE/UHCM/UHCW**: The MCO should ensure the accuracy of the data source and data elements collected.
No strengths were identified for any UHCE, UHCM, or UHCW PIPs in 2021.		
DQ		
Strengths		
Q	*Decreasing TennCare Enrollees Receiving Opioid Prescriptions*	**Step 9. DQ**: The DBM reported the percentage change in prescribing rates between consecutive remeasurements.
No AONs were identified for DQ PIPs in 2021. *No strengths or AONs were identified for ORx PIPs in 2021.*		

Improvements Since the 2020 PIP Validation

For studies that receive AONs for any element, Qsource provides technical assistance to help plans understand CMS protocol and revise PIPs as needed to improve performance. In subsequent validation years, plans should update their PIP Summary Forms with additional information to address any suggestions and elements assessed as Not Met. This year, MCOs made improvements to AONs identified in

three study topics, as outlined in **Table 25**. *Note: The previous PIP Validation was conducted using a PIP Summary Form and Tool based on the 2012 CMS PIP protocol; thus, the CAP evaluations use slightly different terminology than that used in the updated protocol.*

Table 25. 2021 PIP Validation: Improvements Since the 2020 PIP Validation

PIP Topic	2020 AON	2021 Improvements
Plan All-Cause Readmissions	**Activity IV. TCS** should ensure that the study question is completely answered by either dropping the second part of the study question ("predicted probability of an acute readmission") or by adding a study indicator to measure that part of the study question.	**TCS** stated its intent to remove the second part of the study question and acknowledged its failure to execute the removal prior to PIP submission. The AON and requested CAP resulted in a review of its process for PIP development, internal validation, and submission. The MCO revised its procedure (Development and Submission of Performance Improvement Projects) and PIP Internal Validation Tool to focus on the PIP study question and study indicator. The validation process included a review of each aspect of the PIP Summary Form by using a reviewer checklist that specified Met, Partially Met, Not Met, or NA. Any identified corrections occur prior to PIP submission. **These actions satisfied the 2020 AON.**
Transitions of CHOICES Individuals	**Activity III**. **UHCE**, **UHCM**, and **UHCW** should ensure that the study population is accurately and completely defined and that information regarding continuous enrollment requirements is unambiguous and consistent for this activity and throughout the PIP Summary Form.	**UHC** updated and redefined its study population description and continuous enrollment criteria. A brief explanation indicated that these updates had been made to the PIP Summary Form. **These actions satisfied the 2020 AON.**
Increasing the Physical Health Provider Satisfaction Survey	**Activity IV**. **UHCE**, **UHCM**, and **UHCW** should include a discussion of the IRR process, including information about the process, responsible parties, score required for passing, and corrective actions.	**UHC** explained that IRR was not applicable for this PIP's data collection because the survey count was used rather than the survey content. The CAP focused on adding and deleting language in all future PIP Summary Forms to clarify that IRR was not applicable and not performed. The MCO provided the language that will be added to future submissions and indicated that the phrase "data entry is verified for accuracy" will be removed. **These actions satisfied the 2020 AON.**

For the 2021 PIP validation, TennCare required MCCs to submit a CAP for any AONs via a similar evaluation and monitoring process to the AQS CAP process. Eleven PIP topics (27 studies total) received an AON and required CAPs in 2021; the results of these CAP evaluations will be reported next year.

Summary and Conclusions

The results of 2021 EQR activities demonstrate that TennCare's managed care plans are well qualified and committed to facilitating timely, accessible, and high-quality healthcare for TennCare members. Achieving high or perfect compliance scores in all assessment activities, implementing innovative and successful programs and initiatives for improvement, and acting quickly to correct any noted deficiencies, the plans exemplify TennCare's Core Values and strive continuously to fulfill the goals of its Quality Strategy. Qsource recommends that TennCare continue to use stringent measures from the ANA review, AQS, HEDIS audit, and PIP validation as the primary means for assessing the Quality Strategy's success as applied to the integrated physical and behavioral health services delivered by its plans. The 2020 EQR assessment results, including the identification of plan strengths, recommendations, and CAPs, attest to the positive impact of TennCare's strategy in monitoring plan compliance, improving quality, and aligning healthcare goals.

Table 26 presents highlights of the results, recommendations for improvement, and strengths and improvements identified for each TennCare plan during the 2021 evaluation year. The table also labels each EQR activity according to the aspect of care it primarily assesses: **Quality (Q), Access (A)**, and/or **Timeliness (T)**.

Table 26. 2021 Results, Recommendations, and Strengths by Plan

AG			
Results	**A/T**	**ANA Review**	**AG** earned an overall Network Adequacy score of 87.0% and an overall Benefit Delivery score of 97.7%.
	Q/A/T	**AQS**	**AG** earned 100% compliance with all QP standards except Network: Contracting, Availability, Access, and Documentation, for which it earned 91.3%, and Credentialing/Recredentialing P&Ps, for which it earned 97.2%. **AG** earned 100% compliance with all CHOICES credentialing/recredentialing file reviews except CHOICES credentialing quantity, for which it earned 90.0%. **AGM** earned 100% compliance with all PA file reviews, while **AGE** fell short for Appeals (97.5%) and CHOICES Annual LOC Assessment (95.0%), and **AGW** declined for UM Denials (97.5%), Appeals (92.5%), and CHOICES Annual LOC Assessment (90.0%).
	Q	**PMV**	**AG** passed the 2021 annual PMV audit, was determined to be in full compliance with all HEDIS standards (IS and HD), and received an R designation for all audited measures.
	Q	**PIP Validation**	**AGE** and **AGW** earned a Met validation status for all five submitted PIPs, and **AGM** earned a Met status for all four submitted PIPs. **AGE**, **AGM**, and **AGW** each earned 100% element scores for two PIPs.
Recommendations	**A/T**	**ANA Review**	Network Adequacy: **AG** should ensure that the provider files contain opioid use treatment disorder providers contracted to treat with buprenorphine; address the shortage of OB/GYN providers; address the shortage of optometry providers; address the shortage of hospitals contracted to provide services to members; and address the shortage of specialized consultation and training providers in Bledsoe, Claiborne, Grainger, Grundy, Hamblen, Hancock, Jefferson, Monroe, Sequatchie, and Sevier counties. Benefit Delivery: **AG** should ensure that plan documents include the requirement to monitor the ratio of members to providers including opioid use disorder providers contracted to treat with methadone; ensure that every provider contract is signed and dated prior to the provider furnishing services to the TennCare population; and ensure that providers are informed of all available medically necessary employment services/supports for ECF CHOICES members in Groups 4, 5, 6, 7, and 8.

Table 26. 2021 Results, Recommendations, and Strengths by Plan			
	Q/A/T	AQS	**AG** should ensure that it distributes quarterly MAT Network Quality Metrics Reports to all contracted MAT providers on an NPI level within 120 calendar days of the end of each calendar year quarter; that individuals providing behavioral health treatment services are appropriately educated, trained, qualified, and competent to perform their job responsibilities; that the initial credentialing file sample includes only initial provider credentialing records; that expedited UM Denial requests are processed within 72 hours; that Appeals member notifications are sent timely; that the TennCare-mandated letter is used for Appeals member notifications, including the taglines; that the date of the CHOICES Annual LOC reassessment is documented in each member's file; and that the CHOICES LOC assessment is conducted timely and all documentation is appropriately retained.
	Q	PMV	No deficiencies or recommendations for improvement were identified.
	Q	PIP Validation	**AGE**, **AGM**, and **AGW** should ensure that the aim statement clearly specifies the time period for *Improve Childhood Immunization Status* and *Increase Percentage of CHOICES Members Who Had LTSS Assessment*. The same AON was identified for **AGW** for *Improve Diabetic Screening Compliance* and for **AGE** for *Improve East Grand Region Member Satisfaction*. For *Improve Childhood Immunization Status*, all regions should also correctly define the variable according to HEDIS Technical Specifications.
Strengths & Improvements	A/T	ANA Review	**AG** was commended for developing a Virtual Site Visit process to ensure that it maintained critical LTSS credentialing and recredentialing requirements during COVID-19.
	Q/A/T	AQS	Since the 2020 AQS, **AG** updated the *Desktop Process: Provider Termination NDS Step by Step Desktop* to ensure timely notification would be sent if a PCP ceased participation with the MCO. **AG** also updated plan documents concerning the requirement to completely process credentialing applications within 30 calendar days of receipt of a completed credentialing application. **AG** further established procedures to ensure that the practitioner signed a provider agreement and the information was entered into **AG**'s claims system within the 30 calendar day period, and established reports and initiated inter-departmental meetings to ensure compliance with the 30-day requirements. Finally, **AG** updated plan documents concerning the requirement to load all providers submitted from a delegated credentialing agent into its provider files and claims processing system within 30 calendar days of receipt the information. The MCO also established reports and initiated inter-departmental meetings to ensure compliance with the 30-day requirements.
	Q	PMV	No particular strengths or improvements were identified.
	Q	PIP Validation	**AG**'s three regions were commended for a very stringent policy for IRR that required a passing score of 100% for abstractors to ensure data accuracy (*Improve Childhood Immunization Status*) and for reporting the results of additional statistical testing between remeasurements (*Improve EPSDT Screening Rates* and *Increase Percentage of CHOICES Members Who Had LTSS Assessment*). **AGW** was lauded for demonstrating proficient use of the PDSA cycle through multiple fishbone and driver diagrams, meeting minutes from a multidisciplinary workgroup detailing each step of the cycle, and narratives detailing the evaluation and adjustment of improvement strategies for *Improving Diabetic Screening Compliance.*
BC			
Results	A/T	ANA Review	**BC** earned an overall Network Adequacy score of 99.6% and an overall Benefit Delivery score of 99.4%.
	Q/A/T	AQS	**BC** achieved 100% compliance with all QP standards and CHOICES credentialing/recredentialing file reviews. **BCE**, **BCM**, and **BCW** each achieved 100% compliance with all applicable PAs.
	Q	PMV	**BC** passed the 2021 annual PMV audit, was determined to be in full compliance with all HEDIS standards (IS and HD), and received an R designation for all audited measures.
	Q	PIP Validation	Each **BC** region earned a Met validation status for all six submitted PIPs, and a 100% overall element score for two of those six.

Table 26. 2021 Results, Recommendations, and Strengths by Plan			
Recommendations	**A/T**	**ANA Review**	Network Adequacy: **BC** should ensure that the provider files contain opioid use treatment disorder providers contracted to treat with methadone; address the shortage of dermatology providers contracted to provide services to members; address the shortage of hospitals contracted to provide services to members; address the shortage of substance abuse—inpatient facility services providers; and address the shortage of adult day care providers. Benefit Delivery: **BC** should ensure that the correct standards for optometry are listed in all plan documents, and ensure that suburban/rural geographic access standards for PCPs and PCP extenders are listed correctly in the Provider Administration Manual (PAM).
	Q/A/T	**AQS**	No AONs or recommendations for improvement were identified.
	Q	**PMV**	No deficiencies or recommendations for improvement were identified.
	Q	**PIP Validation**	For *Decrease the Use of Opioids in High Dosages*, **BC**'s three regions should identify the focus of the targeted interventions (e.g., providers or members) in the PIP aim statement. For *LTSS Shared Care Plan with Primary Care Practitioner (LTSS-SCP)*, **BC**'s three regions should clearly describe how they considered input from members and/or providers when devising the PIP topic, and identify the focus of the targeted interventions (e.g., providers or members) in the PIP aim statement. **BC**'s regions should identify the change in the rate calculation for CIS Combination 10, which was "after exclusions" for Baseline and "before exclusions" for Remeasurement 1, and explain how it does or does not impact the comparability of results, for *Improving Childhood and Adolescent Immunization Rates*. For *EPSDT*, **BC** should ensure the population is included in the PIP aim statement.
Strengths & Improvements	**A/T**	**ANA Review**	**BC** was commended for using CareTN, a digital care management platform that furnishes real-time progress and clinical alerts for care managers and enables easy two-way communication.
	Q/A/T	**AQS**	**BC** was commended for the Network QP standard for creating an interactive Tableau Dashboard for quarterly MAT Network Quality Metrics Reports, and for its efficient system that tracked BE-SMART providers' attestations.
	Q	**PMV**	No particular strengths or improvements were identified.
	Q	**PIP Validation**	No particular strengths or improvements were identified.
TCS			
Results	**A/T**	**ANA Review**	**TCS** earned an overall Network Adequacy score of 99.5% and an overall Benefit Delivery score of 99.4%.
	Q/A/T	**AQS**	**TCS** earned 100% compliance with all QP standards and PAs.
	Q	**PMV**	**TCS** (reported with **BC** results) passed the 2021 annual PMV audit, was determined to be in full compliance with all HEDIS standards (IS and HD), and received an R designation for all audited measures.
	Q	**PIP Validation**	**TCS** a validation status of Met for all six submitted PIPs, and a 100% overall element score for two of the six.
Recommendations	**A/T**	**ANA Review**	Network Adequacy: **TCS** should ensure that the provider files contain opioid use disorder treatment providers (contracted to treat with methadone); address the shortage of dermatology providers contracted to provide services to members; address the shortage of hospitals contracted to provide services to members; and address the shortage of substance abuse—inpatient facility services providers. Benefit Delivery: **TCS** should ensure that the correct standards for optometry are listed in all plan documents, and that suburban/rural geographic access standards for PCPs and PCP extenders are listed correctly in the Provider Administration Manual (PAM).
	Q/A/T	**AQS**	No AONs were identified. For improvement regardless of compliance scores, **TCS** could explicitly mention in its policies that the community-based residential alternative setting is not applicable for its members.
	Q	**PMV**	No deficiencies or recommendations for improvement were identified.
	Q	**PIP Validation**	**TCS** should identify the change in the rate calculation for CIS Combination 10, which was "after exclusions" for Baseline and "before exclusions" for Remeasurement 1, and explain how it does or does not impact the comparability of results, for *Improving Childhood and Adolescent Immunization Rates*. For *EPSDT*, **TCS** should ensure the population is included in the PIP aim statement. For

Table 26. 2021 Results, Recommendations, and Strengths by Plan			
			Improving Comprehensive Diabetes Care, **TCS** should provide the general focus of the improvement strategies used in the PIP; ensure that the PIP design allows for consistent data collection over PIP time periods and adjust the goal accordingly; address the break in trending identified by NCQA for the CDC measure between MY2019 and MY2020; and acknowledge that there was a change in methodology between measurement years. For *Plan All-Cause Readmissions*, **TCS** should provide the focus of targeted interventions (e.g., providers, members).
Strengths & Improvements	**A/T**	**ANA Review**	**TCS** was commended for using CareTN, a digital care management platform that furnishes real-time progress and clinical alerts for care managers and enables easy two-way communication.
	Q/A/T	**AQS**	**TCS** was commended for the Network QP standard for creating an interactive Tableau Dashboard for quarterly MAT Network Quality Metrics Reports, and for its efficient system that tracked BE-SMART providers' attestations.
	Q	**PMV**	No particular strengths or improvements were identified.
	Q	**PIP Validation**	**TCS** was commended for reporting the results of additional statistical significance testing between remeasurement years for its *FUH* PIP. Since the 2020 PIP Validation, **TCS** addressed an AON in the *Plan All-Cause Readmissions* PIP by removing the second part of the study question. The AON and requested CAP resulted in a review of its process for PIP development, internal validation, and submission. The MCO revised its procedure (Development and Submission of Performance Improvement Projects) and PIP Internal Validation Tool to focus on the PIP study question and study indicator. The validation process included a review of each aspect of the PIP Summary Form by using a reviewer checklist.
UHC			
Results	**A/T**	**ANA Review**	**UHC** earned an overall Network Adequacy score of >99.9% and an overall Benefit Delivery score of 99.7%.
	Q/A/T	**AQS**	**UHC** earned 100% compliance with all but two QP standards, earning 99.8% for EPSDT and 97.2% for Credentialing/Recredentialing P&Ps. For CHOICEs file reviews, **UHC** earned 100% compliance with all but CHOICES credentialing quantity (90.0%) and CHOICES recredentialing quality (98.1%). **UHCE** achieved 100% compliance with three of five PAs, earning 97.5% for UM Denials and 95.0% for CHOICES Annual LOC Assessment. **UHCM** achieved 100% with four of five PAs, earning 95.0% for Appeals. **UHCW** achieved 100% compliance with two of five PAs, earning 94.9% for Appeals, 95.0% for CHOICES Annual LOC Assessment, and 96.3% for Transition of CHOICES Members Between MCOs.
	Q	**PMV**	**UHC** passed the 2021 annual PMV audit, was determined to be in full compliance with all HEDIS standards (IS and HD), and received an R designation for all audited measures.
	Q	**PIP Validation**	**UHCE and UHCM** achieved a validation status of Met for all five submitted PIPs, and **UHCW** for all six. All PIPs also earned 100% overall element scores except for *Impact of Member and Provider Outreach on Immunization Rates for CIS Combo 10*, which earned 97.9% for each of **UHC**'s three regions.
Recommendations	**A/T**	**ANA Review**	Network Adequacy: **UHC** should address the shortage of OB/GYN providers; address the shortage of hospitals contracted to provide services to members; address the shortage of substance abuse—outpatient treatment services providers; and address the shortage of adult day care providers. Benefit Delivery: **UHC** should ensure that providers are informed of assistive technology benefits for ECF CHOICES members in Groups 7 and 8.
	Q/A/T	**AQS**	**UHC** should ensure that all members receive a separate reminder for the member handbook; that all annual reviews for delegated entities are presented to the appropriate committee; that the initial credentialing file sample includes only initial provider credentialing records; that recredentialing provider records include a valid license or certification; that notifications about UM denial decisions are sent timely; that its appeals policy is corrected to accurately reflect the member notification process; that the CHOICES LOC reassessment is conducted timely; and that the face-to-face assessment for transitioning CHOICES members is conducted within 30 days.
	Q	**PMV**	No deficiencies or recommendations for improvement were identified.
	Q	**PIP Validation**	**UHC**'s three regions should ensure the accuracy of the data source and data elements collected for *Impact of Member and Provider Outreach on Immunization Rates for CIS Combo 10*.

Table 26. 2021 Results, Recommendations, and Strengths by Plan			
Strengths & Improvements	**A/T**	**ANA Review**	**UHC** was commended for developing TrustPoint, a treatment model that integrates dialysis services with inpatient psychiatric care.
	Q/A/T	**AQS**	**UHC** was commended for creatively and successfully engaging members despite the restrictions of the COVID-19 pandemic to host several drive-up events offering childhood vaccinations and diapers. Since the 2020 AQS, **UHC** implemented a comprehensive application to monitor all provider terminations and member notifications for CRA requirements compliance. The MCO retrained employees concerning the requirements to ensure that **UHC** sent delegation preassessments or annual assessments to the network management and QI departments for presentation to the relevant committee to approve or deny the initiation or continuation of credentialing delegation. **UHC** also established quality checks by preparing and sending an Active Delegate Report to all Provider Affairs Subcommittee meetings. UHC also completed the process and provided the documentation that would ensure that timely notifications are sent regarding UM Denials and Appeals. In order to ensure timely LOC assessments, **UHC** completed a training with the Support Coordination Team and one-on-one coaching with Support Coordinators regarding the LOC reassessment process.
	Q	**PMV**	No particular strengths or improvements were identified.
	Q	**PIP Validation**	No particular strengths were identified this year. Since the 2020 validation, **UHC** updated and redefined its study population description and continuous enrollment criteria for *Transitions of CHOICES Individuals*, and provided the language that will be added to future submissions to clarify that IRR is not applicable and not performed for *Increasing the Physical Health Provider Satisfaction Survey.*
DQ			
Results	**A/T**	**ANA Review**	**DQ** earned an overall Network Adequacy score of >99.9% and an overall Benefit Delivery score of 99.0%.
	Q/A/T	**AQS**	**DQ** earned 100% compliance with all QP standards except EPSDT, for which it earned 98.0%. **DQ** earned 100% compliance for all three PA file reviews.
	Q	**PMV**	**DQ** was fully compliant with Qsource's findings for claims data system, eligibility data system, and data integration.
	Q	**PIP Validation**	**DQ** earned 100% overall element scores and a Met validation status for both submitted PIPs.
Recommendations	**A/T**	**ANA Review**	Network Adequacy: **DQ** should review the ECF CHOICES provider networks to ensure that providers are available to all members within the required time or distance standards. Benefit Delivery: **DQ** should develop written P&Ps that address the following: Non-discrimination in the provision of services to members on the basis of economic status or payment source in addition to non-discrimination on the basis of race, color, sex, religion, national origin, age, handicap, and health; and non-discrimination in the selection and/or retention of providers that serve high-risk populations or specialize in conditions that require costly treatment.
	Q/A/T	**AQS**	**DQ** should ensure that dental appointment notices are distributed annually, meaning at least once every 12 months, to all members who did not receive dental services in the previous 12 months, as no notifications were sent during calendar year 2020.
	Q	**PMV**	No deficiencies or recommendations for improvement were identified.
	Q	**PIP Validation**	No AONs were identified. For improvement regardless of validation status, **DQ** could address issues noted in Steps 1, 5, 6, and 8 for *Decreasing TennCare Enrollees Receiving Opioid Prescriptions*, and Steps 5 and 8 for *Increasing Provider Use of SDF*.
Strengths & Improvements	**A/T**	**ANA Review**	**DQ** was commended working with TennCare to use synchronous and asynchronous teledentistry for dentists providing certain services after an executive order related to the pandemic forced dental offices to close.
	Q/A/T	**AQS**	No particular strengths were noted. Since the 2020 AQS, **DQ** complaints and grievances staff members underwent training to ensure correct member names were included on appeal member notification letters. **DQ** also provided an email regarding a new complaints, grievances, and appeals system that would use Salesforce and go live in 3Q 2021. It was noted that this new system would have automated features that would ensure compliance in the complaints, grievances, and appeals process.
	Q	**PMV**	No particular strengths or improvements were identified.

Table 26. 2021 Results, Recommendations, and Strengths by Plan			
	Q	PIP Validation	DQ was commended for reporting the percentage change in prescribing rates between consecutive remeasurements for *Decreasing TennCare Enrollees Receiving Opioid Prescriptions.*
ORx			
Results	A/T	ANA Review	ORx earned an overall Network Adequacy score of 100% and an overall Benefit Delivery score of 100%.
	Q/A/T	AQS	ORx earned 100% compliance with all QP standards except Appeals and Grievances, for which it earned 89.2%.
	Q	PMV	ORx was fully compliant with Qsource's findings for claims data system, eligibility data system, and data integration. Qsource determined the two ORx measures met the Adult Core Set technical specifications, and no issues were identified.
	Q	PIP Validation	ORx earned 100% overall element scores and a Met validation status for both submitted PIPs.
Recommendations	A/T	ANA Review	Because ORx scored 100% for both Network Adequacy and Benefit Delivery, there were no recommendations for improvement.
	Q/A/T	AQS	ORx's provider and subcontractor contracts should include information on member grievance rights. The PBM should also ensure that the provider training materials include information about member appeal and grievance rights. In addition, the PBM should ensure that its website includes information on member appeal and grievance rights in addition to the phone numbers.
	Q	PMV	No deficiencies or recommendations for improvement were identified.
	Q	PIP Validation	No AONs were identified. For improvement regardless of validation status, ORx should explicitly describe how the PIP topic aligns with priority areas identified by HHS and/or CMS and elaborate on its consideration of existing measures for *Usage of Diagnosis Code Override*. For *Schizophrenia Medication Compliance Improvement Plan*, the PBM should: provide a specific numeric goal instead of a percent decrease, the time frame for the goal, and an explanation for how the goal rate was determined; explain how the performance measures informed the selection and evaluation of QI strategies; provide a discussion of how existing measures were considered prior to selecting internally developed measures; and provide information about accepted clinical guidelines that pertain to the PIP aim statement.
Strengths & Improvements	A/T	ANA Review	ORx was commended for deploying timely system edits to ensure that members in counties significantly affected by tornadoes in 2020 were able to obtain medications.
	Q/A/T	AQS	ORx provided the resolution of each appeal case to TennCare within one business day after receipt of the ORR for expedited cases, which are contractually due in three days.
	Q	PMV	ORx demonstrated strengths with RxTrack, its integrated data warehouse system that captured all data required for performance measure reporting, including claims, enrollment, and provider data. The system supported seamless data integration and inherently maintained the necessary controls to support data completeness and accurately produce the measures under the scope of the validation.
	Q	PIP Validation	No particular strengths were identified.

APPENDIX A | CFR Crosswalk

Qsource's EQR assessment tools review compliance with the 11 standards of 42 CFR 438, Subparts D and E. **Table A-1** provides a crosswalk between the 11 standards and the tools used to conduct the ANA review, AQS, PMV, and PIP validation.

Table A-1. CFR-Tool Crosswalk

#	CFR Standards	Tool	Standards/Elements
1	**42 CFR 438.206: Availability of services**	**ANA**	♦ MCO tool: Standards for Availability and Accessibility ♦ DBM tool: Standards for Availability and Accessibility
		AQS	♦ MCO: Network: Contracting, Availability, Access, and Documentation ○ #3: Second Opinion ○ #7: MAT Provider Network ○ #8: Initial Engagements ○ #9: Subsequent Engagements ♦ MCO: Member Rights and Responsibilities ○ #3: Member Handbook Inclusions ○ #6: Communication Assistance Services ○ #8: Website ♦ MCO: Early & Periodic Screening, Diagnostic & Treatment (EPSDT) ○ #2: Member Outreach Contacts ○ #8: Coordinating Services ○ #14: Referral Providers List ○ #16: Family Involvement and Accessible Services ♦ MCO: Non-Discrimination Compliance #2: Display of Non-Discrimination Information ♦ DBM: Member Rights and Responsibilities ○ #6: Member Handbook Inclusions ○ #8: Steps to Ensure Accessibility of Services ○ #11: Member Satisfaction ○ #12: Second Opinion ○ #14: Website ♦ DBM: Standards for Facilities #1: DBM Standards ♦ DBM: Non-Discrimination Compliance #3: Display of Non-Discrimination Information and #4: Non-Discrimination Written Materials

Table A-1. CFR-Tool Crosswalk

#	CFR Standards	Tool	Standards/Elements
2	**42 CFR 438.207: Assurances of adequate capacity and services**	**ANA**	♦ MCO: Standards for Availability and Accessibility ♦ MCO: Accessibility and Benefits Review—Member ♦ MCO: Accessibility Benefits Review—Provider ♦ DBM: Standards for Availability and Accessibility ♦ DBM: Benefits Review—Member ♦ DBM: Benefits Review—Provider
		AQS	♦ MCO: QI Activities #1: Coordination Between Physical and Behavioral Health ♦ MCO: Member Rights and Responsibilities #9: Limitations/Capitations/Delays ♦ MCO: EPSDT #17: Family Involvement and Accessible Services ♦ DBM: Member Rights and Responsibilities #8: Steps to Ensure Accessibility of Services ♦ DBM: EPSDT #6: Referrals from One Level of Screening/Diagnosis to Another and #10: Limits/Capitations/Delays
3	**42 CFR 438.208: Coordination and continuity of care**	**ANA**	♦ MCO: Standards for Availability and Accessibility #43: PCP Selection and #44: Family Planning Providers ♦ MCO: Accessibility and Benefits Review—Member ♦ MCO: Accessibility and Benefits Review—Provider ♦ DBM: Standards for Availability and Accessibility #13: Dental Referrals and #15: Direct Access to Specialists ♦ DBM: Benefits Review—Member ♦ DBM: Benefits Review—Provider
		AQS	♦ MCO: QI Activities standard ♦ MCO: Clinical Criteria for Utilization Management (UM) Decisions #2: Transition to Other Care ♦ MCO: EPSDT ○ #7: Prenatal Appointment Assistance ○ #17: Follow-Up After Inpatient or Residential Treatment ○ #20: Transportation ♦ DBM: Dental Records ♦ DBM: EPSDT ○ #4: Appointment Assistance ○ #15: Coordination with MCOs ○ #16: Coordination of Dental Services

Table A-1. CFR-Tool Crosswalk

#	CFR Standards	Tool	Standards/Elements
			♦ MCO PA file reviews: CHOICES Annual Level of Care Assessment and Transition of CHOICES Members Between MCOs
4	**42 CFR 438.210: Coverage and authorization of services**	**ANA**	♦ MCO: Accessibility Benefits Review—Member standard ♦ MCO: Accessibility Benefits Review—Provider standard ♦ DBM: Benefits Review—Member standard ♦ DBM: Benefits Review—Provider standard
		AQS	♦ MCO: QI Activities #10: Population Health Treatment Plans for CHOICES and ECF CHOICES Members ♦ MCO: Clinical Criteria for Utilization Management (UM) Decisions #1: Availability of Criteria and #4: Qualified UM Personnel ♦ MCO: Member Rights and Responsibilities #3: Member Handbook Inclusions and #9: Limitations/Capitations/Delays ♦ MCO: EPSDT #13: Services Without Prior Authorization and #19: Interperiodic Screenings ♦ DBM: Member Rights and Responsibilities #6: Member Handbook Inclusions ♦ DBM: Utilization Review ○ #2: Coverage Limits ○ #3: Qualified Dental Professionals ○ #4: Review Decisions ♦ DBM: EPSDT #5: Prior Authorization and #10: Limits/Capitations/Delays ♦ MCO and DBM PA file review: UM Denials
5	**42 CFR 438.214: Provider selection**	**AQS**	♦ MCO: Network: Contracting, Availability, Access, and Documentation #6: Prohibited Affiliations ♦ MCO: Non-Discrimination Compliance #3: Provision of Services ♦ MCO: Credentialing/Recredentialing Policies and Procedures (P&Ps) standard ♦ DBM: Systematic Process of Quality Assessment and Improvement #10: Prohibited Affiliations ♦ DBM: Coordination of QM Activity with Other Management Activity #1: QM Findings Used in Recredentialing Activities ♦ DBM: Non-Discrimination Compliance #8: Provision of Services

Table A-1. CFR-Tool Crosswalk

#	CFR Standards	Tool	Standards/Elements
6	**42 CFR 438.224: Confidentiality**	**AQS**	♦ MCO: QI Activities #1: Coordination Between Physical and Behavioral Health: criterion e: Confidentiality ♦ MCO: Member Rights and Responsibilities #2: Communication of Rights and Responsibilities in Member Handbook: criterion g: Necessary steps to amend their data in accordance with HIPAA regulations and state law ♦ MCO: Member Rights and Responsibilities #10: Confidentiality/HIPAA Compliance ♦ MCO: Credentialing/Recredentialing P&Ps #30: Initial and Ongoing Education Conducted by CHOICES Providers, criterion c: Ethics and confidentiality training, including HIPAA and HI-TECH ♦ DBM: Member Rights and Responsibilities #10: Confidentiality/HIPAA Compliance
7	**42 CFR 428.228: Grievance and appeal systems**	**AQS**	♦ MCO: QI Activities #23: Health Information System ♦ MCO: Member Rights and Responsibilities #2: Communication of Rights and Responsibilities in Member Handbook and #3: Member Handbook Inclusions ♦ MCO: TennCare Medical Services Grievance and Appeal Process standard ♦ DBM: Member Rights and Responsibilities ○ #1: Policies and Procedures (P&Ps) on Member Rights ○ #4: Communication of Policies to Members ○ #6: Member Handbook Inclusions ○ #7: Complaint and Appeal System ♦ DBM: Utilization Review #5: Appeals Mechanisms and #8: Health Information System ♦ DBM: Coordination of QM Activity with Other Management Activity #1: QM Findings Used in Recredentialing Activities ♦ DBM: EPSDT #9: Medical Necessity ♦ DBM: Non-Discrimination Compliance #6: Complaint Resolution and Reporting ♦ MCO PA file reviews: Complaints and Appeals ♦ DBM PA file reviews: Complaints and Appeals
8	**42 CFR 438.230: Subcontractual relationships and delegation**	**AQS**	♦ MCO: Network: Contracting, Availability, Access, and Documentation #4: Subcontractor Audits ♦ MCO: QI Activities #24: Compliance Program ♦ MCO: Non-Discrimination Compliance #7: Provider and Subcontractor Compliance Education ♦ DBM: Systematic Process of Quality Assessment and Improvement #8: Subcontractor Audits ♦ DBM: Quality Monitoring Supervision #3: Compliance Program

Table A-1. CFR-Tool Crosswalk

#	CFR Standards	Tool	Standards/Elements
			♦ DBM: Non-Discrimination Compliance #5: Written P&P and #7: Provider and Subcontractor Compliance Education
9	**42 CFR 438.236: Practice guidelines**	**AQS**	♦ MCO: Clinical Criteria for UM Decisions #1: Availability of Criteria and #3: Practice Guidelines ♦ DBM: Systematic Process of Quality Assessment and Improvement #2: Practice Guidelines and #4: Address Preventive Health
10	**42 CFR 438.242 Health information systems**	**AQS**	♦ MCO: QI Activities #23: Health Information System ♦ DBM: Utilization Review #8: Health Information System
11	**42 CFR 438.330 Quality assessment and performance improvement program**	**PIP**	♦ Information on PIP methodology and results in the PIP section, with tool in Appendix B and MCC improvement strategies in Appendix C
		PMV	♦ Information on methodology and results in the PMV section, with tool in Appendix B
		AQS	♦ MCO: QI Activities standard ♦ MCO: Non-Discrimination Compliance #6: Health Disparities Projects ♦ DBM: Written QMP Description ○ #3: QMP Activities/Service Delivery ○ #4: Continuous Activity Performance and Tracking ○ #6: Feedback ♦ DBM: Systematic Process of Quality Improvement ○ #1: Population Served ○ #5: Remedial/Corrective Action Procedures ○ #6: Corrective Action Follow-Up ○ #7: Annual Evaluation ♦ DBM: Accountability to the Governing Body ○ #3: QMP Progress Reports ○ #4: Program Modification ○ #5: Follow-Up ♦ DBM: Active Quality Monitoring Program Committee #1: QMP Committee ♦ DBM: Quality Monitoring Supervision #2: External Advisory Committee and #3: Compliance Program ♦ DBM: Member Rights and Responsibilities #11: Member Satisfaction

APPENDIX B | 2021 EQR Tool Templates

ANA Review

ANA Standards Tools—MCOs

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
1) Informing Members of Emergency Medical Services *CRA A.2.7.1.1* *TSA.2.7.1.1* *TCA 56-7-2356(a)(1)* *42 CFR § 438.206(a)* *42 CFR § 438.206(c)(1)(iii)*	There is evidence through a review of P&Ps and the Member Handbook that members are informed that emergency medical services are available at any available emergency care facility 24 hours a day, 7 days a week (including services outside the usual service area).	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
2) Informing Providers of Emergency Medical Services *CRA A.2.7.1.1* *TSA 2.7.1.1* *TCA 56-7-2356(a)(1)* *42 CFR § 438.206(c)(1)(i)*	There is evidence through a review of P&Ps and the Provider Manual that providers are informed that emergency medical services are available at any available emergency care facility 24 hours a day, 7 days a week (including services outside the usual service area).	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
3) Maximum Members per Provider *CRA Attachment IV* *TSA Attachment IV* *42 CFR § 438.206(a)* *42 CFR § 438.207(a)*	The MCO has processes and procedures in place to ensure that ratios of non-dual-eligible members to providers remain below the following maximum limits:	☐ Met ☐ Not Met	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
	Specialty / **Number of Non-dual Members** Allergy & Immunology: 100,000 Cardiology: 20,000 Dermatology: 40,000 Endocrinology: 25,000 Gastroenterology: 30,000 General Surgery: 15,000 Nephrology: 50,000 Neurology: 35,000 Neurosurgery: 45,000 Oncology/Hematology: 80,000 Ophthalmology: 20,000 Opioid Use Disorder Providers contracted to treat with buprenorphine: 10,000 Opioid Use Disorder Providers contracted to treat with Methadone: 50,000 Orthopedic Surgery: 15,000 Otolaryngology: 30,000 Psychiatry (Adult): 25,000 Psychiatry (Child and Adolescent): 150,000 Urology: 30,000			
Findings:				

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
Recommendations:				
4) Appointment/Wait Times for PCPs *CRA Attachment III* *TSA Attachment III* *42 CFR § 438.206(c)(1)(i)*	Through a review of plan documents, there is evidence that the MCO requires that providers offer adequate access to covered services. At a minimum, access standards must specify that **primary care** wait times: a) Do not exceed 3 weeks for a regular appointment b) Do not exceed 48 hours for an urgent care appointment c) Do not exceed 45 minutes for office waiting time	a) ☐ Met ☐ Not Met b) ☐ Met ☐ Not Met c) ☐ Met ☐ Not Met Variables a & b = .33 Variable c = .34	**1.0**	**0.0**
Findings:				
Recommendations:				
5) Appointment/Wait Times for SCPs *CRA Attachment III* *TSA Attachment III* *42 CFR § 438.206(c)(1)(i)*	Through a review of plan documents, there is evidence that the MCO requires that providers offer adequate access to covered services. At a minimum, access standards must specify that referral appointments to **SCP**s: a) Do not exceed 30 days for routine care b) Do not exceed 48 hours for urgent care c) Do not exceed 45 minutes for office waiting time	a) ☐ Met ☐ Not Met b) ☐ Met ☐ Not Met c) ☐ Met ☐ Not Met Variables a & b = .33 Variable c = .34	**1.0**	**0.0**
Findings:				
Recommendations:				
6) Appointment/Wait Times for Optometry *CRA Attachment III* *TSA Attachment III*	Through a review of plan documents, there is evidence that the MCO requires that providers offer adequate access to covered services. At a minimum, access standards must specify that optometry wait times:	a) ☐ Met ☐ Not Met b) ☐ Met	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
42 CFR § 438.206(c)(1)(i)	a) Do not exceed 3 weeks for a regular appointment b) Do not exceed 48 hours for an urgent appointment c) Do not exceed 45 minutes for office waiting time	☐ Not Met c) ☐ Met ☐ Not Met Variables a & b = .33 Variable c = .34		
Findings:				
Recommendations:				
7) Second Opinions *CRA A.2.6.4* *TSA 2.6.4* *CFR 438.206(b)(3)* *42 CFR § 438.206(b)(3)*	The MCO provides for a second opinion in any situation where there is a questions concerning a diagnosis or the options for surgery or other treatment of a health condition when requested by a member, parent, and/or legally appointed representative. The second opinion: a) Is provided by a contracted qualified health care professional or the MCO arranges for a member to obtain one from a non-contracted provider; and b) Is provided at no cost to the member.	a) ☐ Met ☐ Not Met b) ☐ Met ☐ Not Met Each Variable = .50	**1.0**	**0.0**
Findings:				
Recommendations:				
8) Direct Access to Women's Health Specialist *CRA A.2.14.4.3* *TSA 2.14.4.3* *CFR 438.206(b)(2)* *42 CFR § 438.206(b)(2)*	The MCO allows female members direct access (without requiring a referral) to a women's health specialist who is a contracted provider for covered services necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
9) Timeliness Standards for Access to BH Services *CRA Attachment V* *TSA Attachment V* *42 CFR § 438.206(c)(1)(iv–vi)*	The MCO has standards for timeliness of access to BH services. There is evidence in plan documents that the MCO continually monitors its compliance with these standards and takes corrective action as necessary.	☐ Met ☐ Not Met ☐ NA*	**1.0**	**0.0**
Findings:				
Recommendations:				
10) Standards for Timely Access to Psychiatric Inpatient Hospital Services *CRA Attachment V* *TSA Attachment V* *42 CFR § 438.206(c)(1)(i)*	The BH standards include access standards for psychiatric inpatient hospital services within: a) 4 hours (emergency, involuntary) b) 24 hours (involuntary) c) 24 hours (voluntary)	a) ☐ Met ☐ Not Met b) ☐ Met ☐ Not Met c) ☐ Met ☐ Not Met Variables a & b = .33 Variable c = .34	**1.0**	**0.0**
Findings:				
Recommendations:				
11) Standards for Timely Access to 24-Hour Psychiatric Residential Treatment *CRA Attachment V* *TSA Attachment V* *42 CFR § 438.206(c)(1)(i)*	The BH standards include access standards for 24-hour psychiatric residential treatment within 30 calendar days.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				

* *Responses found to be not applicable (NA) do not receive a point value and are not counted against the MCO.*

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
Recommendations:				
12) Standards for Timely Access to Outpatient (Non-Medical Doctor [MD]) and Intensive Outpatient Services *CRA Attachment V* *TSA Attachment V* *42 CFR § 438.206(c)(1)(i)*	The BH standards include access standards for outpatient mental health services, including non-MD and intensive outpatient (may include day treatment [adult], intensive day treatment [children and adolescents] or partial hospitalization), within 10 business days, and within 48 hours if urgent.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
13) Standards for Timely Access to Inpatient Substance Abuse Services *CRA Attachment V* *TSA Attachment V* *42 CFR § 438.206(c)(1)(i)*	The BH standards include access standards for inpatient substance abuse services: a) Within 2 calendar days for detoxification b) Within 4 hours in an emergency c) Within 24 hours for a nonemergency	a) ☐ Met ☐ Not Met b) ☐ Met ☐ Not Met c) ☐ Met ☐ Not Met Variables a & b = .33 Variable c = .34	**1.0**	**0.0**
Findings:				
Recommendations:				
14) Access Standards for Timely Access to 24-Hour Residential Substance Abuse Services *CRA Attachment V* *TSA Attachment V* *42 CFR § 438.206(c)(1)(i)*	The BH standards include access standards for 24-hour residential substance abuse services within 10 business days.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
Recommendations:				
15) Access Standards for Timely Access to Outpatient Substance Abuse Services *CRA Attachment V* *TSA Attachment V* *42 CFR § 438.206(c)(1)(i)*	The BH standards include access standards for outpatient substance abuse treatment: a) Within 10 business days b) Within 24 hours for detoxification	a) ☐ Met ☐ Not Met b) ☐ Met ☐ Not Met Each Variable = .50	**1.0**	**0.0**
Findings:				
Recommendations:				
16) Access Standards for Timely Access to Intensive Community-Based Treatment Services *CRA Attachment V* *TSA Attachment V* *42 CFR § 438.206(c)(1)(i)*	The BH standards include access standards for intensive community-based treatment services within 7 calendar days.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
17) Access Standards for Timely Access to Tennessee Health Link Services *CRA Attachment V* *TSA Attachment V* *42 CFR § 438.206(c)(1)(i)*	The BH standards include access standards for Tennessee Health Link services within 30 calendar days.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
18) Access Standards for Timely Access to Psychosocial Rehabilitation	The BH standards include access standards for psychosocial rehabilitation within 10 business days.	☐ Met ☐ Not Met	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
CRA Attachment V *TSA Attachment V* *42 CFR § 438.206(c)(1)(i)*				
Findings:				
Recommendations:				
19) Access Standards for Timely Access to Supported Employment *CRA Attachment V* *TSA Attachment V* *42 CFR § 438.206(c)(1)(i)*	The BH standards include access standards for supported employment within 10 business days.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
20) Access Standards for Timely Access to Peer Recovery Services or Family Support Services *CRA Attachment V* *TSA Attachment V* *42 CFR § 438.206(c)(1)(i)*	The BH standards include access standards for peer recovery or family support services within 10 business days.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
21) Access Standards for Timely Access to Illness Management and Recovery *CRA Attachment V* *TSA Attachment V* *42 CFR § 438.206(c)(1)(i)*	The BH standards include access standards for illness management and recovery within 10 business days.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
Recommendations:				
22) Standards for Timely Access to Mobile Crisis Services *CRA Attachment V* *TSA Attachment V* *42 CFR § 438.206(c)(1)(i)*	The BH standards include access standards for BH crisis services (mobile), which includes face-to-face contact: a) Within 2 hours for emergency situations b) Within 4 hours for urgent situations	a) ☐ Met ☐ Not Met b) ☐ Met ☐ Not Met Each Variable = .50	**1.0**	**0.0**
Findings:				
Recommendations:				
23) Standards for Timely Access to Crisis Stabilization *CRA Attachment V* *TSA Attachment V* *42 CFR § 438.206(c)(1)(i)*	The BH standards include access standards for crisis stabilization within 4 hours of the referral.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
24) Standards for Timely Access to Supported Housing *CRA Attachment V* *TSA Attachment V* *42 CFR § 438.206(c)(1)(i)*	The BH standards include access standards for supported housing within 30 calendar days.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
25) Geographic Access Requirements *CRA Attachments III, IV, & V* *TSA Attachment III, IV, & V*	The MCO has standards for geographic access to care. There is evidence in plan documents that the MCO continually monitors its compliance with these standards	☐ Met ☐ Not Met	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
42 CFR § 438.206(c)(1)(iv–vi)	and takes corrective action as necessary.			
Findings:				
Recommendations:				
26) Geographic Access Requirements for Primary Care Physician or Extenders *CRA Attachment III* *TSA Attachment III* *42 CFR § 438.206(c)(1)(i)* *42 CFR § 438.207(b)(2)*	The geographic access standards for PCPs and PCP extenders include the following requirements: a) Suburban/Rural: ≤ 30 miles a ≤ 45 minutes travel for all members b) Urban: ≤ 20 miles a ≤ 30 minutes travel for all members	a) ☐ Met ☐ Not Met b) ☐ Met ☐ Not Met Each Variable = .50	**1.0**	**0.0**
Findings:				
Recommendations:				
27) Geographic Access for Hospitals *CRA Attachment III* *TSA Attachment III* *42 CFR § 438.206(c)(1)(i)*	Through a review of plan documents, there is evidence that the MCO requires the following geographic access standards for hospitals: Travel distance is ≤ 30 miles and 45 minutes travel time unless exceptions are justified and documented based on community standards.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
28) Geographic Access for Optometry *CRA Attachment III* *TSA Attachment III* *42 CFR § 438.206(c)(1)(i)*	Through a review of plan documents, there is evidence that the MCO requires the following geographic access standards for optometry: Travel distance is ≤ 30 miles and 45 minutes travel time except in rural areas where community standards and documentation apply	☐ Met ☐ Not Met	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
Findings:				
Recommendations:				
29) Geographic Access Requirements for Psychiatric Inpatient Hospital Services *CRA Attachment V* *TSA Attachment V* *42 CFR § 438.206(c)(1)(i)* *42 CFR § 438.207(b)(2)*	The BH standards include access standards than for psychiatric inpatient hospital services: Travel distance ≤90 miles and 120 minutes travel time for all members.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
30) Geographic Access Requirements for Outpatient Non-MD BH Services *CRA Attachment V* *TSA Attachment V* *42 CFR § 438.206(c)(1)(i)* *42 CFR § 438.207(b)(2)*	The BH standards include access standards for outpatient mental health services: Travel distance for non-MD services is ≤ 30 miles and 45 minutes travel time for at least 75% of members; and is ≤ 60 miles and 60 minutes travel time for all members.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
31) Geographic Access Requirements for Intensive Outpatient BH Services *CRA Attachment V* *TSA Attachment V* *42 CFR § 438.206(c)(1)(i)* *42 CFR § 438.207(b)(2)*	The BH standards include access standards for intensive outpatient *(*may include day treatment [adults], intensive day treatment [children and adolescents] or partial hospitalization): Travel distance is ≤ 90 miles and 90 minutes travel time for 75% of the members; and is ≤ 120 miles and 120 minutes travel time for all members.	☐ Met ☐ Not Met	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
Findings:				
Recommendations:				
32) Geographic Access Requirements for Inpatient Substance Abuse Services *CRA Attachment V* *TSA Attachment V* *42 CFR § 438.206(c)(1)(i)* *42 CFR § 438.207(b)(2)*	The BH standards include access standards for inpatient substance abuse services: Travel distance is ≤ 90 miles and 120 minutes travel time for all members.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
33) Geographic Access Requirements for Outpatient Treatment for Substance Abuse *CRA Attachment V* *TSA Attachment V* *42 CFR § 438.206(c)(1)(i)* *42 CFR § 438.207(b)(2)*	The BH standards include access standards for outpatient treatment: Travel distance is ≤ 30 miles and 30 minutes travel time for 75% of the members; and ≤ 45 miles and 45 minutes travel time for all members.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
34) Geographic Access Requirements for Opioid Use Disorder Treatment Providers *CRA Attachment IV* *TSA Attachment IV* *42 CFR § 438.206(c)(1)(i)* *42 CFR § 438.207(b)(2)*	The BH standards include access standards for opioid use disorder treatment providers: Travel distance is ≤ 45 miles and 45 minutes travel time for 75% of the non-dual members; and ≤ 60 miles and 60 minutes travel time for all non-dual members.	☐ Met ☐ Not Met	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
Findings:				
Recommendations:				
35) Monthly Provider Enrollment File *CRA A.2.30.8.1TSA.2.30.8.1*	The MCO submits a monthly Provider Enrollment File.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
36) Quarterly Reporting Requirements *CRA A.2.30.8.3* *CRA A.2.30.8.6* *CRA A.2.30.8.9–10* *CRA A.2.30.14.1* *CRA A.30.13.4TSA 2.30.8.3* *TSA 2.30.8.6* *TSA 2.30.13.4*	The MCO submits the following required quarterly reports: a) PCP Assignment Report b) BH Appointment Timeliness Summary Report c) CHOICES and ECF CHOICES HCBS Provider Criminal Background Check and Registry Check Report (NA for TennCare*Select*) d) CHOICES AND ECF CHOICES HCBS Member Complaints Reports (NA for TennCare*Select*) e) HCBS Settings Report (NA for TennCare*Select*) f) Provider Complaints and Appeals Report g) Member Complaint Report (TennCare*Select* only)	a) ☐ Met ☐ Not Met ☐ NA b) ☐ Met ☐ Not Met ☐ NA c) ☐ Met ☐ Not Met ☐ NA d) ☐ Met ☐ Not Met ☐ NA e) ☐ Met ☐ Not Met ☐ NA f) ☐ Met ☐ Not Met	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
		☐ NA g) ☐ Met ☐ Not Met ☐ NA Variable a–d = .167 Variable e & f = .166		
Findings:				
Recommendations:				
37) Annual Reporting Requirements *CRA A.2.30.8.2* *CRA A.2.30.8.4* *CRA A.2.30.8.7* *TSA 2.30.8.2* *TSA 2.30.8.4* *TSA 2.30.8.7*	The MCO submits the following required annual reports: a) Provider Compliance With Access Requirements Report b) Report of Essential Hospital Services by September 1 of each year c) Federally Qualified Health Center (FQHC) Report	a) ☐ Met ☐ Not Met b) ☐ Met ☐ Not Met c) ☐ Met ☐ Not Met Variables a & b = .33 Variable c = .34	**1.0**	**0.0**
Findings:				
Recommendations:				
38) Annual Plan for Monitoring BH Appointment Timeliness *CRA A.2.30.8.5TSA 2.30.8.5*	The MCO submits an Annual Plan for the Monitoring of BH Appointment Timeliness that includes the MCO's plan for monitoring BH providers to ensure that they comply with the timeliness of appointment standards.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
39) Provider Satisfaction Survey Report: Medicaid *CRA A.2.30.13.3TSA 2.30.13.3*	A Provider Satisfaction Survey Report that encompasses behavioral and physical health is submitted to TennCare by January 30 each year.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
40) Provider Satisfaction Survey Report: CHOICES and ECF CHOICES HCBS *CRA A.2.30.13.3TSA 2.30.13.3*	A CHOICES and ECF CHOICES HCBS Provider Satisfaction Survey Report addressing results for CHOICES and ECF CHOICES HCBS providers is submitted to TennCare by January 30 each year.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
41) Appointments Scheduling *CRA Attachment III* *TSA Attachment III* *42 CFR § 438.206(c)(1)(v)*	There is evidence through a review of plan documents that the MCO has a system in place to evaluate providers' compliance with appointment scheduling times (e.g., cold calling).	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
42) Exchange of Information *CRA Attachment III* *TSA Attachment III*	There is evidence that the MCO has a system in place to document the exchange of member information if a provider, other than the PCP, provides healthcare (e.g., a school-based clinic or health department clinic).	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
43) PCP Selection	The MCO establishes P&Ps to enable members the	☐ Met	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
CRA A.2.11.2.6 *TSA 2.11.2.7*	opportunity to change PCPs at least every 12 months. If the ability to change PCPs is limited, the MCO includes provisions for more frequent PCP changes with good cause. The P&P for changing with good cause includes a definition of "good cause" and the procedure to request a change.	☐ Not Met		
Findings:				
Recommendations:				
44) Family Planning Providers *CRA 2.17.4.6.10* *TSA 2.7.6.4.8* *42 CFR § 438.206(b)(7)*	The MCO's network includes sufficient family planning providers to ensure timely access to covered services, and the MCO does not require a referral before a member visits a family planning provider .	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
Standard Score for Availability and Accessibility		**<##>%**	**0.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
1) Inpatient Hospital Services *CRA A.2.6.1.3* *TSA 2.6.1.3*	As medically necessary Under age 21: Includes rehabilitation hospital facility Age 21 and older: Inpatient rehabilitation hospital facility services are not covered for adults unless determined to be a cost effective alternative.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other(Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
2) Outpatient Hospital Services *CRA A.2.6.1.3* *TSA 2.6.1.3*	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
3) Physician Inpatient Services *CRA A.2.6.1.3* *TSA 2.6.1.3*	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
4) Physician Outpatient Services/Community Health Clinic Services/ Other Clinic Services	As medically necessary	☐ Member Handbook ☐ Explanation of	**1.0**	**0.0**

* *Check appropriate box for location of benefit. Only one checked box is necessary for a full score.*

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
CRA A.2.6.1.3 *TSA 2.6.1.3*		Benefits ☐ Other (Describe)		
Findings:				
Recommendations:				
5) Lab and X-Ray Services *CRA A.2.6.1.3* *TSA 2.6.1.3*	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
6) Maternity/Postpartum Services *TCA 56-7-2350*	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
7) Hospice Care *CRA A.2.6.1.3* *TSA 2.6.1.3*	As medically necessary (must be provided by a Medicare-Certified Hospice)	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
8) Vision Services *CRA A.2.6.1.3* *TSA 2.6.1.3*	As medically necessary for those younger than 21 years of age: Preventive, diagnostic, and treatment services (including eyeglasses) in accordance with TennCare Kids requirements. As medically necessary for those age 21 years and older: Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye. One pair of cataract glasses or lenses following cataract surgery.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
9) Home Healthcare *CRA A.2.6.1.3* *TSA 2.6.1.3*	As medically necessary for those younger or older than 21 years of age in accordance with the definition of home health care in the Tennessee rules.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
10) Durable Medical Equipment *CRA A.2.6.1.3* *TSA 2.6.1.3*	As medically necessary and covered in accordance with TennCare rules and regulations	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:.				
Recommendations:				
11) Medical Supplies	As medically necessary and covered in accordance	☐ Member Handbook	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
CRA A.2.6.1.3 *TSA 2.6.1.3*	with TennCare rules and regulations	☐ Explanation of Benefits ☐ Other (Describe)		
Findings:				
Recommendations:				
12) Emergency Air and Ground Ambulance Transportation *CRA A.2.6.1.3* *TSA 2.6.1.3*	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
13) Nonemergency Transportation, Including Nonemergency Ambulance Transportation *CRA A.2.6.1.3* *TSA 2.6.1.3*	Nonemergency transportation services are provided in accordance with federal law and the Tennessee Division of TennCare's rules and P&Ps. Nonemergency transportation services are provided to convey members to and from TennCare covered services.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
14) Renal Dialysis Services *CRA A.2.6.1.3* *TSA 2.6.1.3*	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
Recommendations:				
15) TennCare Kids Services *CRA A.2.6.1.3* *TSA 2.6.1.3*	Services for members younger than 21 years of age: a) As medically necessary, except that screenings do not have to be medically necessary b) Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal and state requirements	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:.				
Recommendations:				
16) Preventive Care Services *CRA A.2.7.5.1* *TSA 2.7.5.1*	The MCO provides preventive services, which include, but are not limited to, initial and periodic evaluations, family planning services, prenatal care, laboratory services, and immunizations in accordance with TennCare rules and regulations.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
17) Occupational Therapy *CRA A.2.6.1.3* *TSA 2.6.1.3*	**Occupational Therapy:** a) Age 21 and older, as medically necessary, when provided by a licensed occupational therapist to restore, improve, or stabilize impaired functions b) Younger than age 21, as medically necessary, in accordance with TennCare Kids requirements	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
18) Physical Therapy *CRA A.2.6.1.3* *TSA 2.6.1.3*	**Physical Therapy:** a) Age 21 and older, as medically necessary, when provided by a licensed physical therapist to restore, improve, or stabilize impaired functions b) Younger than age 21, as medically necessary, in accordance with TennCare Kids requirements	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
19) Chiropractic Services *CRA A.2.6.1.3* *TSA 2.6.1.3*	**Chiropractic Services:** a) Age 21 and older, covered when determined to be a cost-effective alternative by the MCO b) Younger than age 21, covered as medically necessary in accordance with TennCare Kids requirements	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
20) Private Duty Nursing *CRA A.2.6.1.3* *TSA 2.6.1.3*	Private duty nursing is covered as medically necessary in accordance with the definition of private duty nursing in the Tennessee rules.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
21) Speech Therapy *CRA A.2.6.1.3* *TSA 2.6.1.3*	**Speech Therapy:** a) Age 21 and older, as medically necessary, when provided by a licensed speech therapist to restore speech (as long as there is continued medical	☐ Member Handbook ☐ Explanation of Benefits	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
	progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic, or personality disorder. b) Younger than age 21, as medically necessary in accordance with TennCare Kids requirements	☐ Other (Describe)		
Findings:				
Recommendations:				
22) Organ and Tissue Transplants and Donor Organ Procurement *CRA A.2.6.1.3* *TSA 2.6.1.3*	**Organ and Tissue Transplants and Donor Organ Procurement:** a) Age 21 and older, all medically necessary and non-investigational/experimental organ and tissue transplants, as covered by Medicare b) Younger than age 21, covered as medically necessary in accordance with TennCare Kids requirements	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
23) Reconstructive Breast Surgery *CRA A.2.6.1.3* *TSA 2.6.1.3* *TCA 56-7-2507*	Reconstructive Breast Surgery is covered in accordance with TCA 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, but not including a lumpectomy, as well as surgical procedures on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a nondiseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a nondiseased breast occurs within five years of the	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
	date the reconstructive breast surgery was performed on a diseased breast.			
Findings:				
Recommendations:				
24) Mammography Screening *TCA 56-7-2502*	The MCO provides mammography screenings a minimum of once for ages 35–40, every two years or more frequently on physician recommendation for ages 40–50, and annually for ages 50 and older.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
25) Phenylketonuria (PKU) *TCA 56-7-2505*	The MCO provides coverage for the treatment of PKU, including licensed professional medical services and special dietary formulas.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
26) Diabetic Services *TCA 56-7-2605*	The MCO provides coverage for diabetic equipment, supplies, and outpatient self-management training and education, including medical nutrition counseling, when medically necessary.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
27) Chlamydia Screens	The MCO provides for one annual chlamydia	☐ Member Handbook	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
TCA 56-7-2606	screening test in conjunction with an annual Pap smear for females who are not more than 29 years of age, if deemed medically necessary.	☐ Explanation of Benefits ☐ Other (Describe)		
Findings:				
Recommendations:				
28) Psychiatric Inpatient Hospital Services (Including Physician Services) *CRA A.2.6.1.4* *TSA 2.6.1.4*	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
29) Outpatient Mental Health Services (Including Physician Services) *CRA A.2.6.1.4* *TSA 2.6.1.4*	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
30) Inpatient/Residential and Outpatient Substance Abuse Benefits *CRA A.2.6.1.4* *TSA 2.6.1.4*	As medically necessary: When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services. Methadone clinic services are not covered for adults.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
Recommendations:				
31) 24-Hour Psychiatric Residential Treatment *CRA A.2.6.1.4* *TSA 2.6.1.4*	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
32) BH Crisis Services *CRA A.2.6.1.4* *TSA 2.6.1.4*	As necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
33) BH Intensive Community Based Treatment *CRA A.2.6.1.4* *TSA 2.6.1.4*	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
34) Psychiatric Rehabilitation Services *CRA A.2.6.1.4* *TSA 2.6.1.4*	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
		☐ Other (Describe)		
Findings:				
Recommendations:				
35) Nursing Facility Care *CRA A.2.6.1.5.3* *CRA A.2.6.1.6.4* *TSA 2.6.1.5.3*	As medically necessary: For CHOICES members in Group 1; on a short-term basis only (up to 90 days) for members in CHOICES Groups 2 and 3. A person enrolled in ECF CHOICES HCBS Groups 4, 5, and 6 may receive short-term nursing facility care, without being required to disenroll from their ECF CHOICES HCBS group until such time that it is determined that transition back to HCBS in ECF CHOICES HCBS will not occur within 90 days from admission. (TennCare*Select* Groups 1, 2, and 3 only)	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA*	**1.0**	**0.0**
Findings:				
Recommendations:				
36) Community-Based Residential Alternatives *CRA A.2.6.1.5.3* *TSA 2.6.1.5.3*	As medically necessary for CHOICES members in Group 2. For CHOICES members in Group 3, specified services and levels of reimbursement only (i.e., assisted care living facility, community living supports [CLS1]), and community living supports—family model (CLS-FM1).	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				

* *Responses found to be not applicable (NA) do not receive a point value and are not counted against the MCO.*

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
Recommendations:				
37) Personal Care Visits *CRA A.2.6.1.5.3* *TSA 2.6.1.5.3*	As medically necessary (up to two visits per day at intervals of no less than four hours between visits) for CHOICES members in Groups 2 and 3.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
38) Attendant Care *CRA A.2.6.1.5.3* *TSA 2.6.1.5.3*	As medically necessary (up to 1,080 hours per calendar year; up to 1,400 hours per full calendar year only for persons who require covered assistance with household chores or errands in addition to hands-on assistance with self-care tasks) for CHOICES members in Groups 2 and 3.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
39) Home-Delivered Meals *CRA A.2.6.1.5.3* *TSA 2.6.1.5.3*	As medically necessary (up to one meal per day) for CHOICES members in Groups 2 and 3.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
40) PERS *CRA A.2.6.1.5.3* *TSA 2.6.1.5.3*	As medically necessary for CHOICES members in Groups 2 and 3.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
41) Adult Day Care *CRA A.2.6.1.5.3* *TSA 2.6.1.5.3*	As medically necessary (up to 2,080 hours per calendar year) for CHOICES members in Groups 2 and 3.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
42) In-Home Respite Care *CRA A.2.6.1.5.3* *TSA 2.6.1.5.3*	As medically necessary (up to 216 hours per calendar year) for CHOICES members in Groups 2 and 3.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
43) Inpatient Respite Care *CRA A.2.6.1.5.3*	As medically necessary (up to nine days per calendar year) for CHOICES members in Groups 2 and 3.	☐ Member Handbook	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
TSA 2.6.1.5.3		☐ Explanation of Benefits ☐ Other (Describe) ☐ NA		
Findings:				
Recommendations:				
44) Assistive Technology *CRA A.2.6.1.5.3* *CRA A.2.6.1.6.3* *TSA 2.6.1.5.3*	As medically necessary up to $900 per calendar year for CHOICES members in Group 2 and 3; and up to $5,000 per calendar year for ECF CHOICES HCBS members in Groups 4, 5, 6, 7, and 8. (TennCare*Select* Groups 2 and 3 only)	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
45) Minor Home Modifications *CRA A.2.6.1.5.3* *CRA A.2.6.1.6.3* *TSA 2.6.1.5.3*	As medically necessary up to $6,000 per project, $10,000 per calendar year, and $20,000 per lifetime for CHOICES members in Groups 2, and 3; and ECF CHOICES HCBS members in Groups 4, 5, 6, 7, and 8 (TennCare*Select* Groups 2 and 3 only)	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
46) Pest Control *CRA A.2.6.1.5.3* *TSA 2.6.1.5.3*	As medically necessary (up to nine units per calendar year) for CHOICES members in Groups 2 and 3. (TennCare*Select* Groups 2 and 3 only)	☐ Member Handbook ☐ Explanation of Benefits	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
		☐ Other (Describe) ☐ NA		
Findings:				
Recommendations:				
47) ECF CHOICES HCBS*: Respite *CRA A.2.6.1.6.3*	As medically necessary (up to 30 days per calendar year or up to 216 hours per calendar year only for persons living with unpaid family caregivers) for ECF CHOICES HCBS members in Groups 4, 5, and 6.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
48) Supportive Home Care (SHC) *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES HCBS members in Group 4.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
49) Family Caregiver Stipend in lieu of SHC *CRA A.2.6.1.6.3*	As medically necessary (up to $500 per month for children under age 18; up to $1,000 per month for adults age 18 and older) for ECF CHOICES HCBS members in Group 4.	☐ Member Handbook ☐ Explanation of Benefits	**1.0**	**0.0**

* *TennCareSelect does not provide services to the ECF CHOICES HCBS population (i.e., Groups 4, 5, 6, 7, and 8)*

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
		☐ Other (Describe) ☐ NA		
Findings:				
Recommendations:				
50) Community Integration Support Services *CRA A.2.6.1.6.3*	As medically necessary subject to limitation specified in the approved 1115 Waiver and TennCare Rule for ECF CHOICES HCBS members in Groups 4, 5, 6, and 7.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:.				
Recommendations:				
51) Community Transportation *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES HCBS members in Groups 4, 5, 6, and 7.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
52) Independent Living Skills Training *CRA A.2.6.1.6.3*	As medically necessary subject to limitation specified in the approved 1115 Waiver and TennCare Rule for ECF CHOICES HCBS members in Groups 4, 5, 6, and 7.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
		☐ NA		
Findings:				
Recommendations:				
53) Community Support *CRA A.2.6.1.6.3*	As medically necessary for community support development, organization, and navigation for ECF CHOICES HCBS members in Groups 4 and 7.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
54) Family Caregiver Education and Training *CRA A.2.6.1.6.3*	As medically necessary (up $500 per calendar year) for ECF CHOICES HCBS members in Group 4 and 7.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
55) Family-to-Family Support *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES HCBS members in Groups 4 and 7.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
Findings:				
Recommendations:				
56) Decision-making Supports *CRA A.2.6.1.6.3*	As medically necessary (up to $500 per lifetime) for ECF CHOICES HCBS members in Groups 4, 5, 6, 7, and 8.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
57) Health Insurance Counseling *CRA A.2.6.1.6.3*	As medically necessary for health insurance counseling/forms assistance (up to 15 hours per calendar year) for ECF CHOICES HCBS members in Groups 4 and 7.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
58) Personal Assistance *CRA A.2.6.1.6.3*	As medically necessary (up to 215 hours per month) for ECF CHOICES HCBS members in Groups 5 and 6.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
Recommendations:				
59) Community Living Supports (CLS) *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES HCBS members in Groups 5 and 6.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
60) CLS-Family Model (CLS-FM) *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES HCBS members in Groups 5 and 6.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
61) Individual Education and Training *CRA A.2.6.1.6.3*	As medically necessary (up to $500 per calendar year) for ECF CHOICES HCBS members in Groups 5, 6, and 8.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:.				
Recommendations:				

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
62) Peer-to-peer Support and Navigation for Person-centered Planning, Self-Direction, Integrated Employment/Self-employment, and Independent Community Living *CRA A.2.6.1.6.3*	As medically necessary (up to $1,500 per lifetime) for ECF CHOICES HCBS members in Groups 5, 6, and 8.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
63) Specialized Consultation and Training *CRA A.2.6.1.6.3*	As medically necessary (up to $5,000 per calendar year) for ECF CHOICES HCBS members in Groups 5, 6, and 8. For adults in Group 6 benefit group determined to have exceptional medical and/or behavioral support needs, and for adults in Group 8, specialized consultation services are limited to $10,000 per person per calendar year.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
64) Adult Dental Services *CRA A.2.6.1.6.3*	As medically necessary (up to $5,000 per calendar year; up to $7,500 across three consecutive calendar years) for ECF CHOICES HCBS members in Groups 4, 5, 6, and 8. Group 4 benefits limited to adults age 21 and older	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
65) Employment Services *CRA A.2.6.1.6.3*	As medically necessary for employment services/supports as specified below (subject to limitations specified in the approved 1115 waiver and in TennCare Rule) for ECF CHOICES HCBS members in Groups 4, 5, 6, 7, and 8: ♦ Exploration ♦ Benefits counseling ♦ Discovery ♦ Situational observation and assessment ♦ Job development plan or self-employment plan ♦ Job development or self-employment start up ♦ Job coaching for individualized, integrated employment, or self-employment ♦ Coworker supports ♦ Supported employment small group enclave or small group mobile work crew ♦ Integrated employment path services: pre-vocational ♦ Employment discovery and customization ♦ Career advancement	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
66) Intensive Behavioral Family-centered Treatment, Stabilization and Supports (IBFCTSS) *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES HCBS members in Group 7.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**
Findings:				

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
Recommendations:				
67) Intensive Behavioral Community Transition and Stabilization Services *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES HCBS members in Group 8.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
68) Regulator Approval: Medicaid Handbook *CRA A.2.17.1.1* *TSA 2.17.1.1*	The MCO's Medicaid Member Handbook was approved by TennCare. Date of Approval: <MM/DD/YY>	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
69) Regulator Approval: ECF CHOICES Handbook *CRA A.2.17.1.1*	The MCO's ECF CHOICES Member Handbook was approved by TennCare. Date of Approval: <MM/DD/YY>	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
Accessibility Benefits Review—Member		**<##>%**	**0.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
1) Inpatient Hospital Services *CRA A.2.6.1.3* *TSA 2.6.1.3*	As medically necessary: Under age 21: Includes rehabilitation hospital facility Age 21 and older: Inpatient rehabilitation hospital facility services are not covered for adults unless determined to be a cost effective alternative.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
2) Outpatient Hospital Services *CRA A.2.6.1.3* *TSA 2.6.1.3*	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
3) Physician Inpatient Services *CRA A.2.6.1.3* *TSA 2.6.1.3*	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
4) Physician Outpatient Services/ Community Health Clinic Services/ Other Clinic Services *CRA A.2.6.1.3* *TSA 2.6.1.3*	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:.				
Recommendations:				

* *Check appropriate box for location of benefit. Only one checked box is necessary for a full score.*

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
5) Lab and X-Ray Services *CRA A.2.6.1.3* *TSA 2.6.1.3*	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:.				
Recommendations:				
6) Maternity/Postpartum Services *TCA 56-7-2350*	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
7) Hospice Care *CRA A.2.6.1.3* *TSA 2.6.1.3*	As medically necessary (must be provided by a Medicare-Certified Hospice)	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
8) Vision Services *CRA A.2.6.1.3* *TSA 2.6.1.3*	Preventive, diagnostic, and treatment services (including eyeglasses) for members younger than 21 years of age as medically necessary in accordance with TennCare Kids requirements. One pair of cataract glasses or lenses following cataract surgery is covered for adults. Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye, is covered as medically necessary.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
9) Home Healthcare *CRA A.2.6.1.3* *TSA 2.6.1.3*	Covered as medically necessary for those younger or older than 21 years of age in accordance with the definition of home healthcare in the Tennessee rules.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
10) Durable Medical Equipment *CRA A.2.6.1.3* *TSA 2.6.1.3*	As medically necessary and covered in accordance with TennCare rules and regulations.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
11) Medical Supplies *CRA A.2.6.1.3* *TSA 2.6.1.3*	As medically necessary and covered in accordance with TennCare rules and regulations.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
12) Emergency Air and Ground Ambulance Transportation *CRA A.2.6.1.3* *TSA 2.6.1.3*	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
13) Nonemergency Transportation, Including Nonemergency Ambulance Transportation *CRA A.2.6.1.3* *TSA 2.6.1.3*	Nonemergency transportation services are provided in accordance with federal law and the Tennessee Division of TennCare's rules and P&Ps. Nonemergency transportation services are provided to convey members to and from TennCare covered	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
	services.			
Findings:				
Recommendations:				
14) Renal Dialysis Services *CRA A.2.6.1.3* *TSA 2.6.1.3*	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
15) TennCare Kids Services *CRA A.2.6.1.3* *TSA 2.6.1.3*	Services for members younger than 21 years of age: a) As medically necessary, except that screenings do not have to be medically necessary b) Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal and state requirements	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
16) Preventive Care Services *CRA A.2.7.5.1* *TSA 2.7.5.1*	The MCO provides preventive services, which include, but are not limited to, initial and periodic evaluations, family planning services, prenatal care, laboratory services, and immunizations in accordance with TennCare rules and regulations.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
17) Occupational Therapy *CRA A.2.6.1.3*	Occupational Therapy:	☐ Provider Manual ☐ Contract	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
TSA 2.6.1.3	a) Age 21 and older, as medically necessary, when provided by a licensed occupational therapist to restore, improve, or stabilize impaired functions b) Younger than age 21, as medically necessary, in accordance with TennCare Kids requirements	☐ Other (Describe)		
Findings:				
Recommendations:				
18) Physical Therapy *CRA A.2.6.1.3* *TSA 2.6.1.3*	Physical Therapy: a) Age 21 and older, as medically necessary, when provided by a licensed physical therapist to restore, improve, or stabilize impaired functions b) Younger than age 21, as medically necessary, in accordance with TennCare Kids requirements	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
19) Chiropractic Services *CRA A.2.6.1.3* *TSA 2.6.1.3*	Chiropractic Services: a) Age 21 and older, covered when determined to be a cost-effective alternative by the MCO b) Younger than age 21, covered as medically necessary in accordance with TennCare Kids requirements	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
20) Private Duty Nursing *CRA A.2.6.1.3* *TSA 2.6.1.3*	Private duty nursing is covered as medically necessary in accordance with the definition of private duty nursing in the Tennessee rules.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
Recommendations:				
21) Speech Therapy *CRA A.2.6.1.3* *TSA 2.6.1.3*	Speech Therapy: a) Age 21 and older, as medically necessary, when provided by a licensed speech therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic, or personality disorder. b) Younger than age 21, as medically necessary in accordance with TennCare Kids requirements	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
22) Organ and Tissue Transplants and Donor Organ Procurement *CRA A.2.6.1.3* *TSA 2.6.1.3*	Organ and Tissue Transplants and Donor Organ Procurement: a) Age 21 and older, all medically necessary and non-investigational/experimental organ and tissue transplants, as covered by Medicare b) Younger than age 21, covered as medically necessary in accordance with TennCare Kids requirements	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
23) Reconstructive Breast Surgery *CRA A.2.6.1.3* *TSA 2.6.1.3* *TCA 56-7-2507*	Reconstructive Breast Surgery is covered (in accordance with TCA 56-7-2507) which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, but not including a lumpectomy, as well as surgical procedures on the non-diseased breast to establish symmetry between the two breasts in the	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
	manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five years of the date the reconstructive breast surgery was performed on a diseased breast.			
Findings:				
Recommendations:				
24) Mammography Screening *TCA 56-7-2502*	The MCO provides mammography screenings a minimum of once for ages 35–40, every two years or more frequently on physician recommendation for ages 40–50, and annually for ages 50 and older.	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
25) PKU *TCA 56-7-2505*	The MCO provides coverage for the treatment of PKU, including licensed professional medical services and special dietary formulas.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
26) Diabetic Services *TCA 56-7-2605*	The MCO provides coverage for diabetic equipment, supplies, and outpatient self-management training and education, including medical nutrition counseling, when medically necessary.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
27) Chlamydia Screens	The MCO provides for one annual chlamydia	☐ Provider Manual	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
TCA 56-7-2606	screening test in conjunction with an annual Pap smear for females who are not more than 29 years of age, if deemed medically necessary.	☐ Contract ☐ Other (Describe)		
Findings:				
Recommendations:				
28) Psychiatric Inpatient Hospital Services (Including Physician Services) *CRA A.2.6.1.4* *TSA 2.6.1.4*	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
29) Outpatient Mental Health Services, Including Physician Services *CRA A.2.6.1.4* *TSA 2.6.1.4*	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
30) Inpatient/Residential and Outpatient Substance Abuse Benefits *CRA A.2.6.1.4* *TSA 2.6.1.4*	As medically necessary: When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services. Methadone clinic services are not covered for adults.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
31) 24-Hour Psychiatric Residential Treatment *CRA A.2.6.1.4*	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
TSA 2.6.1.4				
Findings:				
Recommendations:				
32) BH Crisis Services *CRA A.2.6.1.4* *TSA 2.6.1.4*	As necessary	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
33) BH Intensive Community Based Treatment *CRA A.2.6.1.4* *TSA 2.6.1.4*	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
34) Psychiatric Rehabilitation Services *CRA A.2.6.1.4* *TSA 2.6.1.4*	As medically necessary	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
35) Nursing Facility Care *CRA A.2.6.1.5.3* *CRA A.2.6.1.6.4* *TSA 2.6.1.5.3*	As medically necessary: For CHOICES members in Group 1; on a short-term basis only (up to 90 days) for members in CHOICES Groups 2 and 3. A person enrolled in ECF CHOICES HCBS Groups 4,	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA*	**1.0**	**0.0**

* *Responses found to be not applicable (NA) do not receive a point value and are not counted against the MCO.*

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
	5, and 6 may receive short-term nursing facility care, without being required to disenroll from their ECF CHOICES HCBS group until such time that it is determined that transition back to HCBS in ECF CHOICES HCBS will not occur within 90 days from admission. (TennCare*Select* Groups 1, 2, and 3 only)			
Findings:				
Recommendations:				
36) Community-Based Residential Alternatives *CRA A.2.6.1.5.3* *TSA 2.6.1.5.3*	As medically necessary for CHOICES members in Group 2. For CHOICES members in Group 3, specified services and levels of reimbursement only (i.e., assisted care living facility, community living supports [CLS1]), and community living supports—family model (CLS-FM1).	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
37) Personal Care Visits *CRA A.2.6.1.5.3* *TSA 2.6.1.5.3*	As medically necessary (up to two visits per day at intervals of no less than four hours between visits) for CHOICES members in Groups 2 and 3.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
38) Attendant Care *CRA A.2.6.1.5.3* *TSA 2.6.1.5.3*	As medically necessary (up to 1,080 hours per calendar year; up to 1,400 hours per full calendar year only for persons who require covered assistance	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
	with household chores or errands in addition to hands-on assistance with self-care tasks) for CHOICES members in Groups 2 and 3.	☐ NA		
Findings:				
Recommendations:				
39) Home-Delivered Meals *CRA A.2.6.1.5.3* *TSA 2.6.1.5.3*	As medically necessary (up to one meal per day) for CHOICES members in Groups 2 and 3.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
40) PERS *CRA A.2.6.1.5.3* *TSA 2.6.1.5.3*	As medically necessary for CHOICES members in Groups 2 and 3.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
41) Adult Day Care *CRA A.2.6.1.5.3* *TSA 2.6.1.5.3*	As medically necessary (up to 2,080 hours per calendar year) for CHOICES members in Groups 2 and 3.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
42) In-Home Respite Care *CRA A.2.6.1.5.3*	As medically necessary (up to 216 hours per calendar year) for CHOICES members in Groups 2 and 3.	☐ Provider Manual ☐ Contract	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
TSA 2.6.1.5.3		☐ Other (Describe) ☐ NA		
Findings:				
Recommendations:				
43) Inpatient Respite Care *CRA A.2.6.1.5.3* *TSA 2.6.1.5.3*	As medically necessary (up to nine days per calendar year) for CHOICES members in Groups 2 and 3.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
44) Assistive Technology *CRA A.2.6.1.5.3* *CRA A.2.6.1.6.3* *TSA 2.6.1.5.3*	As medically necessary up to $900 per calendar year for CHOICES members in Groups 2 and 3; and up to $5,000 per calendar year for ECF CHOICES HCBS members in Groups 4, 5, 6, 7, and 8. (TennCare*Select* Groups 2 and 3 only)	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
45) Minor Home Modifications *CRA A.2.6.1.5.3* *CRA A.2.6.1.6.3* *TSA 2.6.1.5.3*	As medically necessary up to $6,000 per project, $10,000 per calendar year, and $20,000 per lifetime for CHOICES members in Groups 2, and 3; and ECF CHOICES HCBS members in Groups 4, 5, 6, 7, and 8. (TennCare*Select* Groups 2 and 3 only)	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
46) Pest Control *CRA A.2.6.1.5.3* *TSA 2.6.1.5.3*	As medically necessary (up to nine units per calendar year) for CHOICES members in Groups 2 and 3.	☐ Provider Manual ☐ Contract	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
		☐ Other (Describe) ☐ NA		
Findings:				
Recommendations:				
47) ECF CHOICES HCBS*: Respite *CRA A.2.6.1.6.3*	As medically necessary (up to 30 days per calendar year or up to 216 hours per calendar year only for persons living with unpaid family caregivers) for ECF CHOICES HCBS members in Groups 4, 5, and 6.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
48) SHC *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES HCBS members in Group 4.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
49) Family Caregiver Stipend in lieu of SHC *CRA A.2.6.1.6.3*	As medically necessary (up to $500 per month for children under age 18; up to $1,000 per month for adults age 18 and older) for ECF CHOICES HCBS members in Group 4.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				

* *TennCareSelect does not participate in the ECF CHOICES program. (i.e., Groups 4, 5, 6, 7, and 8)*

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
50) Community Integration Support Services *CRA A.2.6.1.6.3*	As medically necessary subject to limitation specified in the approved 1115 Waiver and TennCare Rule for ECF CHOICES HCBS members in Groups 4, 5, 6, and 7.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
51) Community Transportation *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES HCBS members in Groups 4, 5, 6, and 7.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
52) Independent Living Skills Training *CRA A.2.6.1.6.3*	As medically necessary subject to limitation specified in the approved 1115 Waiver and TennCare Rule for ECF CHOICES HCBS members in Groups 4, 5, 6, and 7.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
53) Community Support *CRA A.2.6.1.6.3*	As medically necessary for community support development, organization, and navigation for ECF CHOICES HCBS members in Groups 4 and 7.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
54) Family Caregiver Education and Training *CRA A.2.6.1.6.3*	As medically necessary (up $500 per calendar year) for ECF CHOICES HCBS members in Groups 4 and 7.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
55) Family-to-Family Support *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES HCBS members in Groups 4 and 7.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
56) Decision-making Supports *CRA A.2.6.1.6.3*	As medically necessary (up to $500 per lifetime) for ECF CHOICES HCBS members in Groups 4, 5, 6, 7, and 8.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
57) Health Insurance Counseling *CRA A.2.6.1.6.3*	As medically necessary for health insurance counseling/forms assistance (up to 15 hours per calendar year) for ECF CHOICES HCBS members in Groups 4 and 7.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
58) Personal Assistance *CRA A.2.6.1.6.3*	As medically necessary (up to 215 hours per month) for ECF CHOICES HCBS members in Groups 5 and 6.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
59) CLS *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES HCBS members in Groups 5 and 6.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
60) CLS-FM *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES HCBS members in Groups 5 and 6.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
61) Individual Education and Training *CRA A.2.6.1.6.3*	As medically necessary (up to $500 per calendar year) for ECF CHOICES HCBS members in Groups 5, 6, and 8.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
62) Peer-to-peer Support and Navigation for Person-centered Planning, Self-Direction, Integrated Employment/Self-employment, and Independent Community Living *CRA A.2.6.1.6.3*	As medically necessary (up to $1,500 per lifetime) for ECF CHOICES HCBS members in Groups 5, 6, and 8.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
63) Specialized Consultation and Training *CRA A.2.6.1.6.3*	As medically necessary (up to $5,000 per calendar year) for ECF CHOICES HCBS members in Groups 5, 6, and 8. For adults in ECF CHOICES HCBS Group 6 benefit group determined to have exceptional medical and/or behavioral support needs, and for adults in Group 8, specialized consultation services are limited to $10,000 per person per calendar year.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
64) Adult Dental Services *CRA A.2.6.1.6.3*	As medically necessary (up to $5,000 per calendar year; up to $7,500 across three consecutive calendar years) for ECF CHOICES HCBS members in Groups 4, 5, 6, and 8. ECF CHOICES HCBS members in Group 4 benefits limited to adults age 21 and older.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
65) Employment Services *CRA A.2.6.1.6.3*	As medically necessary for employment services/supports as specified below (subject to	☐ Provider Manual	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
	limitations specified in the approved 1115 waiver and in TennCare Rule) for ECF CHOICES HCBS members in Groups 4, 5, 6, 7, and 8: ♦ Exploration ♦ Benefits counseling ♦ Discovery ♦ Situational observation and assessment ♦ Job development plan or self-employment plan ♦ Job development or self-employment start up ♦ Job coaching for individualized, integrated employment, or self-employment ♦ Co-worker supports ♦ Supported employment small group enclave or small group mobile work crew ♦ Integrated employment path services: pre-vocational ♦ Employment discovery and customization ♦ Career advancement	☐ Contract ☐ Other (Describe) ☐ NA		
Findings:				
Recommendations:				
66) Intensive Behavioral Family-centered Treatment, Stabilization, and Supports (IBFCTSS) *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES HCBS members in Group 7.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
67) Intensive Behavioral Community Transition and Stabilization Services	As medically necessary for ECF CHOICES HCBS members in Group 8.	☐ Met	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
CRA A.2.6.1.6.3		☐ Not Met ☐ NA		
Findings:				
Recommendations:				
68) Regulator Approval: Provider Manual *CRA A.2.18.6.11* *TSA 2.18.6.13*	The MCO's Provider Manual was approved by TennCare. Date of Approval: <MM/DD/YY> (Please be prepared to show proof of the approval during the review.)	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
Accessibility Benefits Review—Provider		**<##.#>%**	**0.0**	**0.0**

ANA Standards Tools—DBM

2021 Annual Network Adequacy Survey: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
1) Statewide Network *TennCare Dental Benefit Manager Contract (TDC) A.19.*	The DBM has a statewide provider network, including general dentists and dental specialists.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
2) Standards for Access *TDC A.20.*	Through a review of plan documents there is evidence that the DBM has established standards for access such as routine, urgent, and emergency care. Performance concerning access is assessed against these standards.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
3) Emergency Services *TDC A.20.* *42 CFR § 438.206(a)* *42 CFR § 438.206(c)(1)(iii)*	The DBM is responsible for the provision of treatment for emergency medical conditions 24-hours a day, seven days a week.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
4) Access to Care *TDC A.20.* *42 CFR § 438.206(c)(1)(i)*	Through a review of provider contracts and plan documents, there is evidence that the DBM requires that its contracted providers offer adequate access to covered services. At a minimum, the DBM must maintain a network of dental providers with a sufficient number of providers who accept new TennCare members in accordance with the required standards: a) Appointment wait times do not exceed three weeks for regular appointments	a) ☐ Met ☐ Not Met b) ☐ Met ☐ Not Met Each Variable = 0.50	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
	b) Appointment wait times do not exceed 48 hours for urgent care			
Findings:				
Recommendations:				
5) Hours of Operation *TDC A.20.* *42 CFR § 438.206(c)(1)(ii)*	The network providers must offer hours of operation that are no less than the hours of operation offered to commercial members.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
6) Transport Distance and Time *TDC A.23.* *42 CFR § 438.206(c)(1)(i)* *42 CFR § 438.207(b)(2)*	Through a review of plan documents, there is evidence that transportation time to dental providers as measured by GeoAccess software, do not exceed an average of: a) 30 miles or 45 minutes for general dental services b) 60 miles or 60 minutes for oral surgery services c) 60 miles or 60 minutes for orthodontic services d) 70 miles or 70 minutes for pediatric dental services e) 30 miles or 45 minutes for 75 percent, and 60 miles or 60 minutes for 100 percent of ECF CHOICES HCBS providers	a) ☐ Met ☐ Not Met ☐ NA b) ☐ Met ☐ Not Met ☐ NA c) ☐ Met ☐ Not Met ☐ NA d) ☐ Met ☐ Not Met ☐ NA e) ☐ Met ☐ Not Met ☐ NA Each Variable = 0.20	**1.0**	**0.0**
Findings:				

2021 Annual Network Adequacy Survey: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
Recommendations:				
7) Office Wait Time *TDC A.24.* *42 CFR § 438.206(c)(1)(i)*	Through a review of plan documents, there is evidence that the office wait time does not exceed 45 minutes.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
8) Provider Choice *TDC A.25.*	Through a review of plan documents, there is evidence that each member is permitted to obtain covered services from any general or pediatric dentist in the DBM's network who is accepting new patients.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
9) Access for Emergent and Urgent Care *TDC A.44.* *42 CFR § 438.206(c)(1)(i)*	Through a review of plan documents, there is evidence that the DBM ensures access to services for urgent dental and oral conditions or injuries based on the professional judgment of the member's treating dentist, other dental professional, PCP, or triage nurse who is trained in dental care and oral healthcare.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
10) Out-of-Network Providers *TDC A.26.TDC A.46.A.* *42 CFR § 438.206(b)(4)*	If the DBM is unable to provide necessary medical services covered under the contract, the DBM must adequately and timely cover the services out-of-network for the member for as long as the DBM is unable to furnish the services with an in-network provider.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				

2021 Annual Network Adequacy Survey: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
11) Limited English Proficiency (LEP)/Cultural Competence *TDC A.27.* *42 CFR § 438.206(c)(2)*	The DBM participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with LEP and diverse cultural and ethnic backgrounds.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
12) Non-Discrimination *TDC A.67.* *TDC A.111.* *TDC A. 138* *42 CFR 438.210(c)*	The DBM develops written P&Ps that demonstrate: a) Non-discrimination in the provision of services to members on the basis of race, color, sex, religion, national origin, age, handicap, health, economic status or payment source b) Non-discrimination in the selection and/or retention of providers that serve high-risk populations or specialize in conditions that require costly treatment	a) ☐ Met ☐ Not Met b) ☐ Met ☐ Not Met Each Variable = 0.50	**1.0**	**0.0**
Findings:				
Recommendations:				
13) Dental Referrals *TDC A.46.*	The general dentist or pediatric dentist: a) Must refer members to a dental specialist (e.g., endodontists, oral surgeons, orthodontists, periodontists, or prosthodontists) for the initial visit for services requiring specialized expertise b) Does not need to provide separate referrals for subsequent visits to the same specialist in a course of treatment.	a) ☐ Met ☐ Not Met b) ☐ Met ☐ Not Met Each Variable = 0.50	**1.0**	**0.0**
Findings:				
Recommendations:				
14) Second Opinions *TDC A.46.a.* *42 CFR § 438.206(b)(3)*	The DBM provides for a second opinion from a qualified healthcare professional within the network or arranges for the member to obtain a second opinion outside the network at no	☐ Met ☐ Not Met	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
	cost to the member.			
Findings:				
Recommendations:				
15) Direct Access to Specialists *TDC A.46.b.*	The DBM has a mechanism to allow special needs members and members who require an ongoing course of treatment direct access to specialists, as appropriate.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
16) Non-Traditional Fluoride Varnish and Dental Screening Program *TDC A.5.a.4.*	The DBM implements a program that allows non-traditional providers (such as PCPs, pediatricians, physician assistants, nurse practitioners, and public health nurses) to conduct dental screenings and apply fluoride varnish to the teeth of TennCare members six months through five years of age only if fluoride varnish application and dental screening are also conducted at the same visit.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
Standard Score for Availability and Accessibility		**<##>%**	**0.0**	**0.0**

2021 Annual Network Adequacy Survey: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)				
1) Member Education *TDC A.115.*	Education concerning measures to promote a member's oral health and prevent oral disease as required by EPSDT	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
2) Oral Health Assessments *TDC A.6.*	Oral health assessments	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
3) Examinations of Teeth and Oral Cavity *TDC A.6.*	Examinations of the teeth and oral cavity	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
4) Topical Fluoride *TDC A.6.*	Topical fluoride	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
5) Application of Dental Sealants *TDC A.6.*	Application of dental sealants	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)				
Findings:				
Recommendations:				
6) Dental Prophylaxis Services *TDC A.6.*	Dental prophylaxis services	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
7) Diagnostic Services *TDC A.5*	Radiographic, laboratory and other diagnostic services	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
8) Restorative Services *TDC A.6.*	Restorative services to include amalgams, resin and crowns	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
9) Orthodontic Services *TDC A.5.a.* *TDC A.46.*	Orthodontic services	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
10) Endodontic Services *TDC A.46.*	Endodontic services	☐ Member Handbook	**1.0**	**0.0**

2021 Annual Network Adequacy Survey: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)				
		☐ Explanation of Benefits ☐ Other (Describe)		
Findings:				
Recommendations:				
11) Oral Surgery *TDC A.46.*	Oral surgery	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
12) Periodontic Services *TDC A.46.*	Periodontic services	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
13) Oral Pathology Services *TDC A.66.j.*	Oral pathology services	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
14) Anesthesia Services *TDC A.49.(b)(1–2)*	Anesthesia services	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				

2021 Annual Network Adequacy Survey: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)				
15) Member Handbook Approval *TDC A.10.*	The Member Handbooks were approved by TennCare prior to distribution. Date of Approval: <MM/DD/YY> (Please be prepared to show proof of the approval during the review.)	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
Standard Score for Benefit Review—Member		**<##>%**	**0.0**	**0.0**

2021 Annual Network Adequacy Survey: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)				
1) Member Education *TDC A.115.*	Education concerning measures to promote a member's oral health and prevent oral disease as required by EPSDT	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
2) Oral Health Assessments *TDC A.6.*	Oral health assessments	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
3) Examinations of Teeth and Oral Cavity *TDC A.6.*	Examinations of the teeth and oral cavity	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
4) Topical Fluoride *TDC A.6.*	Topical fluoride	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				

2021 Annual Network Adequacy Survey: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)				
5) Application of Dental Sealants *TDC A.6.*	Application of dental sealants	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
6) Dental Prophylaxis Services *TDC A.5.*	Dental prophylaxis services	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
7) Diagnostic Services *TDC A.5.*	Radiographic, laboratory and other diagnostic services	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
8) Restorative Services *TDC A.6.*	Restorative services to include amalgams, resin and crowns	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
9) Orthodontic Services *TDC A.5.* *TDC A.46.*	Orthodontic services	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				

2021 Annual Network Adequacy Survey: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)				
Recommendations:				
10) Endodontic Services *TDC A.46.*	Endodontic services	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
11) Oral Surgery *TDC A.46.*	Oral surgery	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
12) Periodontic Services *TDC A.46.*	Periodontic services	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
13) Oral Pathology Services *TDC A.66.j.*	Oral pathology services	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				

2021 Annual Network Adequacy Survey: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)				
14) Anesthesia Services *TDC A.49.*	Anesthesia services	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
15) ECF CHOICES HCBS: Preventive Services *TDC A.5.b.2.(a)*	ECF CHOICES Services: Preventive Dental Services	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA*	**1.0**	**0.0**
Findings:				
Recommendations:				
16) ECF CHOICES HCBS: Fillings *TDC A.5.b.2.(a)*	ECF CHOICES HCBS Services: Fillings	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
17) ECF CHOICES HCBS: Root Canals *TDC A.5.b.2.(a)*	ECF CHOICES HCBS Services: Root Canals	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
18) ECF CHOICES HCBS: Extractions *TDC A.5.b.2.(a)*	ECF CHOICES HCBS Services: Extractions	☐ Provider Manual	**1.0**	**0.0**

* *Responses found to be not applicable (NA) do not receive a point value and are not counted against the DBM.*

2021 Annual Network Adequacy Survey: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)				
		☐ Contract ☐ Other (Describe)		
Findings:				
Recommendations:				
19) ECF CHOICES HCBS: Periodontics *TDC A.5.b.2.(a)*	ECF CHOICES HCBS Services: Periodontics	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
20) ECF CHOICES HCBS: Dentures *TDC A.5.b.2.(a)*	ECF CHOICES HCBS Services: Dentures	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
21) ECF CHOICES HCBS: Sedation Services *TDC A.5.b.2.(a)*	ECF CHOICES HCBS Services: Sedation Services—may include medically necessary and appropriate deep sedation or general anesthesia	☐Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
22) ECF CHOICES HCBS: Benefit Maximums *TDC A.5.b.4.*	ECF CHOICES HCBS Services: Benefit maximum of $5,000 per member per calendar year and $7,500 per member across three consecutive calendar years	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				

2021 Annual Network Adequacy Survey: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)				
23) ECF CHOICES HCBS: Provider Training *TDC A.53.*	ECF CHOICES HCBS Provider Training: Furnishes educational training/webinars and best practices information to contracted ECF CHOICES dental providers	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
24) Approval of Provider Manual *TDC A.55.*	Any revisions to the Provider Manual are submitted to TennCare and TDCI for review and approval prior to distribution Date of Approval:<MM/DD/YY> (Please be prepared to show proof of the approval during the review.)	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**
Findings:				
Recommendations:				
Standard Score for Benefit Review—Provider		**<##>%**	**0.0**	**0.0**

ANA Standards Tools—PBM

2021 Annual Network Adequacy Survey: PBM				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
1) Statewide Network *PBMC A.10.* *42 CFR 438.207(a)*	The PBM maintains and monitors a network of appropriate providers that is sufficient to provide adequate access to all services covered under the TennCare contract for all enrollees.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
2) Statewide Network of Pharmacy Providers *PBMC A.49.a* *42 CFR 438.207(a)(b)(c)(d)*	The PBM has statewide network of pharmacy providers with a sufficient number of pharmacies to provide adequate access for TennCare enrollees within the State.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
3) Standards for Access *PBMC A.49.a* *42 CFR 438.207(a)*	When establishing and maintaining a network of pharmacy providers, the PBM considers: a) The anticipated need to have a prescription filled outside the service area b) The expected utilization of services, taking into consideration the pharmaceutical needs of specific TennCare populations served by the PBM c) The numbers and types (in terms of training, experience, and specialization) of pharmacies required to provide the contracted TennCare services d) The geographic location of pharmacy providers and TennCare enrollees, considering: i. distance, travel time	a) ☐ Met ☐ Not Met ☐ NA b) ☐ Met ☐ Not Met ☐ NA c) ☐ Met ☐ Not Met ☐ NA d) ☐ Met ☐ Not Met ☐ NA	**4.0**	**0.0**

2021 Annual Network Adequacy Survey: PBM				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
	ii. the means of transportation ordinarily used by TennCare enrollees iii. whether the location provides physical access for TennCare enrollees with disabilities			
Findings:				
Recommendations:				
4) Emergency Services *PBMC A.49.a* *42 CFR § 438.206(c)(1)(iii)*	The PBM is responsible for the provision of treatment 24-hours a day, seven days a week, when medically necessary.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
5) Hours of Operation *PBMC A.49.a* *42 CFR § 438.206(c)(1)(ii)*	The network providers must offer hours of operation that are no less than the hours of operation offered to commercial members.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
6) Access Distance and Time *PBMC A.49.b* *42 CFR § 438.206(c)(1)(i)*	Through a review of plan documents, there is evidence that transportation distance and time to pharmacy providers as measured by Quest Analytics Analysis software, do not exceed an average of: a) 3 miles and 15 minutes for urban areas b) 10 miles and 20 minutes for suburban areas c) 25 miles and 30 minutes for rural areas	a) ☐ Met ☐ Not Met ☐ NA b) ☐ Met ☐ Not Met ☐ NA c) ☐ Met ☐ Not Met ☐ NA	**3.0**	**0.0**

2021 Annual Network Adequacy Survey: PBM				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
Findings:				
Recommendations:				
7) Exceptions to the Access Requirements *PBMC A.49.b*	Exceptions to the access distance and time requirements are justified and documented to the State on the basis of community standards.	☐ Met ☐ Not Met ☐ NA	**0.0**	**0.0**
Findings:				
Recommendations:				
8) Special Arrangements for Enrollees with Exceptions to the Access Requirements *PBMC A.49.b*	When requested by the State, the PBM makes arrangements to provide pharmacy services to enrollees residing in locations where a suitable network provider is not available.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
9) Out-of-Network Providers *PBMC A.13.* *42 CFR § 438.206(b)(4)*	When necessary, the PBM enters into short-term agreements with non-network pharmacy providers who provide pharmacy services to enrollees for a specified period of time.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
10) Out-of-Network Provider Payments *PBMC A.14.* *42 CFR § 438.206(b)(5)*	The PBM coordinates payment with non-network providers and ensures the cost to the enrollee is no greater than it would be if the services were furnished within the network.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				

2021 Annual Network Adequacy Survey: PBM				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Standards for Availability and Accessibility				
11) Limited English Proficiency (LEP)/Cultural Competence *PBMC A.10.* *42 CFR § 438.206(b)(1)* *42 CFR § 438.206(c)(2)*	The PBM participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with LEP or physical or mental disabilities.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
12) Compliance with State and federal Prescribing Laws *PBMC A.10.c.*	The PBM ensures provider compliance with State and federal prescribing laws requiring written prescriptions only be filled if they are presented on an approved tamper-proof form.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
13) Information on the PBM's Website about the Provider Network *PBMC A.14.*	The PBM furnishes information regarding its provider network on a website.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
Standard Score for Availability and Accessibility		**0%**	**17.0**	**0.0**

ANA Contract File Review Tools—MCOs

Primary Care Providers

MCO: <MCO>	Reviewer:										Date of Review: X/XX/2021										# of Files: ##								
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
A) Specify that the provider may not refuse to provide covered medically necessary or covered preventive services to a child under the age of twenty-one (21) or a TennCare Medicaid patient under this Contract/ Agreement for non-medical reasons. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship. *CRA A.2.12.9.6* *TSA 2.12.9.6*																														
B) Specify the functions and/or services to be provided by the provider and assure that the functions and/or services to be provided are within the scope of his/her professional/ technical practice. *CRA A.2.12.9.7* *TSA 2.12.9.7*																														
C) Specify the amount, duration and scope of services to be provided by the provider and inform the provider of TennCare non-covered services as described in Section A.2.10 of the CRA and Section 2.10 of the TSA and the TennCare rules and regulations. *CRA A.2.12.9.8* *TSA 2.12.9.8*																														

* *Y = Yes, N = No, P = Partial*

MCO: <MCO>	Reviewer:										Date of Review: X/XX/2021										# of Files: ##								
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
D) Provide that emergency services be rendered without the requirement of prior authorization of any kind. *CRA A.2.12.9.9* *TSA 2.12.9.9*																														
E) If the provider performs laboratory services, require the provider to meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988. *CRA A.2.12.9.12* *TSA 2.12.9.12*																														
F) Specify that the Contractor shall monitor the quality of services delivered under the provider agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical, behavioral health, or long-term-care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TennCare. *CRA A.2.12.9.22* *TSA 2.12.9.22*																														
G) Require that the provider comply with corrective action plans initiated by the Contractor. *CRA A.2.12.9.23* *TSA 2.12.9.23*																														

MCO: <MCO>	Reviewer:										Date of Review: X/XX/2021										# of Files: ##								
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
H) Informs providers of the package of benefits that TennCare Kids offers and which requires providers to make treatment decisions based upon children's individual medical and behavioral health needs. All provider agreements shall contain language that references the TennCare Kids requirements. *CRA A.2.12.9.62* *TSA 2.12.9.62*																														
I) Include a provision which states that providers are not permitted to encourage or suggest, in any way, that TennCare children be placed into state custody in order to receive medical, behavioral, or long-term-care services covered by TennCare. *CRA A.2.12.9.63* *TSA 2.12.9.63*																														
J) Provide for the participation and cooperation in any internal and external quality management/quality improvement, monitoring, utilization review, peer review and/or appeal procedures established by the Contractor and/or TennCare. *CRA A.2.12.9.20* *TSA 2.12.9.20*																														
K) Provide that TennCare, the U.S. Department of Health and Human Services Office of the Inspector General (DHHS OIG), Office of the Comptroller of the Treasury, OIG, Tennessee Bureau of Investigation Medicaid Fraud Control Division, and the Department of Justice, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether																														

MCO: <MCO>	Reviewer:																														
	Date of Review: X/XX/2021																											# of Files: ##			
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
announced or unannounced, or other means any records pertinent to this Contract/Agreement including, but not limited to medical records, billing records, financial 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. *CRA A.2.12.9.18* *TSA 2.12.9.18*																														
L) Require safeguarding of information about enrollees according to applicable state and federal laws and regulations and as described in CRA Sections A.2.27 and E.6 and in TSA Sections 2.27 and 5.33 of the Contract/Agreement. *CRA A.2.12.9.55* *TSA 2.12.9.55*																														
M) Specify that unreasonable delay in providing care to a pregnant member seeking prenatal care shall be considered a material breach of the provider's agreement with the Contractor and include the definition of unreasonable delay as described in Section A.2.7.5.2.3 of the CRA and Section 2.7.5.2.3 of the TSA. *CRA A.2.12.9.11* *TSA 2.12.9.11*																														

MCO: <MCO>	Reviewer:										Date of Review: X/XX/2021										# of Files: ##								
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
N) Provide for monitoring, whether announced or unannounced, of services rendered to members. *CRA A.2.12.9.19* *TSA 2.12.9.19*																														
O) Specify that the no person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws are excluded from participation in, except as specified in Section A 2.3.5 of the CRA and Section 2.3.5 of the TSA, or be denied benefits of, or be otherwise subjected to discrimination in the performance of the provider's obligation under its agreement with the Contractor or in the employment practices of the provider. *CRA A.2.12.9.65.1* *TSA 2.12.9.65.1*																														
P) Specify that the provider have written procedures for the provision of language assistance services to members and/or the member's representative. Language assistance services include interpretation and translation services and effective communication assistance in alternative formats for any member and/or the member's representative who needs such services, including but not limited to, members with LEP and individuals with disabilities. *CRA A.2.12.9.65.2* Specify that the provider have written procedures for the provision of language interpretation and translation services for any members who needs such services, including but not limited to members with LEP.																														

MCO: <MCO>	Reviewer:																														
	Date of Review: X/XX/2021																											# of Files: ##			
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
TSA 2.12.9.65.2																														
Q) Require compliance with applicable access requirements, including but not limited to appointment and wait times as referenced in Section A.2.11 of the CRA and Section 2.11 of the TSA. *CRA A.2.12.9.10* *TSA 2.12.9.10*																														
R) Require the provider to conduct criminal background checks and registry checks in accordance with state law and TennCare policy. *CRA A.2.12.9.41* Require the provider to conduct background checks in accordance with state law and TennCare policy. *TSA 2.12.9.41*																														
S) Require providers to screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. The provider shall be required to immediately report to the Contractor any exclusion information discovered. The provider shall be informed by the Contractor that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare members.																														

MCO: <MCO>	Reviewer:										Date of Review: X/XX/2021										# of Files: ##								
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
CRA A.2.12.9.39 *TSA 2.12.9.39*																														
T) Require that providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees. *CRA A.2.12.9.64* *TSA 2.12.9.64*																														
U) Require the provider to have and maintain documentation necessary to demonstrate that covered services were provided in compliance with state and federal requirements. *CRA A.2.12.9.13* *TSA 2.12.9.13*																														
V) Require that the provider comply with the Affordable Care Act and TennCare P&Ps regarding recovery of overpayments, including written notification to the Contractor and TennCare Office of Program Integrity (OPI) of overpayments identified by the provider and, when applicable, returning the overpayment to the Contractor within sixty (60) days from the date the overpayment is identified. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may be a violation of state or federal law. *CRA A.2.12.9.36* *TSA 2.12.9.36*																														
W) Require the provider to comply with 42 CFR Part 438, Managed care, including but not limited to 438.3, compliance with the requirements mandating provider ID of provider-preventable conditions as a condition of payment. At a minimum, this shall mean non-payment of																														

MCO: <MCO>	Reviewer:										Date of Review: X/XX/2021										# of Files: ##																	
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**											
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**										
provider-preventable conditions as well as appropriate reporting as required by the Contractor and TennCare. *CRA A.2.12.9.56* *TSA 2.12.9.56*																																							
Total Number of Points																																							
Maximum Number of Points																																							
Score																																							

Specialty Care Providers

MCO: <MCO>	Reviewer:										Date of Review: X/XX/2021										# of Files: ##																	
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**											
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**										
A) Specify that the provider may not refuse to provide covered medically necessary or covered preventive services to a child under the age of twenty-one (21) or a TennCare Medicaid patient under this Contract/Agreement for non-medical reasons. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship. *CRA A.2.12.9.6* *TSA 2.12.9.6*																																							

* *Y = Yes, N = No, P = Partial*

MCO: <MCO>	Reviewer:									Date of Review: X/XX/2021										# of Files: ##								
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
B) Specify the functions and/or services to be provided by the provider and assure that the functions and/or services to be provided are within the scope of his/her professional/technical practice. *CRA A.2.12.9.7* *TSA 2.12.9.7*																														
C) Specify the amount, duration and scope of services to be provided by the provider and inform the provider of TennCare non-covered services as described in Section A.2.10 of the CRA and Section 2.10 of the TSA and the TennCare rules and regulations. *CRA A.2.12.9.8* *TSA 2.12.9.8*																														
D) Provide that emergency services be rendered without the requirement of prior authorization of any kind. *CRA A.2.12.9.9* *TSA 2.12.9.9*																														
E) If the provider performs laboratory services, require the provider to meet all applicable requirements of the *Clinical Laboratory Improvement Amendment (CLIA) of 1988*. *CRA A.2.12.9.12* *TSA 2.12.9.12*																														
F) Specify that the Contractor shall monitor the quality of services delivered under the provider agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical, behavioral health, or long-term-																														

MCO: <MCO>	Reviewer:										Date of Review: X/XX/2021										# of Files: ##																				
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**														
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**													
care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TennCare. *CRA A.2.12.9.22* *TSA 2.12.9.22*																																										
G) Require that the provider comply with corrective action plans initiated by the Contractor. *CRA A.2.12.9.23* *TSA 2.12.9.23*																																										

MCO: <MCO>	Reviewer:										Date of Review: X/XX/2021										# of Files: ##								
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
H) Informs providers of the package of benefits that TennCare Kids offers and which requires providers to make treatment decisions based upon children's individual medical and behavioral health needs. All provider agreements shall contain language that references the TennCare Kids requirements. *CRA A.2.12.9.62* *TSA 2.12.9.62*																														
I) Include a provision which states that providers are not permitted to encourage or suggest, in any way, that TennCare children be placed into state custody in order to receive medical, behavioral, or long-term-care services covered by TennCare. *CRA A.2.12.9.63* *TSA 2.12.9.63*																														
J) Provide for the participation and cooperation in any internal and external quality management/quality improvement, monitoring, utilization review, peer review and/or appeal procedures established by the Contractor and/or TennCare. *CRA A.2.12.9.20* *TSA 2.12.9.20*																														
K) Provide that TennCare, the DHHS OIG, Office of the Comptroller of the Treasury, OIG, Tennessee Bureau of Investigation Medicaid Fraud Control Division, and the Department of Justice, as well as any authorized state or federal agency or entity shall have the right to evaluate through																														

MCO: <MCO>	Reviewer:										Date of Review: X/XX/2021										# of Files: ##								
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this Contract/Agreement including, but not limited to medical records, billing records, financial 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. *CRA A.2.12.9.18* *TSA 2.12.9.18*																														
L) Require safeguarding of information about enrollees according to applicable state and federal laws and regulations and as described in CRA Sections A.2.27 and E.6 and in TSA Sections 2.27 and 5.33 of the Contract/Agreement. *CRA A.2.12.9.55* *TSA 2.12.9.55*																														
M) Specify that unreasonable delay in providing care to a pregnant member seeking prenatal care shall be considered a material breach of the provider's agreement with the Contractor and include the definition of unreasonable delay as described in Section																														

MCO: <MCO>	Reviewer:									Date of Review: X/XX/2021										# of Files: ##									
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
A.2.7.5.2.3 of the CRA and Section 2.7.5.2.3 of the TSA. *CRA A.2.12.9.11* *TSA 2.12.9.11*																														
N) Provide for monitoring, whether announced or unannounced, of services rendered to members. *CRA A.2.12.9.19* *TSA 2.12.9.19*																														
O) Specify that the no person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws are excluded from participation in, except as specified in Section A 2.3.5 of the CRA and Section 2.3.5 of the TSA, or be denied benefits of, or be otherwise subjected to discrimination in the performance of the provider's obligation under its agreement with the Contractor or in the employment practices of the provider. *CRA A.2.12.9.65.1* *TSA 2.12.9.65.1*																														
P) Specify that the provider have written procedures for the provision of language assistance services to members and/or the member's representative. Language assistance services include interpretation and translation services and effective communication assistance in alternative formats for any member and/or the member's representative who needs such services, including but not limited to,																														

MCO: <MCO>	Reviewer:										Date of Review: X/XX/2021										# of Files: ##								
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
members with LEP and individuals with disabilities. *CRA A.2.12.9.65.2* Specify that the provider have written procedures for the provision of language interpretation and translation services for any members who needs such services, including but not limited to members with LEP. *TSA 2.12.9.65.2*																														
Q) Require compliance with applicable access requirements, including but not limited to appointment and wait times as referenced in Section A.2.11 of the CRA and Section 2.11 of the TSA. *CRA A.2.12.9.10* *TSA 2.12.9.10*																														
R) Require the provider to conduct criminal background checks and registry checks in accordance with state law and TennCare policy. *CRA A.2.12.9.41* Require the provider to conduct background checks in accordance with state law and TennCare policy. *TSA 2.12.9.41*																														
S) Require providers to screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation																														

MCO: <MCO>	Reviewer:									Date of Review: X/XX/2021										# of Files: ##								
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. The provider shall be required to immediately report to the Contractor any exclusion information discovered. The provider shall be informed by the Contractor that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare members. *CRA A.2.12.9.39* *TSA 2.12.9.39*																														
T) Require that providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees. *CRA A.2.12.9.64* *TSA 2.12.9.64*																														
U) Require the provider to have and maintain documentation necessary to demonstrate that covered services were provided in compliance with state and federal requirements. *CRA A.2.12.9.13* *TSA 2.12.9.13*																														
V) Require that the provider comply with the Affordable Care Act and TennCare P&Ps, regarding recovery of overpayments, including written notification to the Contractor and TennCare Office of Program																														

MCO: <MCO>	Reviewer:										Date of Review: X/XX/2021										# of Files: ##															
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**									
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**								
Integrity (OPI) of overpayments identified by the provider and, when applicable, returning the overpayments to the Contractor within sixty (60) days from the date the overpayment is identified. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may be a violation of state or federal law. *CRA A.2.12.9.36* *TSA 2.12.9.36*																																					
W) Require the provider to comply with 42 CFR Part 438, Managed care, including but not limited to 438.3, compliance with the requirements mandating provider ID of provider-preventable conditions as a condition of payment. At a minimum, this shall mean non-payment of provider-preventable conditions as well as appropriate reporting as required by the Contractor and TennCare. *CRA A.2.12.9.56* *TSA 2.12.9.56*																																					
Total Number of Points																																					
Maximum Number of Points																																					
Score																																					

ANA Contract File Review Tools—DBM

General Dental Practitioners

DBM: <DBM>	Reviewer:									Date of Review: X/XX/2021										# of Files: ##								
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
A) Specify that the provider may not refuse to provide medically necessary or covered services to a member under this contract for non-medical reasons, including, but not limited to, failure to pay applicable cost-sharing responsibilities. The DBM specifies that a member who is subject to a copayment requirement be requested to pay applicable cost-sharing responsibilities prior to receiving nonemergency services. However, the provider is not required to accept or continue treatment of a member with whom the provider feels he/she cannot establish and/or maintain a professional relationship. *TDC A.66.f.*																														
B) Specify the functions and/or services to be provided by the provider and ensure that the functions and/or services to be provided are within the scope of his/her professional/ technical practice. *TDC A.66.g.*																														
C) Specify the amount, duration, and scope of services to be provided by the provider. *TDC A.66.h.*																														
D) Provide that emergency services for eligible members be rendered without the requirement of prior authorization. However, the required documentation must be																														

* *Y = Yes, N = No, P = Partial*

DBM: <DBM>	Reviewer:										Date of Review: X/XX/2021										# of Files: ##															
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**								
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**						
submitted post-treatment for retro authorizations in order for the dentist to receive payment. *TDC A.66.i.*																																				
E) If the provider performs laboratory services, the provider must meet all applicable requirements of the *Clinical Laboratory Improvement Act (CLIA) of 1988* at such time that CMS mandates the enforcement of the provisions of CLIA. *TDC A.66.j.*																																				
F) Specify that the contractor monitors the quality of services delivered under the agreement and initiates corrective action when necessary to improve quality of care in accordance with the level of medical care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or in accordance with the standards established by TennCare. *TDC A.66.q.*																																				
G) Require that the provider comply with corrective action plans initiated by the contractor or be subject to recoupment of funds, termination or other penalties determined by TennCare. *TDC A.66.q.2.*																																				
H) Ensure that all provider agreements include language that informs providers of the package of benefits that EPSDT offers and the periodicity schedule with which those benefits must be provided. All provider																																				

DBM: <DBM>	Reviewer:										Date of Review: X/XX/2021										# of Files: ##															
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**								
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**						
agreements must contain language that references the EPSDT benefit package and periodicity schedule. *TDC A.66.ll.*																																				
I) Ensure that all provider agreements include a provision stating that providers are not permitted to encourage or suggest, in writing or verbally, that TennCare children be placed into state custody to receive medical or behavioral services covered by TennCare. *TDC A.66.mm.*																																				
J) Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality management/ improvement, utilization review, peer review and appeal procedures established by the contractor and/or TennCare. *TDC A.66.p.*																																				
K) Provide that TennCare, as a condition of payment, DHHS OIG, Office of the Comptroller of the Treasury, OIG, Tennessee Bureau of Investigation Medicaid Fraud Control Unit (TBI MFCU), and Department of Justice (DOJ), as well as any authorized state or federal agency or entity, have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this contract including, but not limited to medical records, billing records, financial records, and/or any records related to services																																				

DBM: <DBM>	Reviewer:									Date of Review: X/XX/2021										# of Files: ##								
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
rendered, quality, appropriateness and timeliness of services. *TDC A.166.c.*																														
L) Require dental providers to safeguard information about members according to applicable state and federal laws and all *Health Insurance Portability & Accountability of 1996* regulations including, but not limited to, 42 CFR § 431 Subpart F, § 438 Subpart E, and all applicable Tennessee statutes, and TennCare rules and regulations. *TDC A.66.s.*																														
Total Number of Points																														
Maximum Number of Points																														
Score																														

Specialty Dental Providers

DBM: <DBM>	Reviewer:									Date of Review: X/XX/2021										# of Files: ##								
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
A) Specify that the provider may not refuse to provide medically necessary or covered services to a member under this contract for non-medical reasons, including, but not limited to, failure to pay applicable cost-sharing responsibilities. The DBM specifies that a member who is subject to a																														

* *Y = Yes, N = No, P = Partial*

DBM: <DBM>	Reviewer:										Date of Review: X/XX/2021										# of Files: ##								
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
copayment requirement be requested to pay applicable cost-sharing responsibilities prior to receiving nonemergency services. However, the provider is not required to accept or continue treatment of a member with whom the provider feels he/she cannot establish and/or maintain a professional relationship. *TDC A.66.f.*																														
B) Specify the functions and/or services to be provided by the provider and ensure that the functions and/or services to be provided are within the scope of his/her professional/ technical practice. *TDC A.66.g.*																														
C) Specify the amount, duration and scope of services to be provided by the provider. *TDC A.66.h.*																														
D) Provide that emergency services for eligible members be rendered without the requirement of prior authorization. However, the required documentation must be submitted post-treatment for retro authorizations in order for the dentist to receive payment. *TDC A.66.i.*																														
E) If the provider performs laboratory services, the provider must meet all applicable requirements of the *Clinical Laboratory Improvement Act (CLIA) of 1988* at such time that CMS mandates the enforcement of the provisions of CLIA. *TDC A.66.j.*																														

DBM: <DBM>	Reviewer:										Date of Review: X/XX/2021										# of Files: ##																				
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**														
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**														
F) Specify that the contractor monitors the quality of services delivered under the agreement and initiates corrective action when necessary to improve quality of care in accordance with the level of medical care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or in accordance with the standards established by TennCare. *TDC A.66.q.*																																										
G) Require that the provider comply with corrective action plans initiated by the contractor or be subject to recoupment of funds, termination or other penalties determined by TennCare. *TDC A.66.q.2.*																																										
H) Ensure that all provider agreements include language that informs providers of the package of benefits that EPSDT offers and the periodicity schedule with which those benefits must be provided. All provider agreements must contain language that references the EPSDT benefit package and periodicity schedule. *TDC A.66.ll.*																																										
I) Ensure that all provider agreements include a provision stating that providers are not permitted to encourage or suggest, in writing or verbally, that TennCare children be placed into state custody to receive medical or behavioral services covered by TennCare.																																										

DBM: <DBM>	Reviewer:										Date of Review: X/XX/2021										# of Files: ##																				
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**														
Item in Signed Agreement*	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**														
TDC A.66.mm.																																											
J) Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality management/ improvement, utilization review, peer review and appeal procedures established by the contractor and/or TennCare. *TDC A.66.p.*																																											
K) Provide that TennCare, as a condition of payment, 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, have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this contract including, but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services. *TDC A.166.c.*																																											
L) Require dental providers to safeguard information about members according to applicable state and federal laws and all *Health Insurance Portability & Accountability of 1996* regulations including, but not limited to, 42 CFR § 431 Subpart F, § 438 Subpart E, and all applicable Tennessee statutes, and TennCare rules and regulations. *TDC A.66.s.*																																											

DBM: <DBM>	Reviewer:										Date of Review: X/XX/2021										# of Files: ##									
File#	1			2			3			4			5			6			7			8			9			10		
Item in Signed Agreement*	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P
Total Number of Points																														
Maximum Number of Points																														
Score																														

AQS

QP Standards Tool—MCOs

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Network: Contracting, Availability, Access, and Documentation					
1. Specialist Termination CRA and TSA § 2.11.11.1.4*	The MCO provides written timely notification (no less than 30 days prior when possible) to its members affected by the termination of a specialist.	☐ Yes ☐ No	**0.250** **0.000**	**0.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Notice of Provider Termination** CRA and TSA § 2.11.11.1.2	If a primary care provider (PCP) ceases participation in the MCO, the MCO immediately provides written notice—no less than 30 calendar days prior to the effective date of the termination and no more than 15 calendar days after receipt or issue of the termination notice—to each member who has chosen the provider as his or her PCP. The requirement to provide notice 30 calendar days prior to the effective date of termination is waived in instances where a provider becomes physically unable to care for members due to illness, the provider dies, the provider fails to provide 30 calendar days' advance notice to the MCO, the provider moves from the service area and fails to notify the MCO, or a provider fails credentialing, and instead shall be made immediately upon the MCO becoming aware of the circumstances.	☐ Yes ☐ No	**0.250** **0.000**	**0.250**	**0.000**
Findings **Strength** **AON**					

* *For readability, the prefix "A." is not used for CRA references.*
** *The element/criterion will be considered deemed if the MCO provides documentation that it scored 100% on that element/criterion during NCQA accreditation.*

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Network: Contracting, Availability, Access, and Documentation					
Suggestion					
3. Second Opinion** CFR 438.206.b.3	The MCO facilitates a second opinion from a network provider or arranges for the member to obtain one outside the network at no cost to the member.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
4. Subcontractor Audits CRA and TSA § 2.25.6.1; CFR 438.230.c.3-.3.iv	The MCO's contract with a subcontractor includes the right for TennCare or CMS to audit the subcontractor's records and systems at any time through 10 years after the final date of the contract period or the last audit, whichever is later.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
5. Marketing Activities CFR 438.104.b.1.i; .iv-.v	The MCO does not engage in cold-call marketing, distribute marketing materials without TennCare approval, or seek to influence enrollment in conjunction with offering private insurance.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Network: Contracting, Availability, Access, and Documentation					
6. Prohibited Affiliations** CFR 438.610.a-.b	The MCO does not knowingly have a relationship with an individual or entity who is a. debarred, suspended, or otherwise excluded from participating under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549; b. an affiliate, as defined in the Federal Acquisition Regulation, of a person described above; or c. excluded from participation in any federal healthcare program.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
7. MAT Provider Network CRA and TSA § 2.11.4.1.1	The MCO has a provider network for medication-assisted treatment (MAT) for members with opioid use disorder (OUD).	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
8. Initial Engagements CRA and TSA § 2.11.4.1.1.1	The MCO has documentation to show that it provides at least three engagements per MAT network provider during the provider's first two calendar years of participation, including an in-person check-in, an in-person audit meeting, and a virtual education session.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON**					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Network: Contracting, Availability, Access, and Documentation					
Suggestion					
9. Subsequent Engagements CRA and TSA § 2.11.4.1.1.2-2.11.4.1.1.2.2	The MCO has documentation to show that after two calendar years of a provider participating in the MAT network, the MCO provides at least two engagements with the provider per calendar year, including an in-person check-in and a virtual education session.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
10. Quarterly MAT Network Quality Metrics Reports CRA and TSA § 2.11.4.1.1.3	The MCO distributes quarterly MAT Network Quality Metrics Reports in a format described by TennCare to all contracted MAT providers on an NPI-level within 120 calendar days after the end of each calendar year quarter unless otherwise approved by TennCare.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
11. BE-SMART Network Program Description CRA and TSA § 2.11.4.1.1; 2.11.4.1.1.1.1.4; 2.11.4.1.1.2.1	The MCO maintains the most current Buprenorphine Enhanced and Supportive Medication-Assisted Recovery and Treatment (BE-SMART) network program description, and relevant network provider attestations, if applicable.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Network: Contracting, Availability, Access, and Documentation					
Strength					
AON					
Suggestion					
12. BE-SMART Network Provider Audits CRA and TSA § 2.11.4.1.1.1.2	The MCO conducts a BE-SMART network provider audit within 12 calendar months of the provider entering the MCO's network and annually thereafter. The MCO maintains all documentation that supports successful completion of the audit using a TennCare-approved audit template, which includes the completed individual provider audit field tool.	☐ Audit completed within 12 months and annually thereafter ☐ Documentation maintained and based on a TennCare-approved template	**1.000** **1.000**	**2.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Network: Contracting, Availability, Access, and Documentation Score	**0.0%**	**11.500**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
QI Activities					
1. Coordination Between Physical and Behavioral Health CRA and TSA § 2.9.8.1; 2.9.8.3.2	The MCO maintains policies and procedures (P&Ps) for and ensures continuity and coordination between physical health, behavioral health, and long-term care services by including key elements to the right.	☐ a. Screening for behavioral health needs	**0.500**	**6.000**	**0.000**
		☐ b. Referral to physical health and behavioral health providers	**0.500**		
		☐ c. Screening for long-term care needs	**0.500**		
		☐ d. Exchange of information	**0.500**		
		☐ e. Confidentiality	**0.500**		
		☐ f. Assessment	**0.500**		
		☐ g. Treatment plan development	**0.500**		
		☐ h. Collaboration	**0.500**		
		☐ i. Care/Support coordination and population health	**0.500**		
		☐ j. Provider training	**0.500**		
		☐ k. Encourage PCPs and other providers to use TennCare-approved behavioral health screening tool	**0.500**		
		☐ l. Monitor implementation and outcomes	**0.500**		
Findings					
Strength					
AON					
Suggestion					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
QI Activities					
2. Discharge Planning and Follow-Up CRA and TSA § 2.7.2.6.5.2; CFR 438.208.b; 438.208.b.2; 438.208.b.2.i	Members discharged from psychiatric inpatient hospitals and psychiatric residential treatment facilities are provided with appropriate follow-up behavioral health services. If eligible, members are referred to Tennessee Health Link for services.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Integrated Population Health CRA and TSA § 2.8.1.1-2.8.2.1.1; 2.8.2.1.4; 2.8.2.2.1; 2.8.4.2-.2.1	The MCO has an integrated population health program based on member risk stratification. New members are stratified monthly by using predictive modeling and are enrolled into programs based on risk rather than disease-specific categories. The predictive modeling uses a combination of claims and pharmacy data and laboratory results, supplemented by referrals, utilization management (UM) data, and/or health risk assessment (HRA) results. The risk levels range from 0–2. ♦ Risk Level 0: Wellness Program ♦ Risk Level 1: Low-Risk Maternity, Health Risk Management, and Care Coordination ♦ Risk Level 2: Chronic Care Management, High-Risk Maternity, and Complex Case Management For members to be stratified into Level 0, there must be no identified health risks, chronic care conditions, indication of pregnancy, or claims history. Pregnant members are stratified into low- or high-risk pregnancy programs based on the MCO's obstetrical assessment. The MCO transitions Low-Risk Maternity Program members into the High-Risk Maternity Program when ongoing member monitoring identifies an increased health risk.	☐ a. Process in place to identify members ☐ b. High-risk pregnancy members included those with history of tobacco and substance abuse or other high-risk indicators ☐ c. Ongoing assessment for Low-Risk Maternity Program members ☐ d. Staff demonstrated knowledge of the member stratification process	**0.500** **0.500** **0.500** **0.500**	**2.000**	**0.000**
Findings					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
QI Activities					
Strength					
AON					
Suggestion					
4. Outreach to Members Stratified for Chronic Care and Complex Case Management CRA and TSA § 2.8.4.5.1; 2.8.4.7.1	The MCO makes three outreach attempts to each newly identified member eligible for chronic care and/or complex case management to inform the member about the program(s). Outreach attempts must occur within three months of the member's identification. If the MCO is unable to contact the member after three outreach attempts and the member appears on the refreshed list, the MCO is not obligated to make another attempt for 180 days.	☐ Three attempts made to enroll ☐ Attempts made within required timeframe	**0.500** **0.500**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
5. Screening for Risk Factors in High-Risk Maternity Program CRA and TSA § 2.8.3.3	The MCO provides comprehensive HRAs for all members enrolled in the High Risk Maternity Program, which includes screening for physical conditions, mental health, and substance abuse.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
QI Activities					
6. Face-to-Face Visit for High-Risk Members CRA and TSA § 2.8.3.5	For members identified as participants in Level 2 population health programs (Chronic Care Management, Complex Case Management, or High-Risk Maternity), assessment includes whether a member needs a face-to-face visit using the standard assessment criteria provided by TennCare. In cases where a need is identified, the visit is conducted following consent of the member.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
7. Transitioning of Members into Higher/Lower Levels of Care CRA and TSA § 2.8.4.5.2-.3	The MCO provides ongoing assessment for Chronic Care Management Program members to support transition into lower-risk classification or to the Complex Case Management Program for services.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
8. Implementation of Population Health** CRA and TSA § 2.8.3.1	The MCO makes reasonable attempts to assess each member's health risks by using an HRA that meets and/or exceeds the current National Committee for Quality Assurance (NCQA) Population Health Management standard or a comprehensive HRA that meets and/or exceeds that standard.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
QI Activities					
9. Enrollment of CHOICES and ECF CHOICES Members in Population Health Programs CRA and TSA § 2.8.1.1; 2.8.8-.8.1	The MCO has a systematic process in place to identify and enroll eligible members in each population health program, including CHOICES, ECF CHOICES, and dual-eligible CHOICES and ECF CHOICES members. The process integrates members' information with other activities to ensure programs are linked for care coordination.	☐ a. Process to identify and enroll CHOICES and ECF CHOICES members ☐ b. Process to identify and enroll dual-eligible members ☐ c. Process to ensure programs are linked**	**0.500** **0.500** **0.500**	**1.500**	**0.000**
Findings					
Strength					
AON					
Suggestion					
10. Population Health Treatment Plans for CHOICES and ECF CHOICES Members CRA and TSA § 2.8.8.2; 2.8.8.3.6	The Population Health Program Strategy (PHPS) states that the care/support coordinator has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term care services and supports, including appropriate management of chronic conditions. The member's care/support coordinator is responsible for collaborating with the member's providers regarding the development and implementation of an individualized treatment plan. This is integrated into the member's plan of care and includes monitoring the member's condition, helping to ensure compliance with treatment protocols, and to the extent appropriate, lifestyle changes which help to better ensure management of the member's condition.	☐ Elements of treatment plans were individualized and integrated into the CHOICES or ECF CHOICES plans of care or PCSPs. ☐ Treatment plans included monitoring conditions, ensuring compliance with treatment protocols, and making lifestyle changes.	**0.500** **0.500**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
QI Activities					
11. Stratification of CHOICES and ECF CHOICES Members in Population Health Programs CRA and TSA § 2.8.8.4	The PHPS states that, in addition to stratifying population health program members by risk level or by clinical- or member-provided information, the MCO also stratifies CHOICES and ECF CHOICES members by the type of setting where long-term care services are delivered (e.g., nursing facility, home- or community-based residential alternative, or home-based). The MCO's interventions are based on the risk level and setting in which the CHOICES or ECF CHOICES member resides.	☐ Stratification included risk level or clinical- and member-provided information and service setting. ☐ Interventions were based on stratification and service setting.	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
12. Keeping Care/Support Coordinator Informed CRA and TSA § 2.8.8.3-.3.3	The PHPS addresses how the member's care/support coordinator will receive the following: a. Notification of the member's participation in a population health program b. Information collected about the member through a population health program c. Educational materials given to the member through a population health program	☐ a. Participation notification sent ☐ b. Information collected ☐ c. Educational materials given	**0.250** **0.250** **0.250**	**0.750**	**0.000**
Findings **Strength** **AON** **Suggestion**					
13. Care/Support Coordinator Review CRA and TSA § 2.8.8.3.4	The PHPS ensures that the care/support coordinator completes the following: ♦ Verbal reviews of the educational materials with the member and the member's caregiver and/or representative	☐ Educational materials verbally reviewed ☐ Follow-up coordinated	**0.500** **0.500**	**1.000**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
QI Activities					
	♦ Coordination of necessary follow-up regarding the population health program, such as scheduling screenings or appointments				
Findings					
Strength					
AON					
Suggestion					
14. Identification of Increase in Member Needs During Transition CRA and TSA § 2.9.2.1.4.3; 2.9.3.5	If the MCO becomes aware of an increase in the member's needs prior to conducting a comprehensive needs assessment for CHOICES members in or transitioning to Group 2 or 3, the following occurs: a. A comprehensive needs assessment is immediately conducted. b. The plan of care or PCSP is updated. c. The changes in services are implemented within 10 days of the MCO becoming aware of the change in needs.	☐ a. Comprehensive needs assessment conducted ☐ b. Plan of care or PCSP updated ☐ c. Service changes implemented within 10 days of MCO's knowledge of change in needs	**0.250** **0.250** **0.250**	**0.750**	**0.000**
Findings					
Strength					
AON					
Suggestion					
15. Transition of CHOICES Group 2 Members in Community-Based Residential Alternative Settings CRA and TSA § 2.9.6.2.5.2	For members in CHOICES Group 2, who upon CHOICES enrollment are receiving services in a community-based residential alternative setting, within 10 business days of notice of the member's enrollment in CHOICES, the care coordinator conducts a face-to-face visit with the member, performs a comprehensive needs assessment, develops a plan of care, and authorizes and initiates additional CHOICES HCBS specified in the PCSP (i.e., assistive technology).	☐ a. Face-to-face visit with member ☐ b. Comprehensive needs assessment ☐ c. Plan of care development ☐ d. Additional CHOICES HCBS authorized	**0.250** **0.250** **0.250** **0.250**	**1.000**	**0.000**
Findings					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
QI Activities					
Strength					
AON					
Suggestion					
16. Nursing Facility-to-Community Transition for CHOICES and ECF CHOICES Members CRA and TSA § 2.9.6.8.6-.7; .11-.12	If the member wishes to pursue transition to the community (within the required timeframe), the care/support coordinator conducts an in-facility assessment of the member's ability and/or desire to transition using tools and protocols specified or approved in writing by TennCare. As part of the transition assessment, the care/support coordinator conducts a risk assessment in accordance with protocols developed by TennCare. Prior to the member's physical move to the community, the care/support coordinator visits the residence where the member will live to conduct an onsite evaluation of the physical residence and meet with the member's family or other caregiver who will be residing with the member (as appropriate). At a minimum, the transition plan includes member needs related to housing, transportation, caregiver availability, and other transition needs and supports.	☐ a. In-facility risk assessment ☐ b. Risk assessment in accordance with protocols developed by TennCare ☐ c. Onsite evaluation conducted ☐ d. Transition plan included necessary details	**0.250** **0.250** **0.250** **0.250**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
17. Nursing Facility-to-Community Transition Follow-Up CRA and TSA § 2.9.6.8.21	When a CHOICES member transitions from a nursing facility to a community-based residential alternative or to live with a relative or other caregiver, the care/support coordinator contacts the member within the first 24 hours of transition and visits the member in his or her new residence within seven days of transition. During the initial 90 days post-transition period, the care/support coordinator contacts the member at least monthly by telephone to ensure the plan of care or PCSP is being followed, member needs are met, and transition to the community has been successful. Additional face-to-face assessments are conducted when additional needs are identified and to confirm member needs are met.	☐ a. Contacted member within the first 24 hours ☐ b. Visited residence within seven days ☐ c. Made or attempted at least monthly telephone contact within the initial 90 days post-transition ☐ d. Conducted face-to-face assessments as needed	**0.250** **0.250** **0.250** **0.250**	**1.000**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
QI Activities					
Findings					
Strength					
AON					
Suggestion					
18. Telephonic Screening for CHOICES and ECF CHOICES Referrals CRA § 2.9.6.3.4-.4.1; TSA § 2.9.6.3.3-.3.1	If the MCO uses a telephone screening process for members referred to CHOICES or ECF CHOICES, the following process is in place and documented: ♦ Three attempts are made to contact a member by telephone over a period of no less than three days. ♦ If telephone attempts are unsuccessful, a letter with CHOICES or ECF CHOICES information on how to obtain a screening for CHOICES or ECF CHOICES is sent to the member's most recently reported address.	☐ Three attempts by telephone per timeline criteria ☐ Letter sent after unsuccessful telephone attempts	**0.500** **0.500**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
19. CHOICES and ECF CHOICES Level of Care (LOC) Reassessment CRA and TSA § 2.9.6.10.3.1.1	The MCO conducts a LOC reassessment at least annually and within five business days of awareness of a change in a member's functional or medical status that could potentially affect LOC eligibility.	☐ Reassessment conducted annually ☐ Reassessment conducted within five business days of change in member's functional or medical status	**0.500** **0.500**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
QI Activities					
20. High Utilization of Services CRA and TSA § 2.9.6.10.3.4	As part of the Quality Assessment and Performance Improvement (QAPI) program, the MCO monitors and evaluates member emergency department (ED) and behavioral health crisis service utilization to determine the reasons for these visits. The care/support coordinator takes appropriate action to address physical and behavioral health needs and facilitates appropriate utilization of these services, e.g., communicating with the member's providers, educating the member, conducting a needs reassessment, updating the member's plan of care or PCSP, and to better manage the member's condition(s) and/or for persons in ECF CHOICES, referral for Behavioral Crisis Prevention, Intervention, and Stabilization Services if medically necessary.	☐ Member ED and behavioral health crisis service utilization monitored and evaluated ☐ Appropriate action taken to address member needs	**1.000** **1.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
21. Under-Utilization of Services CFR 438.330.b.3	As part of the Quality Assessment and Performance Improvement (QAPI) program, the MCO has mechanisms in place to detect under-utilization of services.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
22. Member Advisory Committee CFR 438.110	The MCO supports a Member Advisory Committee that includes a representative sample of CHOICES and ECF CHOICES members.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON**					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
QI Activities					
Suggestion					
23. Health Information System CFR 438.242.a	The MCO maintains a health information system that collects, analyzes, integrates, and reports data including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for reasons other than loss of TennCare eligibility.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
24. Compliance Program CFR 438.608.a-.a.1	The MCO (and subcontractor, if applicable) maintains a compliance program and procedures that detect and prevent fraud, waste, and abuse.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
QI Activities					
25. Quality Improvement Program (QIP)** CRA and TSA 2.15.1.1; 2.15.1.1.5; 2.15.2.1-.2	The MCO has a written QIP that clearly defines its QI structures and processes and assigns responsibilities to appropriate individuals. The QIP includes a work plan that is evaluated annually and as needed. The MCO also has a QI Committee to evaluate the results of QI activities, make recommendations, and ensure follow-up. The QI Committee keeps written minutes from all meetings.	☐ a. Written QIP ☐ b. Work plan evaluated annually ☐ c. QI Committee performed functions and kept meeting minutes	**0.250** **0.250** **0.250**	**0.750**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		QI Activities Score	**0.0%**	**31.750**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Clinical Criteria for Utilization Management (UM) Decisions					
1. Availability of Criteria CRA § 2.18.5.2; 2.18.5.2.8 and .18; TSA § 2.18.5.3; 2.18.5.3.8 and .18	The MCO includes the following information in its Provider Manuals: ♦ Medical necessity standards and clinical practice guidelines ♦ Prior authorization, referral, and other UM requirements and procedures	☐ Medical necessity standards and clinical practice guidelines included ☐ Prior authorization, referral, and other UM requirements and procedures included	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Transition to Other Care CRA and TSA § 2.9.5.1-.1.2	The MCO assists members in transitioning to another provider when the provider currently treating their condition or providing prenatal services terminates participation with the MCO. Assistance is provided to members with the following conditions: ♦ Chronic or acute medical conditions ♦ Behavioral health conditions ♦ Currently receiving long-term care services ♦ Pregnancy For members in their second or third trimester of pregnancy, the MCO allows continued access to the prenatal care provider and to any provider treating the member's chronic or acute medical or behavioral health condition through the postpartum period. For all other members, continuation of care is provided for up to 90 calendar days or until the member may be reasonably transferred to another provider without disruption of care, whichever is less.	☐ a. Assistance provided to specified members ☐ b. Continuation of current prenatal provider through postpartum period ☐ c. Continuation of care up to 90 calendar days or until transfer without disruption of care for all other members ☐ d. Staff able to demonstrate knowledge of transition requirements and provide examples	**0.500** **0.500** **0.500** **0.500**	**2.000**	**0.000**
Findings **Strength** **AON**					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Clinical Criteria for Utilization Management (UM) Decisions					
Suggestion					
3. Practice Guidelines** CRA and TSA § 2.15.4; CFR 438.236.b-.c	Practice guidelines are based on valid and reasonable evidence or consensus of healthcare professionals in a particular field, consider the needs of members, and are developed, reviewed, and updated in consultation with providers. The guidelines are disseminated to all affected providers and upon request to members and potential members.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
4. Qualified UM Personnel** CRA and TSA § 2.14.1.8	The MCO has a process in place to guarantee that all medical necessity decisions are supervised by appropriately licensed professionals and to specify the type of personnel responsible for each level of UM, including prior authorization and decision-making.	☐ Process in place ☐ Staff licensed and experienced	**0.500** **2.500**	**3.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
5. Utilization Management Program (UMP) CRA and TSA 2.14.1.1; 2.14.1.2	The MCO has a written UMP Description (UMPD) that includes P&Ps with defined structures and processes, assigns responsibility to appropriate individuals, and includes a work plan that is evaluated annually and as appropriate.	☐ a. P&Ps included ☐ b. Responsibility assigned ☐ c. Work plan evaluated annually	**0.250** **0.250** **0.250**	**0.750**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Clinical Criteria for Utilization Management (UM) Decisions					
		Clinical Criteria for Utilization Management (UM) Decisions Score	**0.0%**	**7.750**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
1. Member Handbook Development and Distribution CRA and TSA § 2.17.4.1-.2 and .4	The Member Handbook is developed and updated annually based on TennCare-provided templates. It is distributed to the following: ♦ Members within 30 calendar days of receiving notice of enrollment in the MCO ♦ All contracted providers upon initial credentialing ♦ All members and providers annually and as updates occur	☐ a. Developed/Updated using TennCare templates ☐ b. Sent to members within 30 calendar days of enrollment ☐ c. Sent to providers upon credentialing ☐ d. Redistributed annually ☐ e. Redistributed as updated	**0.200** **0.200** **0.200** **0.200** **0.200**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Communication of Rights and Responsibilities in Member Handbook CRA § 2.17.4.6; 2.17.4.6.24-.25; .29-.31; .33; .36-.39; TSA § 2.17.4.7; 2.17.4.7.22-.23; .27-.29; .31; .34-.37	The Member Handbook informs members of the following: a. Grievance and appeal procedures b. Right to request reassessment of eligibility-related decisions directly to TennCare c. Requirement to notify the MCO and TennCare of each change of address d. Right to request to change MCOs at any time during the 90 calendar day period immediately following their initial enrollment in an MCO e. Right to change MCOs at the next choice period, with a 90 calendar day period immediately following the enrollment, as requested during said choice period, with a new MCO to request to change MCOs f. Right to terminate participation in the TennCare program at any time, with instructions to contact TennCare for termination forms and additional information on termination g. Necessary steps to amend their data in accordance with HIPAA regulations and state law	☐ a. Grievance and appeal procedures ☐ b. Right to request reassessment ☐ c. Requirement to notify MCO and TennCare of address changes ☐ d. Right to request to change MCOs at any time during the 90 calendar day period immediately following initial enrollment ☐ e. Right to change MCOs at the next choice period ☐ f. Right to terminate participation in the TennCare program ☐ g. Steps to amend their data ☐ h. Instructions on how to request and obtain information regarding the “structure and operation of the MCO” and “physician incentive plans”	**0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200**	**2.000**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
	h. Instructions on how to request and obtain information regarding the "structure and operation of the MCO" and "physician incentive plans" i. Right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand j. Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation	☐ i. Right to receive information on available treatment options and alternatives ☐ j. Right to be free from any form of restraint or seclusion	**0.200** **0.200**		
Findings **Strength** **AON** **Suggestion**					
3. Member Handbook Inclusions CRA § 2.17.4.6.3-.5; .8-.12; .16-.17; .23; .27-.28; .34; .42; TSA § 2.17.4.7.3-.5; .8-.12; .15-.16; .21; .25-.26; .32; .40	The Member Handbook includes, at a minimum, the following: a. Explanation on how members will be notified of member-specific information, such as the effective date of enrollment b. Explanation of how members can change PCPs c. Description of services provided, including benefit limits, exclusions, and use of non-contracted providers d. Financial responsibilities of member and explanation that a provider may take steps to collect any copays the member may owe e. Indications that members may not be billed for covered services except for the amounts of the specified TennCare cost-share responsibilities and indications of their right to appeal in the event that they are billed f. Information about preventive services for adults and children, including TennCare Kids for Medicaid-eligible members, listing of covered preventive services, and notice that preventive services are at no cost and without cost-share responsibilities g. Procedures for obtaining required services, including procedures for obtaining referrals to network specialists and providers outside of the plan h. Information advising members that if they need a service that is not available within the plan, they will be referred to a provider outside	☐ a. Member notification methods ☐ b. Information on how to change PCPs ☐ c. Service parameters ☐ d. Financial responsibilities of member, explanation regarding collection, and steps taken to collect any copays the member may owe ☐ e. Billing for covered services and appeal of billed services ☐ f. Preventive services information ☐ g. Obtaining services and referrals in- and out-of-plan ☐ h. Out-of-plan referral and copay requirements ☐ i. Program information for CHOICES and ECF CHOICES members	**0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200**	**3.200**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
	of the plan, and any copayment requirements would be the same as if this provider were in the plan i. Program information for CHOICES and ECF CHOICES members j. Explanation of emergency services and how to obtain them in and out of the MCO's service area, including but not limited to the use of 911 and locations of emergency settings and services k. Information on how to access a PCP on a 24-hour basis and the 24-hour nurse line l. Information about how to report suspected abuse, neglect, and exploitation of members who are adults and suspected brutality, abuse, or neglect of members who are children, including the telephone number to call to report suspected abuse m. Written information concerning advance directives n. Notice indicating that enrollment in the MCO's plan invalidates any prior authorization for services granted by another plan but not utilized prior to enrollment in the new MCO and notice of continuation of care o. Member services toll-free telephone numbers, including the TennCare Hotline, the MCO's customer service line, and the MCO's 24/7 Nurse Triage/Advice Line with a statement indicating that the member may contact the MCO or TennCare regarding questions about TennCare, and the service/information that may be obtained from each line p. Information on appropriate prescription drug usage	☐ j. Emergency services access information ☐ k. PCP and nurse line 24/7 access ☐ l. Information about how to report suspected abuse, neglect, or exploitation ☐ m. Advance directives information ☐ n. Notice for prior authorization and care continuation ☐ o. Required toll-free telephone numbers and notice that members may contact the MCO or TennCare with questions ☐ p. Information on appropriate prescription drug usage	**0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200**		
Findings					
Strength					
AON					
Suggestion					
4. Information about Civil Rights CRA and TSA § 2.17.2.4	All written materials are printed with the notice of non-discrimination and taglines as required by TennCare and set forth in TennCare's tagline template. The MCO may also provide required member materials electronically or on its website pursuant to the specifications set forth in § 2.28.10.3, which require compliance with Section 508 of the Rehabilitation Act of 1973 and Title VI of the Civil Rights Act of	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
	1964.				
Findings					
Strength					
AON					
Suggestion					
5. Notification of Changes to Written Materials CRA and TSA § 2.17.2.9	The MCO provides written notice to members of any changes in policies or procedures described in written materials previously sent to members at least 30 days before the effective date of change.	☐ Written notice to members ☐ Members notified at least 30 days before effective date of change	**0.500** **0.500**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
6. Communication Assistance Services CRA § 2.17.4.6; 2.17.4.6.35; TSA § 2.17.4.7; 2.17.4.7.33; CRA and TSA § 2.17.5.2.2; 2.18.2.1; 2.28.2.1.1	The MCO provides translation services for members and potential members as demonstrated by the following: a. Member Handbooks include information on how to obtain information in alternative formats or how to access interpretation services, as well as a statement indicating that interpretation and translation services are free. b. Quarterly hard copy newsletters include the procedure on how to obtain information in alternative formats and how to access interpretation services, as well as a statement indicating that interpretation and translation services are free. c. The MCO maintains TennCare-approved, written P&Ps for providing members and potential members with language assistance services, which include, but are not limited to, interpretation and translation services and effective communication assistance in alternative formats, such as auxiliary	☐ a. Information in Member Handbook** ☐ b. Information in all quarterly newsletters ☐ c. P&Ps for language interpretation and translation services ☐ d. P&Ps for non-discrimination in the provision of services ☐ e. Non-Discrimination Compliance Coordinator provided required training	**0.200** **0.200** **0.200** **0.200** **0.200**	**1.000**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
	aids to any member and/or representative who needs such services. d. The MCO has P&Ps that demonstrate non-discrimination in the provision of language assistance services for members with limited English proficiency (LEP) and those requiring communication assistance in alternative formats. e. The MCO's Non-Discrimination Compliance Coordinator provides language and cultural competence training for MCO staff, including but not limited to all providers and direct service subcontractors, which includes the potential impact of linguistic and cultural barriers on utilization, quality, and satisfaction with care and how and when to access interpreter services and to promote their appropriate use during the medical encounter.				
Findings **Strength** **AON** **Suggestion**					
7. Translated Vital Documents CRA and TSA § 2.17.2.6	All vital MCO documents are translated and available in Spanish. Within 90 calendar days of notification from TennCare, all vital MCO documents are translated and available to LEP group identified by TennCare that constitutes 5% of the TennCare population or 1,000 members, whichever is less.	☐ All vital documents available in Spanish ☐ Vital documents translated and available within 90 calendar days for LEP groups	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
8. Website CFR 438.10	The MCO operates a website that includes all information from the Member Handbook, Provider Directory, and drug formulary.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
Findings					
Strength					
AON					
Suggestion					
9. Limitations/ Capitations/ Delays CRA and TSA § 2.6.3.3-.4; CFR 438.210. a.4-.4.ii.C	The MCO ensures that services, including long-term services and supports (LTSS) and family planning, are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. The MCO does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The MCO may deny benefits which are excluded under TennCare rule. UM controls do not unreasonably delay the initial or continued receipt of services, and services are provided based on individual needs.	☐ a. Services were sufficient in amount, duration, and scope. ☐ b. Services were not arbitrarily denied or reduced. ☐ c. Benefits were excluded only under TennCare rule. ☐ d. UM controls did not delay services.	**0.500** **0.500** **0.500** **0.500**	**2.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Member Rights and Responsibilities Score	**0.0%**	**13.200**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
1. New Member Calls CRA and TSA § 2.7.6.2.2.1	The MCO conducts telephone calls or digital outreach, such as sending text messages, to the parent/guardian of all new members under the age of 21 years to inform them of TennCare Kids services, including the availability of assistance with appointment scheduling and transportation. (This is not applicable if the MCO's TennCare Kids screening rate is above 90%, as determined in the most recent Centers for Medicare & Medicaid Services [CMS]-416 report.)	☐ Yes or Not Applicable (CMS-416 screening rate above 90%) ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Member Outreach Contacts CRA and TSA § 2.7.6.2.2; 2.7.6.2.2.2; 2.17.4.2	The MCO distributes six outreach contacts a year, which include the following: ♦ Member Handbook sent within 30 calendar days of enrollment and annually thereafter, upon the member's anniversary date of enrollment ♦ Four quarterly newsletters ♦ One reminder before screenings are due (with transportation and scheduling assistance offered) ♦ At least one of the six outreach attempts identified above advises members who are blind, deaf, illiterate, or LEP how to request and/or access such assistance and/or information	☐ a. Member Handbook sent within 30 calendar days of enrollment and annually thereafter ☐ b. Quarterly newsletters ☐ c. Screening due reminder ☐ d. One outreach attempt advises specified members of alternative formats and information availability	**0.250** **0.250** **0.250** **0.250**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
3. Documenting Outreach CRA and TSA § 2.7.6.2.4	The MCO has a written process for following up with members who do not get their screenings timely. It includes provisions for documenting all outreach attempts, with a mechanism for maintaining records of efforts to reach members who miss screening appointments or who have failed to receive regular check-ups. The MCO makes at least two efforts per year in excess of the six "outreach contacts" to schedule a screening for the member, and the efforts are in different formats. MCO staff demonstrates knowledge of the outreach efforts.	☐ Process in place ☐ Staff demonstrated knowledge	**0.750** **0.750**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
4. Re-Notification If No Services Used CRA and TSA § 2.7.6.2.5	The MCO maintains a process for determining whether a member eligible for EPSDT has used services within a year. The MCO follows up with two reasonable attempts in different formats to re-notify members who have not used services in over a year.	☐ Maintained process ☐ Two additional attempts	**0.250** **0.250**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
5. Accurate Provider Lists CRA and TSA § 2.7.6.2.6	For members and families, the MCO provides accurate lists of names and telephone numbers of contracted providers who are currently accepting TennCare.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
6. Targeted Activities for Smoking Cessation CRA and TSA § 2.7.4.1; 2.7.4.1.3	The MCO has established criteria for determining how to target smoking cessation activities for pregnant women and adolescents.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
7. Prenatal Appointment Assistance CRA and TSA § 2.7.5.2.1; 2.7.6.2.7; 2.11.5.2	The MCO provides medically necessary prenatal care for pregnant women who are presumptively eligible for TennCare, members who become pregnant, and members who are pregnant on the effective date of enrollment. On the day eligibility is determined, the MCO offers individual assistance in making a timely first prenatal appointment. For a woman past her first trimester, this appointment occurs within 15 calendar days. Pregnant women are also offered EPSDT services for the child when it is born.	☐ a. Services provided for identified women ☐ b. On the day eligibility was determined, offered appointment assistance ☐ c. For each woman past her first trimester, appointment occurred within 15 calendar days ☐ d. Postpartum EPSDT services offered	**0.500** **0.500** **0.500** **0.500**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
8. Coordinating Services CRA and TSA § 2.7.6.1.3; 2.7.6.1.5; 2.7.6.1.5.2	The MCO has P&Ps in place that include coordinating services with child-serving agencies and providers to provide all medically necessary services to all eligible members, regardless of whether a service is covered by the MCO. The MCO ensures the availability and accessibility of required healthcare resources and requires providers to make and document appropriate referrals.	☐ P&Ps in place ☐ Evidence ensuring provider compliance	**0.500** **0.750**	**1.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					
9. Notify MCO If Unable to Make Referral CRA and TSA § 2.7.6.1.6	The MCO has procedures in place that direct providers to notify the MCO if a screening reveals the need for other healthcare and the provider is unable to make an appropriate referral. These procedures include the MCO's securing an appropriate referral and contacting the member to offer scheduling assistance and transportation. In the event the failed referral is for dental services, the MCO coordinates with the DBM to arrange services.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
10. Medical Necessity Education CRA and TSA §; 2.7.6.1.5; 2.7.6.1.5.3	The MCO has procedures to educate providers quarterly about the necessity of documenting all components of a screening with accurate coding and can demonstrate that provider education has occurred. This education can be provided by webinar, classroom, or in conjunction with the Tennessee Chapter of the American Academy of Pediatrics.	☐ Procedures to educate providers in place ☐ Evidence of provider education	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength**					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
AON					
Suggestion					
11. Rehabilitative Services CRA and TSA § 2.7.6.1.1; 2.7.6.4.8; 2.7.6.4.8.(13)	Rehabilitative services include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts for "maximum reduction of physical or mental disability and restoration of a recipient to the best possible functional level." These services may be delivered in conjunction with the services listed in the Service Chart (2.7.6.4.8) in the CRA and TSA. Covered services must be medically necessary and include treatment "to correct or ameliorate, or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, regardless of whether the required service is a covered benefit."	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings					
Strength					
AON					
Suggestion					
12. Medical Necessity Decisions CRA and TSA § 2.6.3.1-.2 and .5	The MCO has a process in place concerning issues of medical necessity, which ensures that consistent decisions are rendered and that they are compliant with the TennCare medical necessity rule and NCQA standards.	☐ a. Process in place ☐ b. Definition of medical necessity same as contract or no more restrictive ☐ c. Evidence of consistent decisions (e.g., inter-rater reliability [IRR] testing) ☐ d. Appropriate follow-up as applicable	**0.500** **0.500** **0.500** **0.500**	**2.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
13. Services Without Prior Authorization CRA and TSA § 2.7.6.1.7	The MCO does not require prior authorization for periodic and interperiodic screenings conducted by PCPs. The MCO provides all medically necessary covered services, regardless of whether the need for such services was identified by a provider who had received prior authorization from the MCO or a contracted provider.	☐ Yes ☐ No	**1.250** **0.000**	**1.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					
14. Referral Providers List CRA and TSA § 2.14.3.5.1	The MCO provides all PCPs participating in EPSDT with information on how to access a current listing of referral providers, including behavioral health providers, as well as the right to request a hard copy at least 30 calendar days prior to their start date of operations. Thereafter, the MCO provides quarterly notification to PCPs regarding how to access and request a hard copy of an updated version of the listing. The MCO maintains an updated electronic, web-accessible version of the referral provider listing.	☐ Information provided ☐ Electronic listing maintained	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
15. Mental Health Case Management Services CRA and TSA § 2.7.2.1.2	Medically necessary mental health case management services are provided for TennCare Kids members whose behavioral health needs require these services.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength**					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
AON					
Suggestion					
16. Family Involvement and Accessible Services CRA and TSA § 2.7.2.1.2; 2.7.2.1.4; 2.11.1.1	Parents and family members are involved, to the greatest extent possible, in the determination of behavioral health services to be delivered to their child. The MCO provides access to behavioral health providers for covered services in accordance with the geographic, appointment, and wait times access standards.	☐ Parent/Family involvement ☐ Services provided in accordance with standards	**0.750** **0.750**	**1.500**	**0.000**
Findings					
Strength					
AON					
Suggestion					
17. Follow-Up After Inpatient or Residential Treatment CRA and TSA § 2.9.9.3.2	Through coordination efforts with its contracted facilities, the MCO ensures that psychiatric hospital and residential treatment facility discharges do not occur without a discharge plan in which the member has participated. This discharge plan includes an outpatient visit scheduled before discharge, which ensures access to proper provider/medication follow-up. An appropriate placement or housing site is also secured prior to discharge.	☐ a. Discharge plan completed ☐ b. Member participated ☐ c. Outpatient appointment scheduled ☐ d. Appropriate placement or housing secured	**0.500** **0.500** **0.500** **0.500**	**2.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
18. Screening Components Including Follow-Up CRA and TSA § 2.7.6.1.4	The MCO is responsible for and complies with all provisions related to TennCare Kids screenings, including making arrangements for necessary follow-up if all components of a screening cannot be completed in a single visit.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
19. Interperiodic Screenings CRA and TSA § 2.7.6.1.7; 2.7.6.3.1-.2	The MCO provides interperiodic screenings at intervals which meet reasonable standards of medical, behavioral, and dental practice, as determined by TennCare after consultation with recognized medical and dental organizations involved in child healthcare. Interperiodic screenings do not require prior authorization if they are conducted by PCPs.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
20. Transportation CRA and TSA § 2.7.6.4.6.1 and Attachment XI: A.4.1.1	The MCO provides access to non-emergency transportation services. The MCO does not place blanket restrictions or requirements on age or lack of parental accompaniment. Transportation assistance includes related travel expenses, meals, lodging, and cost of an attendant to accompany the child, if necessary.	☐ a. Access provided ☐ b. No blanket restrictions ☐ c. Assistance included identified components	**0.500** **0.500** **0.500**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
21. Program Coordination CRA and TSA § 2.7.6.1.3	The MCO has P&Ps that coordinate TennCare Kids outreach, screening, and treatment services with other children's health and education services and programs. MCO staff is able to describe and demonstrate coordination efforts by the MCO.	☐ P&Ps in place ☐ Coordination described and demonstrated	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
22. Individual Education Plans (IEPs) CRA § 2.9.15.7.1 and .4-.4.3; TSA § 2.9.16.7.1; 2.9.16.7.4-.4.3	The MCO is responsible for the delivery of medically necessary covered services to school-aged children. The MCO is also encouraged to work with school-based providers to manage the care of students with special needs. The Department of Education (DOE) and local education agencies are responsible for documenting a school-aged child's need for medical services in an IEP. When the child is enrolled in TennCare, the school is responsible for obtaining parental consent to share the IEP with the MCO and subsequently sending a copy of the parental consent and IEP to the MCO in the required manner. The MCO decides whether to receive the IEP and parental consent prior to providing and paying for medically necessary covered services or upon request during a post-payment audit. If the MCO requires the school to submit parental consent and the IEP prior to providing and paying for the services, the MCO completes the following after receiving the documentation: ♦ Either accepts the IEP as an indication of a medical problem and treats the IEP as a request for service or does not accept the documentation and assists in making an appointment to have the child re-evaluated by the child's PCP or another contracted provider to make a decision about the appropriateness of the requested service. ♦ Sends a copy of the IEP and related information to the PCP ♦ Notifies the designated school contact of the ultimate disposition of the request within 14 days of receipt of the IEP	☐ a. Accepted problem or had child re-evaluated ☐ b. Shared with PCP ☐ c. Notified school contact of disposition of request	**0.250** **0.250** **0.250**	**0.750**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
Findings					
Strength					
AON					
Suggestion					
23. IEP Services Provided Without Submission of the IEP CRA § 2.9.15.7.2-.3.1; TSA § 2.9.16.7.2-.3.1	The MCO may choose to provide the medically necessary covered services identified either within or outside the school setting. When the MCO does not require the DOE to submit parental consent and the IEP prior to providing and paying for services, the MCO conducts regular post-payment sample audits of the IEP and all other documentation that supports medical necessity of school-based services reimbursed by the MCO. When the MCO requests a copy of an IEP, the provider must also include a copy of the appropriate parental consent.	☐ Yes ☐ No	**0.250** **0.000**	**0.250**	**0.000**
Findings					
Strength					
AON					
Suggestion					
24. Tracking System CRA and TSA § 2.7.6.1.8; 2.7.6.2.3	Tracking system data are used to take action to improve the EPSDT services. The tracking system monitors members' receipt of EPSDT services and has the ability to generate reports with this information for providers. The tracking system also has a mechanism for systematically notifying families when screenings are due. (For more detailed information, refer to the EPSDT Information System Tracking Review Tool.)	☐ Reports generated ☐ Families notified	**1.000** **1.000**	**2.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
25. EPSDT Language in Contracts CRA and TSA § 2.12.9; 2.12.9.62	All provider agreements include language that informs providers of the benefits that TennCare Kids offers and requires providers to make treatment decisions based upon children's individual medical and behavioral health needs.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
26. EPSDT Contract Review CRA and TSA § 2.12.8-.9	Review of provider contracts ensures that there are no provisions which would encourage violations of the EPSDT mandate.	☐ Yes (no provisions) ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
		Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Score	**0.0%**	**27.500**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
TennCare Medical Services Grievance and Appeal Process					
1. Appeals Unit CRA and TSA § 2.19.14	The MCO has sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to member appeals contesting adverse benefit determinations.	☐ Yes ☐ No	**1.500** **0.000**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Grievance and Appeal Procedures CRA and TSA § 2.19.1.1-.2	In accordance with TennCare requirements, the MCO has internal grievance procedures in place for its TennCare members. Further, the MCO has the contractually required procedures in place for handling its obligations related to the TennCare appeal procedure. Appeals staff is able to demonstrate the procedures.	☐ Procedures in place ☐ Procedures demonstrated	**1.000** **1.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
		TennCare Medical Services Grievance and Appeal Process Score	**0.0%**	**3.500**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Non-Discrimination Compliance					
1. Non-Discrimination Compliance Questionnaire CRA and TSA § 2.30.22.1	There is documentation of the MCO's submission of a completed Non-Discrimination Compliance Questionnaire to TennCare within 60 calendar days of receipt of the Questionnaire from TennCare. The completed Non-Discrimination Compliance Questionnaire and Assurance of Non-Discrimination signature dates are the same.	☐ Non-Discrimination Compliance Questionnaire completed within 60 days of receipt ☐ Signature dates were the same	**0.125** **0.125**	**0.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Display of Non-Discrimination Information CRA § D.7; TSA § 5.32.1-.3	The MCO ensures that no employee is subjected to discrimination based on handicap or disability, age, race, color, religion, sex, national origin, or any other classification protected by federal, state, or statutory law. The MCO provides proof of non-discrimination upon request and posts the information in conspicuous places that are accessible for all employees and applicants.	☐ Yes ☐ No	**0.250** **0.000**	**0.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Provision of Services CRA and TSA § 2.28.3	The MCO has written, TennCare-approved, non-discrimination P&Ps on file that demonstrate that services are provided to members in a non-discriminatory manner.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**0.000**
Findings **Strength** **AON**					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Non-Discrimination Compliance					
Suggestion					
4. Complaint Resolution and Reporting CRA and TSA § 2.28.6; 2.30.22.3, .3.2, and .3.2.1	The MCO has processes in place to resolve alleged discrimination complaints against MCO staff, providers, and providers' employees and/or subcontractors. TennCare reviews all complaint investigations provided by the MCO and determines the appropriate resolutions. The MCO submits a quarterly Non-Discrimination Compliance Report to TennCare. The report lists all complaints of alleged discrimination reported to the MCO by employees, members, providers, and subcontractors. It also includes all discrimination complaints related to the provision of TennCare-covered services.	☐ a. Processes in place ☐ b. Provided complaint investigations to TennCare ☐ c. Quarterly reports submitted and included required information	**0.500** **0.250** **0.250**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
Member Handbook Complaint Forms CRA and TSA § 2.28.7	The English and Spanish Member Handbooks include a copy of the Discrimination Complaint Form.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2021 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Non-Discrimination Compliance					
5. Health Disparities Projects CRA and TSA § 2.30.22.4; 2.30.22.4.2	On an annual basis, the MCO documents that it assisted TennCare with its health disparities project and survey efforts, which are conducted online over a period of 10 weeks.	☐ Documentation for project and survey efforts ☐ Conducted over a 10-week period	**0.250** **0.250**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
6. Provider and Subcontractor Compliance Education CRA and TSA § 2.28.2; 2.28.2.1.1	The MCO provides non-discrimination compliance training to all contracted providers and subcontractors, ensuring they have been made aware of their obligations under the applicable civil rights laws, including but not limited to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the Americans with Disabilities Act of 1990, and the Age Discrimination Act of 1975.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
		Non-Discrimination Compliance Score	**0.0%**	**5.000**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Credentialing/Recredentialing P&Ps				
1) Written P&Ps for Credentialing: Contracted/ Employed Providers *National Committee for Quality Assurance (NCQA) CR1*	The MCO has written credentialing P&Ps that include the MCO's initial credentialing for all providers with whom the MCO contracts or employs and who fall within its scope of authority and action.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
2) Written P&Ps for Recredentialing: Contracted/ Employed Providers *CRA A.2.11.10.1.1TSA 2.11.10.1.1* *NCQA CR1*	The MCO has written recredentialing P&Ps that include the MCO's recredentialing of all providers with whom the MCO contracts or employs and who fall within its scope of authority and action.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
3) Credentialing Committee *NCQA CR2*	There is written documentation that the MCO submits all practitioner files to the Credentialing Committee for review or has a process for medical director or qualified physician to review and approve clean files.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
4) Credentialing Prior to Providing Services *NCQA CR2*	Credentialing documents include the statement that practitioners are credentialed prior to providing care to TennCare MCO members.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				

2021 Annual Quality Survey—Quality Process Standards: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Credentialing/Recredentialing P&Ps				
5) Recredentialing Timeline *NCQA CR4*	Written recredentialing P&Ps include the statement that practitioners are recredentialed at least every 36 months.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
6) Provisional Credentialing *NCQA CR1*	The organization has a process for one-time provisional credentialing for practitioners applying to the organization for the first time.	☐ Met ☐ Not Met ☐ NA*	**1.0**	**0.0**
Findings:				
Recommendations:				
7) Length of Provisional Credentialing *NCQA CR1*	If the organization uses provisional credentialing, a practitioner may not be in provisional status for more than 60 calendar days.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
8) Documents Required for Provisional Credentialing *NCQA CR1*	If the MCO uses provisional credentialing, the following documents are obtained prior to the MCO granting provisional credentialing privileges: a) Primary-source verification of a current, valid license to practice b) Primary-source verification of the past five years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank (NPDB) query c) Current, signed application with the attestation d) The MCO follows the same process for presenting provisionally credentialed files to the credentialing committee or medical director as it does for its regular credentialing process.	a) ☐ Met ☐ Not Met ☐ NA b) ☐ Met ☐ Not Met ☐ NA c) ☐ Met ☐ Not Met ☐ NA d) ☐ Met ☐ Not Met	**1.0**	**0.0**

* *Responses found to be not applicable (NA) do not receive a point value and are not counted against the MCO.*

2021 Annual Quality Survey—Quality Process Standards: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Credentialing/Recredentialing P&Ps				
		☐ NA Each Variable = .25		
Findings:				
Recommendations:				
9) Evaluation of Complaints and Adverse Events *NCQA CR5*	The organization monitors for adverse events at least every six months and may limit monitoring of adverse events to PCPs and high-volume behavioral healthcare practitioners.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
10) Delegated Credentialing P&Ps *NCQA CR8*	If credentialing and recredentialing activities are delegated, the MCO has a delegation agreement describing the delegated credentialing activities.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
11) Delegated Credentialing Accountability *NCQA CR8*	If credentialing and recredentialing activities are delegated, the agreement specifies that reporting is at least semi-annual, and the information to be reported by the delegate about the delegated activities.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
12) Delegated Credentialing Reporting *CRA A.2.26.1.4* *TSA 2.26.1.4*	If credentialing and recredentialing activities are delegated, there is evidence (through the review of MCO reports, P&Ps, and minutes) that the MCO monitors the subcontractor's performance on at least an ongoing basis and subjects it to formal review, on at least an annual basis, consistent with NCQA standards and state MCO laws and regulations.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
13) Nondiscrimination in Credentialing and Recredentialing	Credentialing P&Ps concerning nondiscrimination explicitly specify that the organization does not base credentialing decisions based on an applicant's	☐ Met ☐ Not Met	**1.0**	**0.0**

2021 Annual Quality Survey—Quality Process Standards: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Credentialing/Recredentialing P&Ps				
NCQA CR1	race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) in which the practitioner specializes.			
Findings:				
Recommendations:				
14) Monitoring to Prevent Discrimination in Credentialing and Recredentialing *NCQA CR1*	Credentialing P&Ps concerning nondiscrimination explicitly specify the steps that the organization takes to periodically monitor for and prevent discriminatory practices during the credentialing and recredentialing process, and annually audit practitioner complaints for evidence of alleged discrimination.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
15) Interventions for Providers Concerning Poor Quality Care *NCQA CR5*	The organization implements interventions based on its P&Ps if there is evidence of poor quality that could affect the health and safety of its members.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
16) Reporting Quality Deficiencies *CRA A.2.11.11.2.3.1* *TSA 2.11.11.2.3.1*	The MCO notifies appropriate State or other authorities when a practitioner's privileges are terminated within 5 business days of the provider's termination.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
17) Notification of Denial to TennCare *CRA A.2.11.10.2.3* *CRA A.2.20.2.14* *TSA 2.11.10.1.4* *TSA 2.20.2.14*	Plan documents specify that when the MCO denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons, the MCO notifies TennCare.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				

2021 Annual Quality Survey—Quality Process Standards: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Credentialing/Recredentialing P&Ps				
18) Confidentiality *NCQA CR1*	The MCO's credentialing P&Ps describe the organization's process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
19) Provider Appeals Processes *NCQA CR6*	The MCO has written P&Ps for providers to appeal determinations that suspend or terminate a provider's privileges.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
20) Provider Notification *NCQA CR6*	When provider privileges are suspended or terminated, there is evidence of written notification to the provider that includes the reasons for the action (see letter to provider).	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
21) Provider Appeal Rights *NCQA CR6*	When provider privileges are suspended or terminated, there is evidence of written notification to the provider that includes the appeal rights and process (see letter to provider).	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
22) Unlicensed BH Providers *CRA A.2.11.10.3.2* *TSA 2.11.10.3.2*	When individuals providing behavioral health treatment services are not required to be licensed or certified, the MCO ensures, based on applicable State license rules and/or program standards, that the individuals are: a) Appropriately educated b) Trained c) Qualified d) Competent to perform their job responsibilities	a) ☐ Met ☐ Not Met ☐ NA b) ☐ Met ☐ Not Met ☐ NA c) ☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**

2021 Annual Quality Survey—Quality Process Standards: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Credentialing/Recredentialing P&Ps				
		d) ☐ Met ☐ Not Met ☐ NA Each Variable = .25		
Findings:				
Recommendations:				
23) Credentialing Timeline *CRA A.2.11.10.1.2* *TSA 2.11.10.1.2*	The MCO completely processes credentialing applications within 30 calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. Completely processed means that the MCO has reviewed, approved, and loaded approved applicants into the provider files in its claims processing system or denied the application and assured that the provider is not used by the MCO.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
24) Credentialing Timeline for Delegated Vendors *CRA A.2.11.10.1.3* *TSA 2.11.10.1.3*	The MCO ensures that all providers submitted to the MCO from the delegated credentialing agent are loaded to its provider files and into its claims processing system within 30 calendar days of receipt.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
25) Credentialing and Recredentialing CHOICES and ECF CHOICES HCBS Providers *CRA A.2.11.10.4.1.1* *TSA 2.11.9.4.1.1*[*]	The MCO developed policies that specify by HCBS provider type the initial credentialing and recredentialing process including frequency, and ongoing provider monitoring activities.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				

[*] *TennCareSelect does not participate in the ECF CHOICES HCBS program.*

2021 Annual Quality Survey—Quality Process Standards: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Credentialing/Recredentialing P&Ps				
26) Frequency of Recredentialing for Ongoing CHOICES and ECF CHOICES HCBS Providers *CRA A.2.11.10.4.1.1.1* *TSA 2.11.9.4.1.1.1*	The MCO had P&Ps to ensure that the MCO recredentials the ongoing CHOICES and ECF CHOICES HCBS providers at least annually.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
27) Frequency of Recredentialing for Non-ongoing/One Time CHOICES Providers *CRA A.2.11.10.4.1.1.2* *TSA 2.11.9.4.1.1.2*	All other CHOICES and ECF CHOICES HCBS providers must be recredentialed, at a minimum, every three years. (One-time CHOICES providers include in-home respite care, in-patient respite care, assistive technology, minor home modifications, and pest control.)	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
28) Background Checks Conducted by CHOICES and ECF CHOICES HCBS Providers *CRA A.2.11.10.4.1.2.4* *TSA 2.11.9.4.1.2.4*	The MCO had P&Ps to ensure that during credentialing of CHOICES and ECF CHOICES HCBS providers, the MCO verified that the providers had P&Ps that described the requirement to conduct criminal background checks for prospective employees to include: a) Tennessee Abuse Registry b) Tennessee Felony Offender Registry (TennCare*Select* only) c) National and Tennessee Sexual Offender Registry d) List of Excluded Individuals/Entities (LEIE)	a) ☐ Met ☐ Not Met ☐ NA b) ☐ Met ☐ Not Met ☐ NA c) ☐ Met ☐ Not Met ☐ NA d) ☐ Met ☐ Not Met ☐ NA Each Variable = .25	**1.0**	**0.0**
Findings:				
Recommendations:				

2021 Annual Quality Survey—Quality Process Standards: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Credentialing/Recredentialing P&Ps				
29) Initial and Ongoing Education Conducted by CHOICES and ECF CHOICES HCBS Providers *CRA A.2.11.10.4.1.2.5* *TSA 2.11.9.4.1.2.5*	The MCO had P&Ps to ensure that during credentialing, the MCO verified that CHOICES and ECF CHOICES HCBS providers had a process in place to conduct and document initial and ongoing education for employees who provided services to CHOICES and ECF CHOICES HCBS members to include: a) Delivering person-centered services and supports b) Abuse and neglect prevention, ID, and reporting c) Critical incident reporting d) Documentation of service delivery e) Use of the Electronic Visit Verification (EVV) System f) Other training requirements specified by TennCare	a) ☐ Met ☐ Not Met ☐ NA b) ☐ Met ☐ Not Met ☐ NA c) ☐ Met ☐ Not Met ☐ NA d) ☐ Met ☐ Not Met ☐ NA e) ☐ Met ☐ Not Met ☐ NA f) ☐ Met ☐ Not Met ☐ NA Variables a – d = .167 Variables e & f = .166	**1.0**	**0.0**
Findings:				
Recommendations:				
30) Initial and Ongoing Education Conducted by CHOICES and ECF CHOICES HCBS Providers *CRA A.2.11.10.4.1.2.5*	The MCO had a process to ensure that during credentialing, the MCO verified that CHOICES and ECF CHOICES HCBS providers had a process in place to conduct and document initial and ongoing education for employees who provided services to CHOICES and ECF CHOICES HCBS members to include: a) Orientation to the population that the staff will support (e.g., elderly and adults with physical disabilities) b) Disability awareness and cultural competency training, including person-first language; etiquette when meeting and supporting a person with a disability; and working with individuals who use	a) ☐ Met ☐ Not Met ☐ NA b) ☐ Met ☐ Not Met ☐ NA c) ☐ Met ☐ Not Met	**1.0**	**0.0**

2021 Annual Quality Survey—Quality Process Standards: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Credentialing/Recredentialing P&Ps				
	alternative forms of communication, such as sign language or non-verbal communication, or who may rely on assistive devices for communication or who may need auxiliary aids or services in order to effectively communicate c) Ethics and confidentiality training, including Health Insurance Portability and Accountability Act (HIPAA) and HI-TECH d) Federal HCBS setting requirements and the importance of the member's experience e) Supporting community integration and participation in the delivery of HCBS	☐ NA d) ☐ Met ☐ Not Met ☐ NA e) ☐ Met ☐ Not Met ☐ NA Each Variable= .20		
Findings:				
Recommendations:				
31) Initial and Ongoing Education Conducted by CHOICES and ECF CHOICES HCBS Providers *CRA A.2.11.10.4.1.2.5*	The MCO had a process to ensure that during credentialing, the MCO verified that CHOICES and ECF CHOICES HCBS providers had a process in place to conduct and document initial and ongoing education for employees who provided services to CHOICES and ECF CHOICES HCBS members to include: a) Facilitating individual choice and control b) Working with family members and/or conservators, while respecting individual choice c) An introduction to behavioral health, including behavior support challenges or other cognitive limitations (including Alzheimer's Disease, dementia, etc.) may face; understanding behavior as communication; potential causes of behavior, including physiological or environmental factors; and person-centered supports for individuals with challenging behaviors, including positive behavior supports d) The paid caregiver's responsibility in promoting healthy lifestyle choices and in supporting self-management of chronic health conditions	a) ☐ Met ☐ Not Met ☐ NA b) ☐ Met ☐ Not Met ☐ NA c) ☐ Met ☐ Not Met ☐ NA d) ☐ Met ☐ Not Met ☐ NA Each Variable= .25	**1.0**	**0.0**
Findings:				
Recommendations:				
32) Provider Policies and Processes Concerning Critical Incident Reporting	The MCO had P&Ps to confirm that during the credentialing, the MCO verified that the CHOICES and ECF CHOICES HCBS providers had P&Ps to ensure that the providers complied with:	a) ☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**

2021 Annual Quality Survey—Quality Process Standards: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Credentialing/Recredentialing P&Ps				
for CHOICES and ECF CHOICES HCBS Providers *CRA A.2.11.10.4.1.2.6* *TSA 2.11.9.4.1.2.6*	a) The MCO's critical incident reporting and management process b) Appropriate use of the EVV system	b) ☐ Met ☐ Not Met ☐ NA Each Variable = .50		
Findings:				
Recommendations:				
33) Recredentialing Verifications for CHOICES and ECF CHOICES HCBS Providers *CRA A.2.11.9.10.4.1.4* *TSA 2.11.9.4.1.3*	The MCO had plan documents in place to ensure that the recredentialing of CHOICES HCBS and ECF CHOICES providers included: a) Verification of licensure/certification b) Verification of background checks c) Verification of training requirements d) Verification of critical incident reporting and management e) Verification of reportable event reporting and management (CRA only) f) Verification of the use of the EVV	a) ☐ Met ☐ Not Met ☐ NA b) ☐ Met ☐ Not Met ☐ NA c) ☐ Met ☐ Not Met ☐ NA d) ☐ Met ☐ Not Met ☐ NA e) ☐ Met ☐ Not Met ☐ NA f) ☐ Met ☐ Not Met ☐ NA Variables a – d = .167 Variables e & f = .166	**1.0**	**0.0**
Findings:				
Recommendations:				
34) Volunteers and employees hired after last credentialing visit	The MCO verifies that any persons required to have background checks, including registry checks, as applicable, who have been employed or have	☐ Met	**1.0**	**0.0**

2021 Annual Quality Survey—Quality Process Standards: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Credentialing/Recredentialing P&Ps				
CRA A.2.11.10.4.1.4.1	begun volunteering since the last credentialing visit have had criminal background checks, including registry checks, as applicable. (This element is NA for TennCare*Select*.)	☐ Not Met ☐ NA		
Findings:				
Recommendations:				
35) Site Visits for CHOICES and ECF CHOICES HCBS Providers *CRA A.2.11.10.4.1.5* *TSA 2.11.9.4.1.4* *42 CFR § 438.206(c)(3)*	The MCO had plan documents to ensure that the MCO conducted a site visit for providers for both credentialing and recredentialing, unless the provider is located out of state. If the provider is located out of state, the site visit may be waived if documentation concerning the reason for not completing the site visit is included in the provider's file. The MCO ensures that providers furnish physical access, reasonable accommodations, and accessible equipment for enrollees with physical or mental disabilities.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
36) Monthly Verification of CHOICES and ECF CHOICES HCBS Providers *CRA A.2.11.10.4.1.6* *TSA 2.11.9.4.1.5* *42 CFR § 438.214(d)*	The MCO had P&Ps to ensure that the MCO conducted monthly checks to ensure that CHOICES and ECF CHOICES HCBS providers had not been excluded from participation in Medicare, Medicaid, or the State Children's Health Insurance Program (SCHIP).	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**
Findings:				
Recommendations:				
	Credentialing/Recredentialing P&Ps Score	**<##>%**	**0.0**	**0.0**

QP Standards Tool—DBM

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Written QMP Description					
1. Quality Monitoring Program (QMP) Description DBMC A.133; A.142	The DBM has a written QMP Description (QMPD) that clearly defines its quality improvement (QI) structures, processes, and related activities to pursue opportunities for improvement on an ongoing basis. The description also includes the staff responsible.	☐ a. Clearly defined ☐ b. QI structures ☐ c. Processes ☐ d. Staff	**0.250** **0.250** **0.250** **0.250**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. QMP Work Plan DBMC A.142.a; A.142.a.2 and .e	The DBM has an annual work plan that identifies QMP activities, yearly objectives, timeframes for completion, and staff responsible for oversight of QMP activities. The work plan is submitted annually to TennCare.	☐ Yes ☐ No	**1.500** **0.000**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. QMP Activities/ Service Delivery DBMC A.142; A.142.c–.d	The DBM uses the results of QMP activities to improve the quality of dental health with appropriate input from providers and members, and takes appropriate action to address service delivery including continuity and coordination of care, access to care, utilization of services, health education and emergency services; patient safety; provider; and other QMP issues as they are identified.	☐ Used the results of QMP activities to improve the quality of dental health ☐ Took appropriate action to address service delivery	**0.500** **0.500**	**1.000**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Written QMP Description					
Findings					
Strength					
AON					
Suggestion					
4. Continuous Activity Performance and Tracking DBMC A.133; A.142	The written QMPD includes, and there is evidence of, continuous performance of the quality of care activities and tracking of issues over time.	☐ Continuous performance ☐ Tracking of issues over time	**0.500** **0.500**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
5. Provider Peer Review Committee (PPRC) DBMC A.136; A.136.a	The PPRC meets at least quarterly to review processes, outcomes, and appropriateness of dental care provided to members for any participating provider. The PPRC reviews and provides detailed written findings, recommendations, and appropriate corrective action for any participating dental provider who has provided inappropriate care.	☐ a. Meetings held at least quarterly ☐ b. Findings, recommendations, and appropriate corrective action provided ☐ c. For quality issues, the analysis included quality indicators and used practice guidelines to make determinations	**0.500** **0.500** **0.500**	**1.500**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Written QMP Description					
6. Feedback DBMC A.135.b	The QMP Committee analyzes and evaluates QMP activity results; recommends policy decisions; ensures that providers are involved in the QMP; institutes needed action; and ensures that appropriate follow-up occurs.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
		Written QMP Description Score	**0.0%**	**7.000**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest						
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**		
				Value	**Score**	
Systematic Process of Quality Assessment and Improvement						
1. Population Served DBMC A.143.c	The DBM's performance improvement projects reflect the population served in terms of age groups, disease categories, and special risk status. This includes ECF CHOICES members.	☐ a. Age groups ☐ b. Disease categories ☐ c. Special risk status	**0.250** **0.250** **0.250**	**0.750**	**0.000**	
Findings **Strength** **AON** **Suggestion**						
2. Practice Guidelines DBMC A.56.a–.f	Practice guidelines comply with TennCare medical necessity rule, are based on valid and reasonable evidence or consensus of healthcare professionals in a particular field, consider the needs of members, and are developed, reviewed, and updated by plan providers. The practice guidelines are also disseminated to all affected providers and, upon request, to members and potential members. The needs of members with intellectual and developmental disabilities (I/DD) and ECF CHOICES members are also included.	☐ Yes ☐ No	**0.750** **0.000**	**0.750**	**0.000**	
Findings **Strength** **AON** **Suggestion**						
3. Provider Manual Supplement DBMC A.55	The Provider Manuals include a supplement specific to providers participating in ECF CHOICES.	☐ Yes ☐ No	**0.250** **0.000**	**0.250**	**0.000**	

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Systematic Process of Quality Assessment and Improvement					
Findings **Strength** **AON** **Suggestion**					
4. Address Preventive Health DBMC A.114	Practice guidelines address preventive dental services for all members, including ECF CHOICES members.	☐ Yes ☐ No	**0.250** **0.000**	**0.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					
5. Remedial/ Corrective Action Procedures DBMC A.142.b-.b.7	The QMP includes written procedures for taking remedial/corrective action when, as determined by the QMP, inappropriate or substandard services are furnished, or when services that should have been furnished were not. Written remedial/corrective action procedures include the following: a. Specific types of problems requiring remedial/corrective action b. Specific person(s) or body responsible for making final determinations regarding quality problems c. Specific actions to be taken d. Provision of feedback to appropriate dental professionals and staff e. Schedule of corrective actions to be completed, due dates, and persons responsible for implementing corrective actions f. Methodology for modifying corrective actions if improvements do not occur g. Procedures for terminating DBM affiliation with a dental professional when warranted	☐ a. Specific types of problems requiring action ☐ b. Party responsible for final determinations ☐ c. Specific actions ☐ d. Provision of feedback to professionals and staff ☐ e. Schedule and persons responsible for corrective action implementation ☐ f. Method for modifying corrective actions if no improvements ☐ g. Procedures for terminating a dental professional	**0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.300**	**1.500**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest						
Evaluation Elements		**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
					Value	**Score**
Systematic Process of Quality Assessment and Improvement						
	Findings					
	Strength					
	AON					
	Suggestion					
6.	Corrective Action Follow-Up DBMC A.142.b	The DBM follows up on identified issues to ensure that actions for improvement have been effective.	☐ Yes ☐ No	**0.750** **0.000**	**0.750**	**0.000**
	Findings					
	Strength					
	AON					
	Suggestion					
7.	Annual Evaluation DBMC A.142.e	The DBM prepares an annual evaluation of the QMP that addresses a. studies and other activities completed; b. trending of clinical and service indicators and other performance data; c. demonstrated improvements in quality; d. areas of deficiency and recommendations for corrective action; and e. an evaluation of the overall effectiveness of the QMP.	☐ a. Studies and other activities completed ☐ b. Trending of clinical and service indicators and other performance data ☐ c. Demonstrated improvements in quality ☐ d. Areas of deficiency and recommendations for corrective action ☐ e. Evaluation of the overall effectiveness of the QMP	**0.200** **0.200** **0.200** **0.200** **0.200**	**1.000**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Systematic Process of Quality Assessment and Improvement					
Findings **Strength** **AON** **Suggestion**					
8. Subcontractor Audits CFR 438.230.c.3-.3.iv	The DBM's contract with a subcontractor includes the right for TennCare or CMS to audit the subcontractor's records and systems at any time through 10 years after the final date of the contract period or the last audit, whichever is later.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
9. Marketing Activities DBMC A.12; A.12.f; A.12.j; CFR 438.104.b.1.i; .iv-.v	The DBM does not engage in cold-call marketing, distribute marketing materials without TennCare approval, or seek to influence enrollment in conjunction with offering private insurance.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
10. Prohibited Affiliations DBMC A.65; A.166; D.23; CFR 438.610.a-	The DBM does not knowingly have a relationship with an individual	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Systematic Process of Quality Assessment and Improvement					
.b	who is a. debarred, suspended, or otherwise excluded from participating under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549; b. an affiliate, as defined in the Federal Acquisition Regulation, of a person described above; or c. excluded from participation in any federal healthcare program.				
Findings					
Strength					
AON					
Suggestion					
		Systematic Process of Quality Assessment and Improvement Score	**0.0%**	**8.250**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Accountability to the Governing Body					
1. Governing Body DBMC A.135.d	The governing body that is accountable for the DBM's QMP is the Board of Directors or, where the Board's participation with the QMP is not direct, a designated committee of the DBM's senior management.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Oversight of QMP DBMC A.135.d-.d.1	The governing body is accountable for monitoring, evaluating, and making improvements to care. There is documentation showing that the governing body approves the written QMP and annual work plan.	☐ Yes ☐ No	**1.750** **0.000**	**1.750**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. QMP Progress Reports DBMC A.135.d.2	The QMP Committee provides written reports to the governing body that describe actions taken, progress in meeting QM objectives, and improvements made.	☐ Yes ☐ No	**0.750** **0.000**	**0.750**	**0.000**
Findings **Strength** **AON** **Suggestion**					
4. Program Modification DBMC A.135.d.3	Following review of written QMP progress reports, the governing body takes action, as appropriate, and directs that the operational QMP be modified on an ongoing basis to accommodate review findings and issues of DBM concern.	☐ Yes ☐ No	**0.750** **0.000**	**0.750**	**0.000**
Findings					

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Accountability to the Governing Body					
Strength					
AON					
Suggestion					
5. Follow-Up DBMC A.135.d.3	Governing body meeting minutes include documentation in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to QM/QI.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Accountability to the Governing Body Score	**0.0%**	**6.250**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Active Quality Monitoring Program Committee					
1. QMP Committee DBMC A.135.a	The written QMP establishes and defines a committee responsible for performing QM functions within the organization.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Meeting Frequency DBMC A.135.e	The QMP Committee has meetings no less than quarterly to oversee QMP activities. The frequency of meetings is sufficient to demonstrate committee follow-up.	☐ Meetings held at least quarterly ☐ Follow-up demonstrated on all findings and required actions	**0.750** **0.750**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Meeting Documentation DBMC A.135.f	The QMP Committee keeps written minutes of all meetings. The minutes are signed, dated, and available for review upon request and during the annual onsite EQRO review.	☐ Yes ☐ No	**1.500** **0.000**	**1.500**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Active Quality Monitoring Program Committee					
Findings					
Strength					
AON					
Suggestion					
4. Membership DBMC A.135.a	The QMP Committee includes a designated senior executive responsible for program implementation, the DBM's Dental Director, and dental plan providers.	☐ Designated senior executive and DBM's Dental Director participation ☐ TennCare dental plan provider participation	**0.750** **0.750**	**1.500**	**0.000**
Findings					
Strength					
AON					
Suggestion					
5. Committee Approval of QMP DBMC A.135.c	The QMP Committee reviews and approves the written QMP and associated work plan prior to submission to TennCare.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Active Quality Monitoring Program Committee Score	**0.0%**	**7.500**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Monitoring Supervision					
1. Dental Director Involvement DBMC A.17.b	The DBM's Dental Director has substantial involvement in QM activities.	☐ Yes ☐ No	**3.000** **0.000**	**3.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
2. External Advisory Committee DBMC A.17.b	The DBM's Dental Director participates in the TennCare Dental Advisory Committee empowered to review and make recommendations to the DBM and TennCare regarding changes to clinical guidelines.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
3. Compliance Program CFR 438.608.a-.a.1	The DBM (and subcontractor, if applicable) maintains a compliance program and procedures that detect and prevent fraud, waste, and abuse.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Quality Monitoring Supervision Score	**0.0%**	**5.000**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Adequate Resources					
1. Resources and Staffing DBMC A.142.a.3	The DBM has designated sufficient material resources and staff with the necessary education, experience, or training to carry out QMP activities effectively.	☐ Material resources ☐ Staff with necessary education, experience, or training, including transportation coordinator(s)	**5.000** **5.000**	**10.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Adequate Resources Score	**0.0%**	**10.000**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Provider Participation in the QMP					
1. Informed Providers DBMC A.142.f	The DBM makes all information about its QMP available to its providers. The DBM also includes a requirement for cooperation with the QMP in all of its provider contracts and employment agreements with dentists and non-dentist providers.	☐ Yes ☐ No	**3.500** **0.000**	**3.500**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Provider Participation in the QMP Score	**0.0%**	**3.500**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
1. Policies and Procedures (P&Ps) on Member Rights DBMC A.144.a.1-.9; D.9	The DBM has established P&Ps to protect member rights and ensure that each member is a. treated with respect, including recognition of his or her dignity and need for privacy; b. provided with information about the DBM, its services, the practitioners providing care, and members' rights and responsibilities; c. a participant in decision-making regarding his or her dental care; d. free to voice complaints or appeals about the DBM or care provided; e. guaranteed the right to request and receive a copy of his or her records, and to request that they be amended or corrected as specified in 45 CFR Part 164; f. free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; g. free to exercise his or her rights, and that the exercising of those rights does not adversely affect the way the DBM and its providers or TennCare treat the member; h. provided information on available treatment options and alternatives presented in a manner appropriate to the member's condition and ability to understand; i. provided services without discrimination due to disability, age, sex, race, color, religion, national origin, and other protected statuses; and j. free to exercise an advance directive, and receive information about state law.	☐ a. Treated with respect, dignity, and privacy ☐ b. Provided with listed information ☐ c. Participate in decision-making ☐ d. Voice complaints or appeals ☐ e. Request and receive a copy of records, and request that they be amended or corrected ☐ f. Free from any form of restraint or seclusion ☐ g. Free to exercise his or her rights ☐ h. Receive information on treatment options/alternatives in an appropriate and understandable manner ☐ i. Receive services without discrimination due to disability, age, sex, race, color, religion, national origin, or other protected statuses ☐ j. Exercise an advance directive	**0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200**	**2.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
2. Member Responsibilities Policy DBMC A.144.b-.b.2	The DBM has a written policy that addresses the member's responsibility for cooperating with those providing dental care services. The policy includes responsibility for providing, to the extent possible, information needed by professional staff in caring for the member and for following instructions and guidelines given by those providing dental care services.	☐ Addressed responsibility for providing needed information ☐ Addressed responsibility for following instructions and guidelines	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Communication of Policies to Providers DBMC A.144.c	A copy of the DBM's policies on member rights and responsibilities is provided to all participating providers.	☐ Yes ☐ No	**0.750** **0.000**	**0.750**	**0.000**
Findings **Strength** **AON** **Suggestion**					
4. Communication of Policies to Members DBMC A.144.d; d.3-.6 and d.8-.9	Members are provided a written statement upon enrollment that	☐ a. Provisions for emergency coverage ☐ b. Policy on referrals for specialty care ☐ c. Policy on payment charges and copayment/fees ☐ d. Procedures for notifying members about changes to benefits, services, or service delivery offices/sites ☐ e. Procedures for changing practitioners	**0.125** **0.125** **0.125** **0.125** **0.125**	**0.750**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
	includes information on the following: a. Provisions for emergency coverage b. Policy on referrals for specialty care c. Policy on charges to members, if applicable, including (1) policy on payment of charges and (2) copayment and fees for which the member is responsible d. Procedures for notifying members affected by the termination or change to any benefits, services, or service delivery offices/sites e. Procedures for changing practitioners f. Procedures for voicing complaints and/or appeals	☐ f. Procedures for voicing complaints and/or appeals	**0.125**		
Findings **Strength** **AON** **Suggestion**					
5. Member Handbook DBMC A.10.a.1	The Member Handbook is distributed to members within 30 days of receipt of notice of enrollment.	☐ Yes ☐ No	**1.500** **0.000**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
6. Member Handbook Inclusions DBMC A.10.a.3; .3.b-.s		☐ a. Table of contents ☐ b. Process for notifying members of their specific information ☐ c. Services provided including limitations, exclusions, and out-of-plan use ☐ d. Financial responsibilities and collection and steps taken to collect any copays a member may owe	**0.200** **0.200** **0.200** **0.200**	**3.800**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
	The Member Handbook includes the following: a. Table of contents b. Explanation on how members will be notified of member-specific information, such as effective date of enrollment c. Description of services provided including limitations, exclusions, and out-of-plan use d. Description of applicable cost-sharing responsibilities for eligible members, including an explanation that providers and/or the DBM may use legal actions to collect any copays the member may owe e. Procedures for obtaining required services, including procedures for obtaining referrals to specialists and to providers outside of the plan; the Handbook should advise members that if they need a provider who is not available within the plan, they will be referred to a provider outside of the plan, and any copayment requirements would be the same as if this provider were in the plan f. An explanation that prior authorization is required for some services, including non-emergency services provided by a non-contract provider; such services will be covered and reimbursed only if such prior authorization/service authorization is received before the service is provided; that all prior/service authorizations are null and void upon expiration of a member's TennCare eligibility; and that the member shall be responsible for payment for any services provided after the member's eligibility has expired g. An explanation of emergency services and procedures on how to obtain these services both in and out of the DBM's service area h. Complaint/appeal procedures i. Policies on member rights and responsibilities j. Information concerning advance directives k. Notice that it is the member's responsibility to notify the DBM, TennCare, and Department of Human Services (or for Supplemental Security Income-eligible, the Social Security Administration) every time the member moves to a new address	☐ e. Procedures for obtaining services, including referrals outside of plan ☐ f. Explanation of prior authorization ☐ g. Emergency services and how to obtain them in and out of the DBM service area ☐ h. Complaint/appeal procedures ☐ i. Policies on rights and responsibilities ☐ j. Information concerning advance directives ☐ k. Notification by member when they move ☐ l. Toll-free telephone number for contacting TennCare ☐ m. Right to receive services without discrimination ☐ n. Ways to obtain information in alternative formats and access interpretation services, as well as a statement such services are free—TennCare taglines ☐ o. Rights and necessary steps to amend data in accordance with HIPAA regulations ☐ p. Requirements for accessing entitled services, including special factors ☐ q. Copy of the Discrimination Complaint Form ☐ r. Information about preventive services	**0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200**		

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
	and that failure to notify could result in the member not receiving important eligibility and/or benefit information l. The toll-free telephone number for TennCare with a statement that the member may contact the DBM or TennCare regarding questions about TennCare m. Explanation that the member has a right to receive services without discrimination due to race, color, national origin, language, sex, age, religion, disability, or other protected statuses and that they have a right to file a complaint n. Details on how to obtain information in alternative formats and how to access interpretation services, as well as a statement that interpretation and translation services are free o. Information educating members on their rights and necessary steps to amend their data in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations p. Information on requirements for accessing services to which they are entitled under the contract, including factors such as physical access and non-English languages spoken q. Copy of the Discrimination Complaint Form r. Information about preventive services s. Information about EPSDT benefits and services	☐ s. Information about EPSDT benefits and services	**0.200**		
Findings **Strength** **AON** **Suggestion**					
7. Complaint and Appeal System DBMC A.144.e-.e.5	The DBM has a system linked to the QMP for resolving member complaints and appeals. The system includes a. procedures for registering and responding to complaints and appeals in a timely fashion; b. documentation of the substance of complaints or appeals, and actions taken; c. procedures to ensure a resolution of the complaint or appeal;	☐ a. System was in place ☐ b. Procedures for timely registration and response ☐ c. Documentation of complaints and appeals, and actions taken ☐ d. Procedures ensuring resolution	**0.250** **0.250** **0.250** **0.250**	**1.750**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest						
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**		
				Value	**Score**	
Member Rights and Responsibilities						
	d. aggregation, analysis, and use of complaint and appeal data for QI; and e. an appeal process for adverse actions. DBM staff is able to demonstrate knowledge of the complaint and appeal system and how it relates to the QMP.	☐ e. Aggregation, analysis, and use of the data for QI ☐ f. Appeal process for adverse actions ☐ g. Staff demonstrated knowledge of the system	**0.250** **0.250** **0.250**			
	Findings **Strength** **AON** **Suggestion**					
8. Steps to Ensure Accessibility of Services DBMC A.144.f-.f.2.c	The DBM takes steps to ensure accessibility of services offered to members. These steps include ♦ identifying the points of access to dental services, specialty care, and hospital or ambulatory surgical center services and ♦ providing information about obtaining services during regular hours of operation; emergency care; and the names, qualifications, and titles of the professionals providing and/or responsible for their care.	☐ Member points of access were identified ☐ Members were given information regarding services during regular business hours, emergency care, and their providers	**1.500** **0.750**	**2.250**	**0.000**	
	Findings **Strength** **AON** **Suggestion**					

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
9. Written Information for Members DBMC A.13.a; A.144.g.1	Member information (e.g., subscriber brochures, announcements, handbooks) is written in prose that is readable and easily understood. All material is worded at a sixth-grade reading level unless TennCare approves otherwise.	☐ Yes, or approved by TennCare ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
10. Confidentiality/ HIPAA Compliance DBMC A.10.a.3 and A.10.a.3.o; A.144.h-.h.5	To ensure that the confidentiality of specified member information and records is protected, the DBM a. educates members regarding their rights and the necessary steps to amend their data in accordance with HIPAA regulations; b. has established in writing and enforced P&Ps on confidentiality, including confidentiality of medical records; c. ensures patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the dental care organization; d. holds confidential all information obtained about members related to their examination, care, and treatment, and does not divulge it without member authorization, unless (1) it is required by law; (2) it is necessary to coordinate the member's care with physicians, hospitals, or other healthcare entities or to coordinate insurance or other matters pertaining to payment; or (3) it is necessary in compelling circumstances to protect the health or safety of an individual; e. reports to the member any release of information in response to a court order in a timely manner; and f. discloses records, whether authorized by the member, to qualified personnel for the purpose of conducting scientific research; these personnel may not identify, directly or indirectly, an individual participant in any report of the research or otherwise disclose a participant's identity in any manner.	☐ a. Members were educated on amending data. ☐ b. Confidentiality P&Ps were established and enforced. ☐ c. Offices had mechanisms against disclosure of confidential information. ☐ d. Member information was kept confidential unless (1) required by law; (2) used to coordinate care; or (3) needed in compelling circumstances. ☐ e. Court-ordered releases were reported timely. ☐ f. Information was de-identified in research reports.	**0.125** **0.125** **0.125** **0.125** **0.125** **0.125**	**0.750**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
Findings					
Strength					
AON					
Suggestion					
11. Member Satisfaction DBMC A.144.j - .1	The DBM conducts periodic surveys of member satisfaction with its services. The surveys include content on perceived problems in the quality, availability, and accessibility of care.	☐ Yes ☐ No	**0.250** **0.000**	**0.250**	**0.000**
Findings					
Strength					
AON					
Suggestion					
12. Second Opinion DBMC A.46-.46.a; CFR 438.206.b.3	The DBM facilitates a second opinion from a network provider or arranges for the member to obtain one outside the network at no cost to the member.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
13. Cultural Competence DBMC A.27; CFR 438.206.c.2	The DBM shows evidence that it participates in TennCare's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency (LEP), disabilities, and/or diverse cultural and ethnic backgrounds and regardless of sex.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
Strength					
AON					
Suggestion					
14. Website DBMC A.13.c; CFR 438.10	The DBM operates a readily accessible website that includes all information in the Member Handbook, Provider Directory, and drug formulary.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Member Rights and Responsibilities Score	**0.0%**	**18.300**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Standards for Facilities					
1. DBM Standards DBMC; D.20	The DBM maintains standards for facilities (e.g., provider offices, surgery centers) in which patients receive care. Those standards include the following: a. Compliance with existing state and local laws regarding safety and accessibility b. Availability of emergency equipment (applicable to site) c. Storage of medications (including samples) d. Inventory control for expired medications e. Compliance with HIPAA regulations	☐ a. Compliance with state and local laws ☐ b. Availability of emergency equipment ☐ c. Medications storage ☐ d. Inventory control ☐ e. HIPAA compliance	**0.400** **0.400** **0.400** **0.400** **0.400**	**2.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Standards for Facilities Score	**0.0%**	**2.000**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Dental Records					
1. Appropriate Access to Records DBMC A.145.a.1	The DBM includes language in its contracts with providers that allows appropriate access to DBM member dental records for the purpose of quality reviews conducted by the Secretary (Department of Health and Human Services), TennCare agencies, or agencies thereof.	☐ Yes ☐ No	**1.250** **0.000**	**1.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Dental Records Standards DBMC A.145.b-.b.1.o	The DBM has written standards for the maintenance of dental records in a legible, current, detailed, organized, and comprehensive manner that permits effective patient care and quality review. At a minimum, dental record standards include the following requirements: a. Each page includes the member's name or ID number. b. Member data include age, sex, address, employer, home and work telephone numbers, and marital status. c. All entries are dated. d. Every date of service includes written submission of treatment. e. All entries include the author's name. f. Records are legible to the reader. Any record determined by one reviewer to be illegible should be evaluated by a second reviewer. If still not legible, it is deficient. g. Any medication allergies and/or adverse reactions or absence of allergies (no known allergies) are noted in an easily recognizable location. h. The record contains an easily identified past medical history for patients seen three or more times. The history includes serious accidents, operations, and illnesses. i. For members ages 12 years and under, there is a completed immunization record or notation that immunizations are up-to-date. j. The record contains diagnostic information.	☐ a. Member identification ☐ b. Personal/biographical data ☐ c. Dated entries ☐ d. Dated, written submission of treatment ☐ e. Author identified ☐ f. Legible records ☐ g. Noted allergies ☐ h. Past medical history ☐ i. Immunization record ☐ j. Diagnostic information ☐ k. Current medication ☐ l. Current problems ☐ m. Cigarette and/or alcohol use and/or substance abuse ☐ n. Referrals and results	**0.125** **0.125** **0.125** **0.125** **0.125** **0.125** **0.125** **0.125** **0.125** **0.125** **0. 125** **0. 125** **0. 125** **0.125**	**1.875**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Dental Records					
	k. The record contains medication information. l. Information on current significant illnesses, medical conditions, and health maintenance concerns is documented. m. For members ages 12 years and older and seen three or more times, there is a notation concerning cigarette and/or alcohol use and/or substance abuse. n. There are notations of any referrals and results. o. Any emergency dental care rendered is noted.	☐ o. Emergency care	**0.125**		
Findings **Strength** **AON** **Suggestion**					
3. Patient Visit Data DBMC A.145.b.2-.2.i	At a minimum, documentation of patient visits includes a. history and physical examination, including appropriate subjective and objective information for the presenting complaints; b. plan of treatment; c. diagnostic tests; d. therapies and other prescribed regimens; e. monitoring when in-office sedation is administered; f. charting of conditions and treatment; g. encounter forms or notes with a notation, when indicated, concerning follow-up care, calls, or visits. Specific time to call or return is noted as days, weeks, months, or as needed; h. unresolved concerns from previous visits are addressed in subsequent visits; i. Consultation, lab, and x-ray reports filed in the chart have the ordering dentist's/physician's initials or other documentation	☐ a. History and physical exam ☐ b. Plan of treatment ☐ c. Diagnostic tests ☐ d. Therapies and other prescribed regimens ☐ e. In-office sedation monitored ☐ f. Conditions and treatment charted ☐ g. Follow-up care noted ☐ h. Unresolved concerns from previous visits are addressed ☐ i. Evidence of consult notes and follow-up noted where required	**0.250** **0.250** **0.250** **0.250** **0.250** **0.250** **0.250** **0.250** **0.250**	**2.500**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Dental Records					
	signifying review. Consultations and significantly abnormal lab and imaging study results specifically note follow-up plans. Consultations for speech/language pathology include supporting documentation that the condition must be non-responsive to speech therapy without orthodontic treatment; and j. all other aspects of patient care, including ancillary services.	☐ j. All other aspects of care	**0.250**		
Findings					
Strength					
AON					
Suggestion					
4. Record Review Process DBMC A.145.c.1	The DBM has a process for assessing dental records for legibility, organization, completion, and conformance to its standards.	☐ a. Legibility ☐ b. Organization ☐ c. Completion ☐ d. Conformance	**0.250** **0.250** **0.250** **0.250**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Dental Records Score	**0.0%**	**6.625**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest						
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Utilization Review					
1. Utilization Management (UM) P&Ps DBMC A.38-.a	The DBM has written UM P&Ps that minimally include a. procedures to evaluate medical necessity; b. the process used to review and approve the provision of dental services; and c. mechanisms to detect over- and under-utilization, as part of the Quality Assessment and Performance Improvement (QAPI) program requirements.	☐ a. Procedures to evaluate medical necessity ☐ b. Process to review and approve provision of dental services ☐ c. Mechanisms to detect over- and under-utilization	**0.500** **0.500** **0.500**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Coverage Limits DBMC A.106	For prior authorization or medical necessity review, the DBM does not employ or permit others acting on its behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individual determination of medical necessity based on the needs of the member and his or her history.	☐ Yes (does not) ☐ No	**0.750** **0.000**	**0.750**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Qualified Dental Professionals DBMC A.38.b.2–.3	Prior authorization and medical necessity review decisions are supervised by qualified dental professionals. Documented efforts are made to obtain all necessary information, including pertinent clinical information, and to consult with the treating dentists as appropriate. DBM staff is able to describe and demonstrate the authorization process.	☐ a. Decisions supervised appropriately ☐ b. Necessary information obtained ☐ c. Authorization process described and demonstrated	**1.000** **0.750** **0.750**	**2.500**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Utilization Review					
Findings					
Strength					
AON					
Suggestion					
4. Review Decisions DBMC A.38.b and .b.4	Reasons for decisions regarding prior authorization and medical necessity review are clearly documented and available to the member.	☐ Clearly documented ☐ Made available to the member	**0.750** **0750**	**1.500**	**0.000**
Findings					
Strength					
AON					
Suggestion					
5. Appeals Mechanisms DBMC A.38.b.5	There are well-publicized and readily available appeals mechanisms for both providers and members.	☐ Providers ☐ Members	**0.750** **0.750**	**1.500**	**0.000**
Findings					
Strength					
AON					
Suggestion					
6. Retrospective Utilization Review DBMC A.43	The DBM conducts a retrospective treatment utilization review for members in all DBM programs that includes basic provider profiling, test edits, and statistical process controls to flag potential under- and over-utilization, as part of the Quality Assessment and Performance Improvement (QAPI) program requirements. Cases identified as outliers are forwarded to the PPRC for evaluation. The DBM submits quarterly reports that include a summary of its investigations, PPRC recommendations, and actions taken based on results.	☐ a. Profiling conducted ☐ b. Outliers sent to PPRC ☐ c. Quarterly reports included required information	**0.250** **0.250** **0.500**	**1.000**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Utilization Review					
Findings					
Strength					
AON					
Suggestion					
7. Mechanisms to Evaluate DBMC A.38.b.7	The mechanisms to evaluate the effects of the program include using data on member satisfaction, provider satisfaction, and other appropriate measures.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
8. Health Information System CFR 438.242.a	The DBM maintains a health information system that collects, analyzes, integrates, and reports data including, but not limited to, utilization, claims, and complaints and appeals.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Utilization Review Score	**0.0%**	**10.750**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination of QM Activity with Other Management Activity					
1. QM Findings Used in Recredentialing Activities DBMC A.138.f and f.4-.d	The DBM has P&Ps to describe the process used in its periodic reverification of clinical credentials, including recredentialing, recertification, and reappointment. The process includes the review of data from member complaints, quality review results, UM, and member satisfaction surveys.	☐ Process in place ☐ Data from required sources reviewed	**0.750** **0.750**	**1.500**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Coordination of QM Activity with Other Management Activity Score	**0.0%**	**1.500**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
1. Outreach Contacts DBMC A.10.a.1 and .b; A.115.a.6	The DBM distributes six outreach contacts a year that include the following: d. Member Handbook sent within 30 days of enrollment e. Four quarterly newsletters f. Annual notice informing members of their dental benefits and encouraging them to schedule an appointment	☐ a. Member Handbook ☐ b. Four quarterly newsletters ☐ c. Annual reminder to schedule appointment	**0.250** **0.250** **0.250**	**0.750**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Re-Notification If No Services Used DBMC A.10.d	The DBM is responsible for distributing dental appointment notices annually to the heads of households for all TennCare members who have not had a dental service within the past year.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Accurate Provider List DBMC A.10.c	The DBM provides information on how to access the Provider Directory, including the right to request a hard copy, how to contact member services, and how to access the online version, to new members within 30 calendar days of receipt of notification of enrollment. The DBM updates the Provider Directory on a regular basis and makes an updated version available at least annually.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
4. Appointment Assistance DBMC A.32; CFR 441.62 and 441.62.b	The DBM assists members in obtaining appointments for covered services, including facilitation of member contact with a participating dental provider, who establishes an appointment. The DBM also tracks the number of requests for assistance to obtain an appointment, including the service area in which the member required assistance.	☐ Assisted members ☐ Tracked number of requests	**0.750** **0.750**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
5. Prior Authorization DBMC A.41 and .a-.c	The DBM has P&Ps that clearly identify all services that require prior authorization for network providers, as well as any additional submissions (such as radiographs) that may be required for approval of service. TennCare has 30 days to review and approve or request modification to the P&Ps. Dental management P&Ps are consistent with the following requirements: a. The DBM notifies the requesting provider of its prior authorization decision within 14 days of receiving a standard request. b. Prior authorizations are not required for referrals from the public health screening program, primary care physicians (PCPs), and for preventive services. c. UM activities may not be structured to provide incentives for the individual provider or DBM to deny, limit, or discontinue medically necessary services to any member.	☐ a. Notification of denial within 14 days of receipt ☐ b. Prior authorizations not required for referrals from the public health screening program, PCPs, or preventive services ☐ c. UM activities structured so no incentives were provided	**1.000** **1.000** **1.000**	**3.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
6. Referrals from One Level of Screening/ Diagnosis to Another DBMC A.46; A.145.b.1; A.145.b.1.n; A.145.b.2; A.145.b.2.h	The DBM has methods in place to ensure providers make and document appropriate referrals from one level of screening or diagnosis to another, more sophisticated level (e.g., general dentist to specialist) as needed to determine medical necessity. Notes from any consultations are also included in member records.	☐ Methods in place ☐ Evidence ensuring provider compliance	**0.500** **0.750**	**1.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					
7. Medically Necessary Services DBMC A.110	The DBM has a process in place to provide all medically necessary EPSDT services as required by law.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
8. Provider Education DBMC A.52.a	The DBM holds at least two training sessions per year for each Grand Region in the state. At a minimum, the training addresses ♦ the extent and limits of TennCare dental and orthodontic treatment coverage rules and medical necessity rule and ♦ federal EPSDT law, Children and Youth with Special Needs, and TennCare rules.	☐ Yes ☐ No	**1.250** **0.000**	**1.250**	**0.000**
Findings					

2021 Annual Quality Survey—Quality Process Standards: DentaQuest						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)						
Strength						
AON						
Suggestion						
9. Medical Necessity DBMC A.106 and 109.c	The DBM determines medical necessity on a case-by-case basis, and the procedures used are consistent with the contractual definition of medical necessity and applicable TennCare rules. The DBM is able to provide documentation to support medical necessity determinations to TennCare upon request, including responses to any appeals filed.	☐ a. Medical necessity determined on a case-by-case basis ☐ b. Procedures are consistent with contractual definition and TennCare rules ☐ c. All documentation provided upon request		**0.500** **0.500** **0.500**	**1.500**	**0.000**
Findings						
Strength						
AON						
Suggestion						
10. Limits/ Capitations/ Delays DBMC A.106	The DBM demonstrates that it does not impose benefit limitations, duration/scope limitations, or monetary capitations upon EPSDT services, unless they are excluded under TennCare rule. Services are provided based upon each child's individual needs. The DBM does not employ utilization control guidelines/limits unless supported by individualized determination of medical necessity based upon the member's medical history.	☐ a. No limits or capitations imposed unless excluded under TennCare rule ☐ b. Services based on individual needs ☐ c. No utilization control guidelines/limits unless supported by individual member's medical history		**0.500** **0.500** **0.500**	**1.500**	**0.000**
Findings						
Strength						
AON						
Suggestion						

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
11. Qualified UM Personnel DBMC A.109	The DBM has a process in place that guarantees only appropriately licensed professionals supervise all medical necessity decisions and specifies the type of personnel responsible for each level of UM decision-making. Personnel making such decisions are trained or experienced as described above.	☐ Process ☐ Staff appropriately licensed	**0.500** **2.500**	**3.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
12. Dentists Supervise TCA 63-5-108, Rules of Tennessee Board of Dentistry, Rule 0460-02–.11	All dental services are performed by or under the supervision of dentists.	☐ Yes ☐ No	**1.500** **0.000**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
13. Compliance with Screening Obligation DBMC A.115.d; A.192	The DBM demonstrates that the annual EPSDT Dental Screening Percentage is met. If the DBM fails to meet this benchmark, significant monetary sanctions will be enforced and the implementation of a corrective action plan will be required. Also, if the DBM's Dental Screening Percentage is below 80%, the DBM conducts a new initiative, approved by TennCare, to increase participation of all children who have not received screenings.	☐ Yes ☐ No	**1.500** **0.000**	**1.500**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest						
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element		
				Value	Score	
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)						
Findings						
Strength						
AON						
Suggestion						
14. Transportation DBMC A.49.a; A.112	It is the responsibility of the member's MCO to arrange transportation to covered services. The DBM has a process for coordinating with the MCOs to ensure that transportation to a dental service is provided if deemed necessary.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**	
Findings						
Strength						
AON						
Suggestion						
15. Coordination with MCOs DBMC A.49.c and .e	The DBM makes arrangements with the MCO for services that are not covered by the DBM. A DBM staff member is designated as lead for coordination of services with each MCO.	☐ DBM staff member designated ☐ Evidence of coordination	**1.000** **1.000**	**2.000**	**0.000**	
Findings						
Strength						
AON						
Suggestion						
16. Coordination of Dental Services DBMC A.20; A.113	The DBM has a process ensuring that, when children with urgent dental needs or unmet dental treatment needs are identified through the Department of Health's School-Based Dental Prevention Program, the DBM arranges care according to geo access standards (urgent needs are scheduled within 48 hours and routine within three weeks).	☐ Process in place ☐ Evidence of coordination	**0.500** **0.750**	**1.250**	**0.000**	
Findings						

2021 Annual Quality Survey—Quality Process Standards: DentaQuest						
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element		
				Value	Score	
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)						
Strength						
AON						
Suggestion						
17. Tracking System DBMC A.50	The DBM has a process in place for tracking the current screening status, pending preventive services, screening due dates, referrals for corrective treatment, whether corrective treatment was provided, and dates of service for corrective treatment for each member.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**	
Findings						
Strength						
AON						
Suggestion						
18. EPSDT Provisions DBMC A.66.ll	All contracts with dental providers contain language that informs providers of the EPSDT benefit package and periodicity schedule, including information as described in A.114 and .115.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**	
Findings						
Strength						
AON						
Suggestion						
19. Contract Review: Practice Guidelines DBMC A.114	All contracts with dental providers contain language requiring providers to follow practice guidelines for preventive health services, including EPSDT, identified by TennCare.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**	

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
Findings					
Strength					
AON					
Suggestion					
		Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Score	**0.0%**	**25.500**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Non-Discrimination Compliance					
1. Non-Discrimination Questionnaire DBMC A.165.b.1	The DBM answers the questions contained in the Non-Discrimination Compliance Questionnaire provided by TennCare and submits the completed Plan to TennCare within 60 days of receipt of the Questionnaire with any requested documentation, which includes the DBM's Assurance of Non-Discrimination.	☐ Yes ☐ No	**0.250** **0.000**	**0.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Assurance of Non-Discrimination DBMC A.165.b.1	The signature dates of the DBM's Non-Discrimination Compliance Questionnaire and Assurance of Non-Discrimination are the same.	☐ Yes ☐ No	**0.250** **0.000**	**0.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Display of Non-Discrimination Information DBMC D.9	The DBM ensures that no employee, member, applicant, or participant is subjected to discrimination based on handicap or disability, age, race, creed, color, religion, sex, national origin, or any other classification protected by federal, state, or statutory law. The DBM provides proof of non-discrimination upon request and posts the information in conspicuous places accessible to all employees and applicants.	☐ Yes ☐ No	**0.250** **0.000**	**0.250**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Non-Discrimination Compliance					
Findings					
Strength					
AON					
Suggestion					
4. Non-Discrimination Written Materials DBMC A.13.e.–.g	All vital DBM documents and member materials are made available to members as noted below: a. All vital DBM documents and member materials are translated and available in Spanish. Within 90 calendar days of notification from TennCare, all vital DBM documents are translated and available to each LEP group identified by TennCare that constitutes 5% of the TennCare population or 1,000 members, whichever is less. b. If there are fewer than 50 members in a language group that is part the population that reaches the 5% trigger, the DBM sends written notice in those members' primary language that instead of written translation of vital documents, it provides free oral interpretation of those written materials. c. All written materials notify members that auxiliary aids or services and language interpretation and translation are available at no expense to the member and how to access them. d. All written materials are made available in alternative formats for persons with disabilities and are provided by the DBM at no cost to the member. e. DBM staff can demonstrate the capability to provide vital documents in alternative formats to members with impaired sensory skills (e.g., visually impaired) who require communication assistance.	☐ a. Documents translated as described ☐ b. Written notice provided to specified members ☐ c. Written materials notify members of communication and language assistance services at no expense—TennCare taglines ☐ d. Written materials made available in alternative formats at no cost ☐ e. Staff demonstrated availability of vital documents in alternative formats	**0.250** **0.250** **0.250** **0.250** **0.250**	**1.250**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Non-Discrimination Compliance					
5. Written P&P DBMC A.29; A.30.a-.c	The DBM has a written P&P on file for the provision of language interpretation and translation services for any member with LEP. The P&P also addresses the provision of communication assistance in alternative formats (e.g., members or potential members who are visually impaired, hearing impaired, and/or hearing/visually impaired). The DBM shows that it provides member translation services and communication assistance in alternative formats through member services and provider services help-lines.	☐ a. Language interpretation and translation services addressed ☐ b. Communication assistance in alternative formats addressed ☐ c. Telephone numbers made known to members and providers ☐ d. Proof of available help-lines demonstrated	**0.250** **0.250** **0.250** **0.250**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
6. Complaint Resolution and Reporting DBMC A.165.b.2; A.165.b.2.c-.d; A.165.c.1-.3	The DBM submits a quarterly Non-Discrimination Compliance Report to TennCare, which includes all reported discrimination complaints related to the provision of and/or access to TennCare's covered services provided by the DBM or its subcontractors. The DBM reports these complaints to TennCare within two business days of receipt, assists with initial investigations if requested, and completes any corrective action required by TennCare.	☐ a. Quarterly Non-Discrimination Compliance Reports submitted to TennCare ☐ b. Reports included all required information ☐ c. All complaints reported within two business days ☐ d. Provided assistance to TennCare as needed	**0.500** **0.500** **0.500** **0.500**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Non-Discrimination Compliance					
7. Provider and Subcontractor Compliance Education DBMC A.165.a-.a.1; D.9	The DBM can document that its providers and subcontractors have been made aware of their obligations under the federal civil rights laws, including but not limited to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, and 42 U.S.C. § 18116 (codified at 45 CFR 92).	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
8. Provision of Services DBMC A.165.a.3	The DBM has written non-discrimination P&Ps on file that demonstrate services are provided to members, applicants, and participants in a non-discriminatory manner.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
		Non-Discrimination Compliance Score	**0.0%**	**6.500**	**0.000**

QP Standards Tool—PBM

2021 Annual Quality Survey—Quality Process Standards: OptumRx					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
1. Procedures to Deliver Care CFR 438.208.b-.b.2 and b.3-b.5	The PBM has procedures to deliver care by ensuring the maintenance and appropriate sharing of medical records; and protecting patients' privacy.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Long-Term Services and Supports PBMC A.48.a	The PBM maintains a statewide provider network of pharmacies, including LTSS pharmacies. The network is adequate to provide pharmaceutical services and pharmacy location sites that are available and accessible in accordance with the requirements established by TennCare.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Education or Care Coordination Efforts PBMC Attachment H, #2	The PBM conducts education or care coordination efforts that support the appropriate usage and pharmacologic treatment for members. The PBM provides ideas that include, but are not limited to, interventions to support better clinical and pharmacologic treatment options or improve prescribing and adherence patterns.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: OptumRx					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Coordination and Continuity of Care					
Findings					
Strength					
AON					
Suggestion					
		Coordination and Continuity of Care Score	**0.0%**	**3.000**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: OptumRx						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Coverage and Authorization of Services						
1. Eligibility PBMC A.42.d.10	The PBM uses the 834 Eligibilty File provided by TennCare to identify changes in member enrollment and update its data system. The information in the 834 Eligibility File and data system must match 100% on a daily basis.	☐	Yes	**1.000**	**1.000**	**0.000**
		☐	No	**0.000**		
Findings **Strength** **AON** **Suggestion**						
2. Prior Authorization Process PBMC A.46.b	The PBM ensures that prior authorization decisions are based on all available pertinent information, including the member's prescription history and available medical history, and must account for whether the request is for a prescription drug that is a controlled substance or has potential for abuse. The PBM also queries the State of Tennessee's Controlled Substance Monitoring Database (CSMDB) for the member's profile and include the information the decision-making process when applicable or when requested by TennCare. If the request is consistent with the prior authorization and/or medical necessity criteria approved by TennCare, the PBM documents the request in the pharmacy case management system and enters an override in the PBM's claim adjudication system for the appropriate period of time. If the request is not consistent with applicable prior authorization criteria, it is sent to a clinical pharmacist in the Prior Authorization Unit for review.	☐	a. All information gathered and documented	**0.500**	**1.500**	**0.000**
		☐	b. Requests added to the pharmacy case management system with an override if consistent with criteria	**0.500**		
		☐	c. Requests sent to clinical pharmacist when needed	**0.500**		

2021 Annual Quality Survey—Quality Process Standards: OptumRx					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Findings					
Strength					
AON					
Suggestion					
3. PA Request Review Deadlines PBMC A.46.b	PA decisions for outpatient drugs must be made within 24 hours, unless the request does not include the required information. In that case, the PBM is allowed three additional days to complete the request.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Coverage and Authorization of Services Score	**0.0%**	**3.500**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: OptumRx					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Information Requirements					
1. Definitions PBMC A.8.b.11	The PBM uses the TennCare-developed definition for the following terms: appeal; co-payment; durable medical equipment; emergency medical condition; emergency medical transportation; emergency room care; emergency services; excluded services; grievance; habilitation services and devices; health insurance; home healthcare; hospice services; hospitalization; hospital outpatient care; medically necessary; network; non-participating provider; participating provider; physician services; plan; preauthorization; premium; prescription drug coverage; prescription drugs; primary care physician; PCP; provider; rehabilitation services and devices; skilled nursing care; specialist; and urgent care.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Plain Language PBMC A.8.b.1	All member materials are worded in Plain Language in a manner and format that is easily understood and is readily accessible by members and potential members, unless TennCare approves a different standard.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Taglines PBMC A.8.b.3	All written materials are printed with the notice of non-discrimination and taglines as required by TennCare and set forth in TennCare's tagline template.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: OptumRx					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Information Requirements					
Findings					
Strength					
AON					
Suggestion					
4. Effective Communication PBMC A.8.b.4	All written member materials ensure effective communication and are available in appropriate alternative formats at the request of members, potential members, or their representatives at no cost. Alternative formats may include, but are not limited to, auxiliary aids, written translations, and language assistance services.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
5. Confidentiality PBMC A.44.h.3	The PBM has policies to ensure compliance with federal and state laws and regulations regarding member information confidentiality.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
6. Provider Selection CFR 438.214.b.2-.d	The PBM follows the TennCare-approved documented process for credentialing and recredentialing network providers. Network provider selection policies and procedures (P&Ps) do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The PBM does not employ or contract with providers excluded from participation in federal healthcare programs.	☐ a. Credentialing and recredentialing process ☐ b. No discrimination against providers ☐ c. No prohibited affiliations	**0.250** **0.250** **0.250**	**0.750**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: OptumRx					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Information Requirements					
Findings					
Strength					
AON					
Suggestion					
7. Audits PBMC A.18	If TennCare initiates an audit of services performed by the PBM, its providers, and/or its subcontractors, the PBM provides all requested information and provides prompt access to any and all systems that pertain to services performed.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
8. Subcontractor Compliance CFR 438.230	All contracts between the PBM and subcontractor(s) must require compliance with all Medicaid regulations and include the subcontractor's reporting responsibilities and potential solutions for unsatisfactory performance.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Information Requirements Score	**0.0%**	**7.750**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: OptumRx					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Improvement					
1. Performance Improvement Projects (PIPs) PBMC A.54	The PBM conducts PIPs accordance with federal law and CMS protocols, and all PIPs must be approved by TennCare prior to implementation.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
2. Program Integrity Process PBMC A.60.g.1	The PBM maintains a program integrity process that detects and prevents errors, fraud, or abusive pharmacy utilization by members, pharmacies, or prescribers.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Quality Improvement Score	**0.00**	**2.000**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: OptumRx						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Appeals and Grievances						
1. Processes PBMC A.46.d-.d.2	The PBM has an internal grievance process, but not an internal appeal process because TennCare delegated back to itself certain aspects of the appeal process.	☐ Yes ☐ No		**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**						
2. Assistance for Members PBMC A.46.d.5.a	The PBM provides reasonable assistance to members regarding the appeal and grievance processes.	☐ Yes ☐ No		**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**						
3. Adverse PA Determinations PBMC A.46.b and A.46.d.7-7.d	If the PBM denies a provider's PA request, it must notify the requesting provider and issue a Notice of Adverse Benefit Determination (NABD) to the member. The NABD explains the member's right to request an appeal and the procedures for requesting one. The NABD also explains the member's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of continued services.	☐ a. ☐ b. ☐ c.	Provider and member notified NABD includes right to request an appeal and procedure for doing so NABD includes information about continuous benefits	**0.250** **0.250** **0.250**	**0.750**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: OptumRx						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Appeals and Grievances						
Findings						
Strength						
AON						
Suggestion						
4. Appeal Request Process PBMC A.46.d.11-.11.e	A request for an appeal may be filed either orally or in writing by the member, his/her provider, or his/her representative. Unless the appeal warrants an expedited resolution, an oral request must be followed by a written, signed request. The filing date of an oral request is the date of the oral request, not the date on which the written request is submitted. When a member files a request for an expedited appeal, TennCare issues an on-request report (ORR), which requires the PBM to determine whether the appeal warrants expedited or standard resolution and, within one business day of the ORR's issuance, notify TennCare of its decision if it determines that expedited resolution is needed.	☐ a. Member, provider, or representative eligible for filing appeals ☐ b. Oral requests for expedited appeals followed by written requests and filing date is the date of the oral request ☐ c. PBM notifies TennCare within one business day of ORR receipt		**0.250** **0.250** **0.250**	**0.750**	**0.000**
Findings						
Strength						
AON						
Suggestion						
5. Timelines for Processing Appeal Requests PBMC A.46.d.11.e.1-.3	If the PBM determines that an appeal request warrants expedited resolution, it submits its decision to TennCare within 72 hours of the time that the appeal request was filed. If the PBM determines that an appeal request warrants standard resolution, it submits its decision within 14 days of the filing date. An appeal warrants expedited resolution if the PBM determines that taking the time for a standard resolution could seriously jeopardize the member's health.	☐ Decisions made within required timeframes ☐ Appeals are classified as expedited if standard resolutions would jeopardize member health		**0.500** **0.500**	**1.000**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: OptumRx						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Appeals and Grievances						
Findings						
Strength						
AON						
Suggestion						
6. Continuous Benefits PBMC A.46.d.12.a-.a.3	The PBM continues the member's benefits during the appeal process if all of the following occur: a. The member files the appeal request within 60 calendar days following the date on the NABD. b. The contested issue at the state fair hearing involves a drug that has been previously prescribed (either on an ongoing basis or with unlimited refills), but which is now subject to PA. c. The request for continuation of benefits is filed within 10 calendar days following the date on the NABD.	☐	a. Appeal request filed within 60 days following date on NABD	**0.250**	**0.750**	**0.000**
		☐	b. Hearing involves drug prescribed as ongoing or with unlimited refills	**0.250**		
		☐	c. Continuation of benefits request filed within 10 days following date on NABD	**0.250**		
Findings						
Strength						
AON						
Suggestion						

2021 Annual Quality Survey—Quality Process Standards: OptumRx						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Appeals and Grievances						
7. Reversed Appeal Resolutions PBMC A.46.d.13.d	If the PBM reverses a decision to deny authorization of disputed benefits, it pays for disputed services received by the member while the TennCare appeal was pending.	☐	Yes	**1.000** **0.000**	**1.000**	**0.000**
		☐	No			
Findings **Strength** **AON** **Suggestion**						
8. Grievances PBMC A.46.d.14.a-.f	Members may file a grievance at any time either orally or in writing. The PBM provides notice of resolution within 90 calendar days from the day of receipt unless the member requests an extension or the PBM indicates the need for additional information, in which the timeframe can be extended by 14 calendar days. If the PBM extends the timeline not at the request of the member, it gives the member written notice within two calendar days that includes the reason for the extension and informs the member of the right to file a grievance if he or she disagrees with the decision. Notifications are in a format and language approved by TennCare.	☐	a. Grievances may be filed at any time either orally or in writing	**0.250**	**1.000**	**0.000**
		☐	b. Notice of resolution provided within 90 days unless 14-day maximum extension needed	**0.250**		
		☐	c. Written notice within two days if extension not requested by member	**0.250**		
		☐	d. TennCare-approved format and language	**0.250**		
Findings **Strength** **AON** **Suggestion**						
9. Information for Providers and Subcontractors PBMC A.46.d.17-.17.b.5	The PBM includes information about member appeal and grievance rights in the following materials: a. NABDs b. Provider and subcontractor contracts with the PBM c. Provider Manual d. Provider training materials e. PBM website	☐	Yes	**1.000** **0.000**	**1.000**	**0.000**
		☐	No			

2021 Annual Quality Survey—Quality Process Standards: OptumRx					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Appeals and Grievances					
Findings					
Strength					
AON					
Suggestion					
10. Recordkeeping Requirements PBMC A.46.d.15.a-.c	The PBM retains member grievance and appeal process-related records for no less than 10 years and makes them available to TennCare and CMS upon request. Each record includes the following: a. General description of the reason for the appeal request or grievance b. Date of receipt c. Date of each review d. How the grievance or appeal was resolved e. Date of resolution f. Member name on whose behalf the appeal request or grievance was filed	☐ Records retained for 10 years and available to TennCare and CMS ☐ Records included all required information	**0.500** **0.500**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Appeals and Grievances Score	**0.0%**	**9.250**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: OptumRx					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Non-Discrimination Compliance					
1. Provision of Services PBMC A.6.a.3	The PBM has written, TennCare-approved, non-discrimination P&Ps on file that demonstrate that services are provided to members in a non-discriminatory manner.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Cultural Competency PBMC A.6.i	The PBM shows evidence that it participates in TennCare's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency (LEP), disabilities, and/or diverse cultural and ethnic backgrounds and regardless of sex.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Written Materials PBMC A.6.a.7-.8; A.8.b.4-.5	All vital PBM documents and member materials are made available to members and potential members as noted below: a. All vital PBM documents and member materials are translated and available in Spanish. Within 90 calendar days of notification from TennCare, all vital PBM documents are translated and available to each LEP group identified by TennCare that constitutes 5% of the TennCare population or 1,000 members, whichever is less. b. If there are fewer than 50 members in a language group that is part of the population that reaches the 5% trigger, the PBM sends written notice in those members' primary language that instead of written translation of vital documents, it provides free oral interpretation of those written materials. c. PBM staff can demonstrate the capability to provide vital documents in alternative formats to members with impaired	☐ a. Documents translated as described ☐ b. Written notice provided to specified members ☐ c. Staff demonstrated availability of vital documents in alternative formats	**0.250** **0.250** **0.250**	**0.750**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: OptumRx					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Non-Discrimination Compliance					
	sensory skills (e.g., visually impaired) who require communication assistance.				
Findings					
Strength					
AON					
Suggestion					
4. Complaint Resolution and Reporting PBMC A.6.b.2; A.6.b.2.c; A.6.c	The PBM has processes in place to resolve alleged discrimination complaints against PBM staff, providers, and providers' employees and/or subcontractors. TennCare reviews all complaint investigations provided by the PBM and determines the appropriate resolutions. The PBM submits a quarterly Non-Discrimination Compliance Report to TennCare. The report lists all complaints of alleged discrimination filed against the PBM by employees, members, providers, and subcontractors.	☐ a. Processes in place ☐ b. Provided complaint investigations to TennCare ☐ c. Quarterly reports submitted and included required information	**0.250** **0.250** **0.250**	**0.750**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2021 Annual Quality Survey—Quality Process Standards: OptumRx					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Non-Discrimination Compliance					
5. Non-Discrimination Questionnaire PBMC A.6.b.1	The PBM answers the questions contained in the Non-Discrimination Compliance Questionnaire provided by TennCare and submits the completed Plan to TennCare within 60 days of the end of receipt of the Questionnaire with any requested documentation, which includes the PBM's Assurance of Non-Discrimination.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
6. Assurance of Non-Discrimination PBMC A.6.b.1	The signature dates of the PBM's Non-Discrimination Compliance Questionnaire and Assurance of Non-Discrimination are the same.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Quality Survey—Quality Process Standards: OptumRx					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Non-Discrimination Compliance					
7. Staff Compliance Training PBMC A.6.b.2.-.2.b	The PBM can document that its staff have been made aware of their obligations under the federal civil rights laws, including but not limited to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, and 42 U.S.C. § 18116 (codified at 45 CFR 92).	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Non-Discrimination Compliance Score	**0.0%**	**6.500**	**0.000**

2021 Annual Quality Survey—Quality Process Standards: <PBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Credentialing/Recredentialing P&Ps				
1) Initial Credentialing Policies and Procedures (P&Ps) *TennCare Pharmacy Benefit Manager Contract (PBMC)* *PBMC A.15.* *TennCare Requirements* *42 CFR § 438.214(a)* *42 CFR § 438.214(b)*	The PBM has written P&Ps for the selection of provider pharmacies. The documents include the instructions for inclusion required by TennCare for the following pharmacy providers: a) Chain pharmacies b) Independent pharmacies c) Specialty pharmacies d) Long-term care pharmacies e) 340B pharmacies f) Physician dispensaries g) Pharmacies not enrolled as of May 1, 2020: i. Newly opened independent pharmacy locations ii. Newly opened chain pharmacy locations in the State of Tennessee iii. Newly opened chain pharmacies outside of the State of Tennessee iv. Pharmacies new to the TennCare provider network located in the State of Tennessee previously open for business	a) ☐ Met ☐ Not Met ☐ NA b) ☐ Met ☐ Not Met ☐ NA c) ☐ Met ☐ Not Met ☐ NA d) ☐ Met ☐ Not Met ☐ NA e) ☒ Met ☐ Not Met ☐ NA f) ☐ Met ☐ Not Met ☐ NA g) ☐ Met ☐ Not Met ☐ NA	**7.0**	**0.0**
Findings:				
Recommendations:				
2) Recredentialing P&Ps *PBMC A.15.* *42 CFR § 438.214(a)* *42 CFR § 438.214(b)*	The PBM has written P&Ps for the monitoring and retention of providers.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				

2021 Annual Quality Survey—Quality Process Standards: <PBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Credentialing/Recredentialing P&Ps				
3) Electronic Provider Registration and Valid TennCare Provider Number *PBMC A.10.b.* *42 CFR § 438.206(b)(6)* *42 CFR § 438.214(b)(2)* *42 CFR § 438.214(e)*	The PBM ensures that provider pharmacies have completed TennCare's electronic provider registration process and have been issued a current valid TennCare provider number.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
4) Maintaining Licenses, Certifications, and Permits *PBMC A.10.b.* *42 CFR § 438.206(b)(6)* *42 CFR § 438.214(e)*	The PBM ensures that provider pharmacies maintain all required federal, state, and local licenses; certifications; and permits without restriction necessary to provide pharmaceutical services to TennCare PBM Program enrollees that fully comply with all applicable State and federal laws and regulations.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
5) Any Willing Provider *PBMC A.6.g.* *PBMC A.14.* *42 CFR § 438.214(e)*	The PBM maintains a network that includes any willing provider. The PBM does not deny any licensed pharmacy or licensed pharmacist the right to participate as a participating provider in any policy, contract, or plan on the same terms and conditions as are offered to any other provider of pharmacy services under the policy, contract, or plan.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
6) OptumRx Staff Licensing and Certification Requirements *PBMC A.7.a.*	The PBM provides TennCare annually with documents verifying that all staff members are licensed to practice in his/her area of specialty.	☐ Met ☐ Not Met ☐ Not Applicable	**0.0**	**0.0**
Findings:				
Recommendations:				

2021 Annual Quality Survey—Quality Process Standards: <PBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Credentialing/Recredentialing P&Ps				
7) Denial of Provider Participation in the Network *PBMC A.16.* *42 CFR § 438.214(e)*	If the PBM declines to include an individual pharmacy provider or group of pharmacy providers in its provider network serving TennCare enrollees, the PBM gives the affected pharmacy providers written notice of its decision.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
8) Non-discrimination *PBMC A.6.g.* *PBMC A.15.* *42 CFR § 438.214(c)*	The PBM does not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
9) Providers Acting Within the Scope of Licensure *PBMC A.6.g.* *PBMC A.15.* *42 CFR § 438.214(e)*	The PBM's written P&Ps confirm that the PBM does not discriminate against any provider (i.e., limiting participation, reimbursement, or indemnification) who is acting within the scope of his or her license or certification under applicable state law solely on the basis of that license or certification.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
10) Providers Excluded from Participation in Federal Health Care Programs *PBMC A.40.h.* *42 CFR § 438.214(d)*	The PBM does not employ or contract with providers excluded from participation in Federal health care programs.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				
Recommendations:				
11) Dismissal for not Complying with State and Federal Prescribing Laws *PBMC A.10.c.* *42 CFR § 438.214(e)*	The Provider Services Agreement states that the failure of a provider to follow the prescribing laws will be ground for dismissal from the PBM's network as a provider for the purposes of providing services to the TennCare PBM Programs.	☐ Met ☐ Not Met	**1.0**	**0.0**
Findings:				

2021 Annual Quality Survey—Quality Process Standards: <PBM>				
Evaluation Elements	Criteria	Criteria Met	Element	
			Value	Score
Credentialing/Recredentialing P&Ps				
Recommendations:				
	Credentialing/Recredentialing P&Ps Score	**0%**	**16.0**	**0.0**

PA File Review Tools

Complaints File Review Tool

MCC: <DBM>												x/xx/2021
1	2	3	4		5		6	7	8	9		10	
File#	Case ID*	Complaint Rcvd. Date	Complaint Documented		Investigation of Complaint		Date Resolved	Number of Days to Resolve	Time Standard	Timeliness Standard Met		Notification of Resolution	
			Y	N	Y	N				Y	N	Y	N
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
Compliant Answers													
Applicable Answers													

**Case IDs have been used to protect member information.*

Total Compliant	
Total Applicable	
Percent Compliant	

UM Denials File Review Tool

MCC: <MCO/DBM> **x/xx/2021**

1	2	3	4		5			6		7		8	9	10	11	12	
File #	Case ID*	Date Request Received	Appropriate Review Criteria Used		Requesting Provider Consulted			Final Denial Decision by Qualified Professional		Decision NOT Arbitrary = Yes		E/S**	Date Notified	# of Days for Notification	Notification Time Standard	Notification Time Standard Met	
			Y	N	Y	N	NA	Y	N	Y	N					Y	N
1																	
2																	
3																	
4																	
5																	
6																	
7																	
8																	
9																	
10																	
Compliant Answers																	
Applicable Answers																	

**Case IDs have been used to protect member information.*
***Expedited or Standard*

Total Compliant	
Total Applicable	
Percent Compliant	

Appeals File Review Tool

MCC: <MCO> x/xx/2021

1	2	3	4			5		6	7	8	9	10		11	
File #	Case ID*	Date Appeal Received	Reviewed by Qualified Staff			Appeal Investigation Documented		A/E/ S**	Date Member Notified of Decision	# of Days for Reso-lution	Resolution Time Standard	Resolution Time Standard Met		State-Mandated Letter Used	
			Y	N	NA	Y	N					Y	N	Y	N
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
Compliant Answers															
Applicable Answers															

*Case IDs have been used to protect member information.
** Accelerated/Expedited/Standard

Total Compliant	
Total Applicable	
Percent Compliant	

Appeals File Review Tool

MCC: <DBM> **m/d/21**

1	2	3	4			5		6	7	8	9	10		11	
File #	Case ID*	Date Appeal Received	Reviewed by Qualified Staff			Appeal Investigation Documented		E/S**	Date Member Notified of Decision	# of Days for Resolution	Resolution Time Standard	Resolution Time Standard Met		State-Mandated Letter Used	
			Y	N	NA	Y	N					Y	N	Y	N
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
		Compliant Answers													
		Applicable Answers													

**Case IDs have been used to protect member information.*
***Expedited or Standard*

Total Compliant	
Total Applicable	
Percent Compliant	

EPSDT Information System Tracking File Review Tool											
MCC:											x/xx/2021
1	2	3	4		5		6			7	
File #	Case ID*	Medical Record (MR) / Information System (IS)	Receipt of Screening (Including Lab Work)		Diagnosis Documented		Treatment Documented (Including Immunizations)			Ability to Determine Screening Status	
			Y	N	Y	N	Y	N	NA	Y	N
1		MR									
		IS									
2		MR									
		IS									
3		MR									
		IS									
4		MR									
		IS									
5		MR									
		IS									
6		MR									
		IS									
7		MR									
		IS									
8		MR									
		IS									
9		MR									
		IS									
10		MR									
		IS									
Compliant Answers											
Applicable Answers											

Case IDs have been used to protect member information.

Total Compliant	
Total Applicable	
Percent Compliant	

CHOICES Annual Level of Care Assessment File Review Tool

MCC: <MCO> **x/xx/2021**

1	2	3	4		5		6		
File #	Case ID*	CHOICES Group Category After Evaluation	Level of Care Reassessment Conducted		Date of Level of Care Reassessment Documented in Member File		If Reassessment Indicated a Change in Level of Care, It Was Forwarded to TennCare for Determination		
			Y	N	Y	N	Y	N	NA
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
		Compliant Answers							
		Applicable Answers							

**Case IDs have been used to protect member information.*

Total Compliant	
Total Applicable	
Percent Compliant	

Transition of CHOICES Members Between MCOs: Criteria for Receiving MCO File Review Tool														
MCC: <MCO>														x/xx/2021
Row #1		File #	1	2	3	4	5	6	7	8	9	10	Answers	
2	Case ID*												Compliant	Applicable
3	CHOICES Group Category													
4	Date of CHOICES Enrollment with Receiving MCO													
5	Transition of Care Data Requested from Sending MCO	Y												
		N												
		NA												
6	Transition of Care Data from Sending MCO Reviewed	Y												
		N												
		NA												
7	For Group 2 or 3 Members, Svcs. Auth. by Sending MCO Cont'd for Min. 30 Days and Not Reduced until Needs Assessment, Plan of Care, and New Services Auth. and Implemented	Y												
		N												
		NA												
8	For Group 2 or 3 Members, F-to-F Visit, Plan of Care, and Auth. and Implement. of Services within 30 Days	Y												
		N												
		NA												
9	Svcs. Cont'd According to Level of Nursing Facility Svcs. and/or Reimbursement Approved by TennCare for Group 2 Members Rec. Short-Term Nursing (STN) Facility Care	Y												
		N												
		NA												

Transition of CHOICES Members Between MCOs: Criteria for Receiving MCO File Review Tool														
MCC: <MCO>													x/xx/2021	
Row #1		File #	1	2	3	4	5	6	7	8	9	10	Answers	
2	Case ID*												Compliant	Applicable
10	For Group 2 or 3 Members Rec. STN Facility Svcs. on Date of Enrollment, F-to-F Visit Occurred within 30 Days	Y												
		N												
		NA												
11	If Exp. Date for STN Facility Svcs. for Group 2 or 3 Members Occurs Prior to 30 Days Post Enrollment and MCO Is Unable to Conduct Visit, MCO Facilitates Discharge to Community or Enrollment in Group 1	Y												
		N												
		NA												
12	For Group 2 or 3 Members, If MCO Becomes Aware of Increase in Member Needs Prior to Comp. Needs Assessment, One Is Conducted Immediately and Member Plan of Care Is Updated and Change in Svcs. Initiated within 10 Business Days	Y												
		N												
		NA												
13	For Group 1 Members, Nursing Facility Svcs. Cont. in Accordance with Level of Nursing Facility Svcs. and/or Reimb. Approved by TennCare	Y												
		N												
		NA												
14	For Group 1 Members, F-to-F Visit Occurred within 30 Days of Enrollment and Needs Assess. Conducted as Necessary	Y												
		N												
		NA												
												Totals		
												Percent Compliant		

*Case IDs have been used to protect member information.

CHOICES Credentialing and Recredentialing File Review Tools

CHOICES Credentialing

MCO:	Reviewer:				Date of Review: x/xx/21																# of Files:			
Item Verified?		**Y**	**N**	**NA**		**Y**	**N**	**NA**		**Y**	**N**	**NA**		**Y**	**N**	**NA**		**Y**	**N**	**NA**		**Y**	**N**	**NA**
Valid license or certification *CRA A.2.11.10.4.1.2.1*	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
Medicare and Medicaid: The provider is not excluded from participation in the Medicare or Medicaid programs. *CRA A.2.11.10.4.1.2.2*	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
The provider has a National Provider Identifier (NPI), if applicable. *CRA A.2.11.10.4.1.2.3*	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
The provider has obtained a Medicaid provider number from TennCare. *CRA A.2.11.10.4.1.2.3*	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							

MCO:	Reviewer:				Date of Review: x/xx/21															# of Files:			
Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA
A site visit is conducted for all in-state providers. Requirement may be waived for out-of-state providers and the reason documented in the provider file. *CRA A.2.11.10.4.1.5*	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
FINAL SCORE	**YES**				**NO**				**SCORE**				**PERCENTAGE**											
	<X>				**<X>**				**<X/X>**				**<XX%>**											

CHOICES Recredentialing

MCO:	Reviewer:				Date of Review: x/xx/21															# of Files:			
Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA
Valid license or certification *CRA A.2.11.10.4.1.2.1*	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
Medicare and Medicaid: The provider is not excluded from participation in the Medicare or Medicaid programs. *CRA A.2.11.10.4.1.2.2*	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
	#1				#8				#15				#22				#29				#36			

MCO:	Reviewer:				Date of Review: x/xx/21																# of Files:			
Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA
A site visit is conducted for all in-state providers. Requirement may be waived for out-of-state providers and the reason documented in the provider file. *CRA A.2.11.10.4.1.5*	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
Ongoing (i.e., provide service on a regular basis) CHOICES providers are recredentialed at least annually; all other CHOICES providers must be recredentialed at least every three years. ECF CHOICES HCBS providers are recredentialed annually. *CRA A.2.11.10.4.1.1.1*	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							

FINAL SCORE	YES	NO	SCORE	PERCENTAGE
	<X>	<X>	<X/X>	<XX%>

PMV—MCOs

NCQA's HEDIS Audit protocol was used to develop the following tools for validating MCO performance measures.

NCQA's Information Systems Standards		
Standard	**Audit Findings**	**Impact on Reporting**
IS 1.0 Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry		
IS 1.1 Industry standard codes (e.g., ICD-10-CM, ICD-10-PCS, CPT, HCPCS) are used and all characters are captured. **IS 1.2** Principal codes are identified and secondary codes are captured. **IS 1.3** Nonstandard coding schemes are fully documented and mapped back to industry standard codes. **IS 1.4** Standard submission forms are used and capture all fields relevant to measure reporting. All proprietary forms capture equivalent data. Electronic transmission procedures conform to industry standards. **IS 1.5** Data entry and file processing procedures are timely and accurate and include sufficient edit checks to ensure accurate entry and processing of submitted data in transaction files for measure reporting. **IS 1.6** The organization continually assesses data completeness and takes steps to improve performance. **IS 1.7** The organization regularly monitors vendor performance against expected performance standards.		
IS 2.0 Enrollment Data—Data Capture, Transfer, and Entry		
IS 2.1 The organization has procedures for submitting measure-relevant information for data entry. Electronic transmissions of membership data have necessary procedures to ensure accuracy. **IS 2.2** Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files. **IS 2.3** The organization continually assesses data completeness and takes steps to improve performance. **IS 2.4** The organization regularly monitors vendor performance against expected performance standards.		

NCQA's Information Systems Standards		
Standard	**Audit Findings**	**Impact on Reporting**
IS 3.0 Practitioner Data—Data Capture, Transfer, and Entry		
IS 3.1 Provider specialties are fully documented and mapped to provider specialties necessary for measure reporting. **IS 3.2** The organization has effective procedures for submitting measure-relevant information for data entry. Electronic transmissions of practitioner data are checked to ensure accuracy. **IS 3.3** Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files. **IS 3.4** The organization continually assesses data completeness and takes steps to improve performance. **IS 3.5** The organization regularly monitors vendor performance against expected performance standards.		
IS 4.0 Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight		
IS 4.1 Forms capture all fields relevant to measure reporting. Electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off, and sign-off). **IS 4.2** Retrieval and abstraction of data from medical records is reliably and accurately performed. **IS 4.3** Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in the files for measure reporting. **IS 4.4** The organization continually assesses data completeness and takes steps to improve performance. **IS 4.5** The organization regularly monitors vendor performance against expected performance standards.		
IS 5.0 Supplemental Data—Capture, Transfer, and Entry		
IS 5.1 Nonstandard coding schemes are fully documented and mapped to industry standard codes. **IS 5.2** The organization has effective procedures for submitting measure-relevant information for data entry. Electronic transmissions of data have checking procedures to ensure accuracy.		

NCQA's Information Systems Standards		
Standard	**Audit Findings**	**Impact on Reporting**
IS 5.3 Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files. **IS 5.4** The organization continually assesses data completeness and takes steps to improve performance. **IS 5.5** The organization regularly monitors vendor performance against expected performance standards. **IS 5.6** Data approved for ECDS reporting met reporting requirements.		
IS 6.0 Data Preproduction and Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity		
IS 6.1 Nonstandard coding schemes are fully documented and mapped to industry standard codes. Organization-to-vendor mapping is fully documented. **IS 6.2** Data transfers to HEDIS repository from transaction files are accurate. **IS 6.3** File consolidations, extracts, and derivations are accurate. **IS 6.4** Repository structure and formatting is suitable for measures and enable required programming efforts. **IS 6.5** Report production is managed effectively and operators perform appropriately. **IS 6.6** The organization regularly monitors vendor performance against expected performance standards.		
IS 7.0 Data Integration—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity		
IS 7.1 Data transfers to the HEDIS measure vendor from the HEDIS repository are accurate. **IS 7.2** Report production is managed effectively and operators perform appropriately. **IS 7.3** Measure reporting software is managed properly with regard to development, methodology, documentation, version control, and testing. **IS 7.4** The organization regularly monitors vendor performance against expected performance standards.		

PIP Validation

2021 PIP Validation Tool—<MCC> <PIP Title>				
Step 1: Review the Selected PIP Topic				
PIP topics should target improvement in relevant areas of clinical or nonclinical services.				
Element #	**The PIP topic:**	**Met**	**Not Met**	**NA***
1	Reflects comprehensive analysis of member needs, care, and services	☐	☐	☐
2	Considers performance on CMS Child or Adult Core Set measures	☐	☐	☐
3	Considers input from members or providers who are users of, or concerned with, specific service areas	☐	☐	☐
4	Addresses care of special populations or high-priority services, as appropriate	☐	☐	☐
5	Aligns with priority areas identified by the Department of Health and Human Services (HHS) and/or CMS	☐	☐	☐
Step 1 Results:	**Total**	**Met**	**Not Met**	**NA**
Elements				
Comment:				
Strength:				
AON:				
Suggestion:				

* *Not Applicable*

2021 PIP Validation Tool—<MCC>					
<PIP Title>					
Step 2: Review the PIP Aim Statement					
The PIP aim statement identifies the focus of the PIP and establishes the framework for data collection and analysis.					
Element #	**The aim statement:**		**Met**	**Not Met**	**NA**
1	Specifies the general PIP improvement strategy		☐	☐	☐
2	Clearly specifies the PIP population		☐	☐	☐
3	Clearly specifies the PIP time period		☐	☐	☐
4	Is concise		☐	☐	☐
5	Is answerable		☐	☐	☐
6	Is measurable		☐	☐	☐
Step 2 Results:		**Total**	**Met**	**Not Met**	**NA**
Elements					
Comment:					
Strength:					
AON:					
Suggestion:					

2021 PIP Validation Tool—<MCC> <PIP Title>				
Step 3: Review the Identified PIP Population				
The population should be clearly defined in relation to the PIP aim statement.				
Element #	**The PIP population:**	**Met**	**Not Met**	**NA**
1	Is clearly defined in terms of the PIP aim statement	☐	☐	☐
2	Includes the entire eligible population or a representative and generalizable sample	☐	☐	☐
3	Captures all enrollees to whom the PIP aim statement applies, if the entire population is included	☐	☐	☐
Step 3 Results:	**Total**	**Met**	**Not Met**	**NA**
Elements				
Comment:				
Strength:				
AON:				
Suggestion:				

2021 PIP Validation Tool—<MCC> <PIP Title>				
Step 4: Review the Sampling Method				
Appropriate sampling methods are necessary to ensure that the collection of information produces valid and reliable results.				
Element #	**The sample:**	**Met**	**Not Met**	**NA**
1	Frame contains a complete, recent, and accurate list of the target PIP population	☐	☐	☐
2	Method considers and specifies the true or estimated frequency of the event, the confidence interval to be used, and the acceptable margin of error	☐	☐	☐
3	Contains a sufficient number of members to account for non-response (if applicable)	☐	☐	☐
4	Method assesses the representativeness of the sample according to subgroups	☐	☐	☐
5	Techniques are valid and protect against bias	☐	☐	☐
Step 4 Results:	**Total**	**Met**	**Not Met**	**NA**
Elements				
Comment:				
Strength:				
AON:				
Suggestion:				

2021 PIP Validation Tool—<MCC> <PIP Title>				
Step 5: Review the Selected PIP Variables and Performance Measures				
Selected variables should identify performance on PIP questions, and performance measures should be reliable and clearly defined indicators of performance.				
Element #	**Variables are:**	**Met**	**Not Met**	**NA**
1(a)	Objective, clearly defined, and time-specific	☐	☐	☐
1(b)	Available to measure performance and track improvement over time	☐	☐	☐
	Performance measures			
2	Assess an important aspect of care that will make a difference to members' health or functional status	☐	☐	☐
3	Are appropriate based on availability of data and resources to collect the data	☐	☐	☐
4	Are based on current clinical knowledge or health services research	☐	☐	☐
5	Address performance at a point in time; track performance over time; compare performance measures to benchmarks over time; and inform the selection and evaluation of quality improvement strategies	☐	☐	☐
6	Consider existing measures	☐	☐	☐
7	If internally developed: - Address accepted clinical guidelines relevant to the PIP aim statement - Address an important aspect of care or operations meaningful to members - Have data sources available to allow reliable and accurate measure calculation - Have clearly defined criteria	☐	☐	☐
8	Capture changes in member satisfaction or experience of care (if applicable)	☐	☐	☐
9	Include a strategy for inter-rater reliability (for manual data collection, if applicable)	☐	☐	☐
10	Are based on strong evidence that the process being measured is meaningfully associated with outcomes for process measures	☐	☐	☐
Step 5 Results:	**Total**	**Met**	**Not Met**	**NA**
Elements				
Comment:				
Strength:				
AON:				
Suggestion:				

2021 PIP Validation Tool—<MCC>				
<PIP Title>				
Step 6: Review the Data Collection Procedures				
Data collection procedures must ensure production of valid and reliable performance measures. Validity means that the data are measuring what is intended to be measured. Reliability means that the data are producing consistent results.				
Element #	**The PIP design/data collection plan:**	**Met**	**Not Met**	**NA**
1	Includes a systematic method for collecting valid and reliable data that represent the PIP population	☐	☐	☐
2	Specifies the frequency of data collection	☐	☐	☐
3	Clearly specifies the data sources	☐	☐	☐
4	Clearly identifies the data elements to be collected	☐	☐	☐
5	Links to the data analysis plan to ensure appropriate data are available	☐	☐	☐
6	Allows for consistent and accurate data collection over PIP time periods	☐	☐	☐
7	Specifies well-defined methods to collect meaningful and useful information, if qualitative data collection methods were used	☐	☐	☐
8	Includes an estimated degree of data completeness for administrative data collection	☐	☐	☐
9	Describes qualifications of staff responsible for abstracting data for medical record review	☐	☐	☐
10	Describes the intra- and inter-rater reliability processes in place for medical record review	☐	☐	☐
11	Includes guidelines developed for abstraction staff for medical record review	☐	☐	☐
Step 6 Results:	**Total**	**Met**	**Not Met**	**NA**
Elements				
Comment:				
Strength:				
AON:				
Suggestion:				

2021 PIP Validation Tool—<MCC>				
<PIP Title>				
Step 7: Review the Data Analysis and Interpretation of PIP Results				
Data analysis and interpretation should be based on appropriate techniques and a continuous quality improvement philosophy and reflect an understanding of lessons learned and opportunities for improvement.				
Element #	**Analysis and interpretation:**	**Met**	**Not Met**	**NA**
1	Are conducted in accordance with the data analysis plan	☐	☐	☐
2	Include a description of the baseline measurement and remeasurement(s) of performance measures	☐	☐	☐
3	Include a discussion of the statistical significance of any differences between baseline and repeat measurement(s)	☐	☐	☐
4	Identify any factors that may influence comparability of initial and repeat measurements	☐	☐	☐
5	Identify factors that threaten internal or external validity of findings	☐	☐	☐
6	Compare results across multiple entities, if applicable	☐	☐	☐
7	Are presented in a concise and easily understood manner	☐	☐	☐
8	Include lessons learned about less-than-optimal performance	☐	☐	☐
Step 7 Results:	**Total**	**Met**	**Not Met**	**NA**
Elements				
Comment:				
Strength:				
AON:				
Suggestion:				

2021 PIP Validation Tool—<MCC> <PIP Title>				
Step 8: Assess the Improvement Strategies				
Improvement results from developing and implementing effective improvement strategies.				
Element #	**Improvement strategies are:**	**Met**	**Not Met**	**NA**
1	Evidence-based	☐	☐	☐
2	Related to causes/barriers identified through data analysis and quality improvement processes	☐	☐	☐
3	Implemented on a rapid-cycle basis	☐	☐	☐
4	Culturally and linguistically appropriate	☐	☐	☐
5	Reflective of major confounding factors that could have an obvious impact on PIP outcomes	☐	☐	☐
6	Successful in terms of improvement, with follow-up activities identified	☐	☐	☐
Step 8 Results:	**Total**	**Met**	**Not Met**	**NA**
Elements				
Comment:				
Strength:				
AON:				
Suggestion:				

2021 PIP Validation Tool—<MCC>				
<PIP Title>				
Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred				
PIP methods and findings should reflect statistically significant improvement that may be associated with the PIP improvement strategy. Sustained improvement is demonstrated by improvement over repeat measurements.				
Element #	**Assessments for real improvement indicate:**	**Met**	**Not Met**	**NA**
1	Whether the remeasurement methodology is the same as the baseline methodology	☐	☐	☐
2	Whether there is quantitative evidence of improvement in processes or outcomes of care	☐	☐	☐
3	How the reported improvement in performance is likely to be the result of the selected improvement strategy	☐	☐	☐
4	The statistical evidence that any observed improvement is the result of the improvement strategy	☐	☐	☐
5	Whether sustained improvement was demonstrated through repeated measurements over time	☐	☐	☐
Step 9 Results:	**Total**	**Met**	**Not Met**	**NA**
Elements				
Comment:				
Strength:				
AON:				
Suggestion:				
Overall Results for PIP Study				
Overall Results:	**Total**	**Met**	**Not Met**	**NA**
All Elements				

APPENDIX C | 2021 PIP Summary Table

Improvement strategies are not applicable to PIPs that were in their baseline measurement year in 2021. Verbiage quoted from the MCCs' PIP Summary Forms appears in italics and is included to capture MCCs' strategies in their own words. Also included in **Table C-1** are each PIP's measurement year (Baseline [B]; Remeasurement 1 [R1]; Remeasurement 2 [R2]; Remeasurement 3 [R3]; Remeasurement 4 [R4]) and classification as clinical (C) or non-clinical (NC).

Table C-1. 2021 Performance Improvement Projects

Year	C/ NC	Topic	PIP Aim Statement	Improvement Strategies	Results
Amerigroup					
B	C	*Improve Childhood Immunization Status (CIS) Combination 10 Rates—East, Middle, and West Regions* (AGE/AGM/AGW)	*Will targeted interventions, such as member incentives, digital outreach, and innovative community collaborations, increase the percentage of members receiving childhood combination 10 immunizations?*		B AGE: 33.58% AGM: 45.26% AGW: 24.09%
B	NC	*Increase Eye Exam Screening Rates for Members with Diabetes* (AGE/AGM/AGW)	*In pursuit of health equity goals, will member and provider incentives focused on minimizing the impact of social determinates of health improve retinal eye exam screenings for members with type 1 or type 2 diabetes within their community during the HEDIS® measurement year?*		B AGE: 33.09% AGM: 40.15% AGW: 35.28%
R1	NC	*Improve East Grand Region Member Satisfaction with the Health Plan* (AGE)	*Will health plan and provider education along with telehealth and additional transportation options increase the percentage of respondents that answered Question 49 (Rating of Health Plan) on the CAHPS Child Medicaid-General Population survey with a score of 8, 9, or 10?*	♦ CAHPS Awareness Training to address barriers such as lack of provider tools/ awareness on how to improve the patient/member experience ♦ Enhanced telehealth services to improve access, continuity and coordination of care ♦ Enhanced non-emergency medical transportation (NEMT) to improve lack of transportation options along with other social determinants of health factors	B AGE: 83.96% R1 AGE: 86.68%
R2	C	*Improve EPSDT Screening Rates in the 18–20-Year-Old Age Group Statewide* (AGE/AGM/AGW)	*Will targeted member outreach, provider engagement, along with member and provider incentives improve the EPSDT Screening Rate in the 18-20 year old age group over the measurement period?*	♦ Keeping Members Healthy (KMH) Provider Incentive Program that offers providers an opportunity to earn a financial incentive for increasing their EPSDT screening rates contingent on meeting or exceeding the defined percentage point improvement ♦ Healthy Rewards Member Incentive Program in which members were able to earn one	B AGE: 32% AGM: 38% AGW: 33% R1 AGE: 35% AGM: 37% AGW: 35%

Table C-1. 2021 Performance Improvement Projects

Year	C/ NC	Topic	PIP Aim Statement	Improvement Strategies	Results
				annual financial reward for completing an EPSDT screening visit ♦ HealthCrowd Member Outreach, a vendor managed program, to notify young adult members of important information related to EPSDT screenings using modalities such as SMS, text messaging, IVR calls, and email ♦ Quality Management Provider Engagement Visits entail Amerigroup staff developing and implementing a plan with targeted providers one-on-one to improve rates by providing education, highlighting areas of opportunity and providing gap in care lists and other resources to support annual EPSDT Screenings ♦ Member EPSDT Service Reminder Mailings (Birthday Cards) are sent as a preventative reminder to members 45-90 days prior to their date of birth to remind them of the importance of their well child visit	R2 AGE: 29% AGM: 32% AGW: 26%
R2	NC	*Increase Percentage of CHOICES Members Who Had LTSS Assessment with Nine Core Elements* (AGE/AGM/AGW)	*Will targeted interventions, Patient Centered Support Plan (PCSP) tool coupled with electronic capture system enhancements, staff PCSP training and PCSP auditing with feedback, improve the rate of CHOICES - Group 2 and 3 Members who had a comprehensive LTSS assessment with 9 core elements documented within 90 days of enrollment for new members or during the measurement year for established members?*	♦ Participation in NCQA Learning Collaborative Pilot with utilization of feedback and guidance for nine elements of compliance ♦ Re-audit of 2018 CAU Sample conducted, applying NCQA clarification guidance for compliance elements and reestablishment of the 2018 Baseline ♦ An internal PCSP audit tool implemented that includes NCQA standards and assessment expectations, which allows for identification of trends and patterns, consistent feedback and re-education to coordination staff with tracking of improvement regarding adherence to the 9 core elements of the standards. The process entails communication of audit findings to the manager, manager reviews and discusses with the coordinator with remediation as applicable. The closed loop concludes with feedback to the auditor manager for awareness of training and audit tool effectiveness	B AGE: 59.38% AGM: 60.11% AGW: 53.00% R1 AGE: 98.11% AGM: 95.24% AGW: 93.97% R2 AGE: 96.77% AGM: 100% AGW: 100%

Table C-1. 2021 Performance Improvement Projects

Year	C/ NC	Topic	PIP Aim Statement	Improvement Strategies	Results
				♦ Enhanced Training conducted for NCQA standards and assessment expectations for the Person-Centered Support Plan (PCSP) of care coordination staff ♦ Implementation of the Healthy Innovations Platform (HIP) care management system, which incorporates the updated PCSP with key required fields to ensure NCQA and HEDIS® standards are assessed and documented in a systematic and consistent method. ♦ In coordination with TennCare, updates made to the Person Centered Support Plan (PCSP) to incorporate NCQA and HEDIS® standards into the document to ensure all required standards are assessed and documented.	
R1	C	*Improve Diabetic Screening Compliance for Members with Schizophrenia or Bipolar Disorder Using Antipsychotic Medication (SSD)* (AGW)	*Will targeted interventions consisting of education, member gap closures and incentives for gap closures improve diabetic screening compliance in members with Schizophrenia, Schizoaffective disorder or Bipolar disorder that are taking antipsychotic medications?*	♦ Provider support to target members with gaps in care (GIC) to increase provider awareness of the need for diabetes screening ♦ Provider incentives to mitigate provider costs associated with claims submission ♦ Glucose and hemoglobin A1c testing during inpatient behavioral health (BH) hospitalization encounter to address barrier of multiple locations needed for lab testing	B AGW: 81.61% R1 AGW: 73.48%
BlueCare					
B	NC	*LTSS Shared Care Plan with Primary Care Practitioner (LTSS-SCP)* (BCE/BCM/BCW)	*Will targeted interventions improve the rate of sharing the care plan with the Primary Care Practitioner (PCP) or other documented medical care practitioner identified by a CHOICES or ECF CHOICES member within 30 days of its development, over each remeasurement year?*		B BCE: 65.63% BCM: 33.33% BCW: 35.29%
R1	C	*Improving Antidepressant Medication Management (AMM)* (BCE/BCM/BCW)	*Will focused provider interventions increase member compliance with the continuation phase of antidepressant therapy for treatment of major depression over each remeasurement year?*	♦ Initiated text message and telephone calls for new fills and refills of antidepressant medication to MCO plan members statewide ♦ Conduct periodic provider education statewide on the AMM-C measure in partnership with the Provider Incentive and Engagement (PIE) team	B BCE: 31.57% BCM: 27.35% BCW: 26.12% R1 BCE: 34.25%

Table C-1. 2021 Performance Improvement Projects

Year	C/ NC	Topic	PIP Aim Statement	Improvement Strategies	Results
				♦ 90-day refill changes for antidepressant medications ♦ Implemented telehealth coverage and developed provider notification	BCM: 29.73% BCW: 26.83%
R1	NC	*Decrease the Use of Opioids at High Dosage (HDO)* (BCE/BCM/BCW)	*Will implementing targeted interventions decrease the proportion of BlueCare Statewide members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days over each remeasurement year?*	♦ External Vendor Enhancement of monitoring practice pattern analysis of providers, combining analytics with personalized services to improve outcomes for members with or at risk for OUD. Risk Identification and Mitigation (RIM) Reports are available for providers. ♦ Behavioral Health Quality Coaches - conducted educational webinars on targeted measures that included HDO. Will continue ongoing education during onsite visits. ♦ BlueCare shift to new PH model/program that included development of opioid cohort and internal dashboards statewide ♦ Integration of Controlled Substance Monitoring Database (CSMD) into the documentation system of record. Internal Interactive Module Education and Training was completed statewide - interactive module loaded into Learning Center and email sent out to complete training.	B BCE: 6.01% BCM: 4.68% BCW: 2.67% R1 BCE: 5.87% BCM: 4.21% BCW: 2.62%
R1	NC	*Social Determinants of Health Data Collection Process* (BCE/BCM/BCW)	*Will the development of a systematic process to collect SDoH information targeting the social determinants of health assessment in the internal documentation system of record on members with an open care management case in the Statewide BlueCare population, increase the number of SDoH assessments completed, social determinants identified, and referral needs addressed, and improve member outcomes over each measurement year?*	♦ Implementation of the new modified SDoH Assessment Tool and internal education for all case managers on the use/documentation of the tool in the documentation system of record, so that the data are in the same location for use by case managers ♦ Community Resource Tool – Repository of community resources identified by category needs, county, and ZIP code. This tool is for all staff to utilize for the member's needs ♦ Identification of process for collecting the SDoH Performance Measures data directly from the internal documentation system of record based on the assessment tool completed by the case managers	**Performance Measure 1:** B BCE: 90.84% BCM: 94.42% BCW: 92.78% R1 BCE: 81.40% BCM: 82.20% BCW: 77.50% **Performance Measure 2:**

Table C-1. 2021 Performance Improvement Projects

Year	C/ NC	Topic	PIP Aim Statement	Improvement Strategies	Results
				♦ Shift to new PH Model/Program, which included a focus on identifying social determinants and addressing through referral sources	B BCE: 50.72% BCM: 36.61% BCW: 69.04% R1 BCE: 43.90% BCM: 40.70% BCW: 35.00% **Performance Measure 3:** B BCE: 44.74% BCM: 48.34% BCW: 47.73% R1 BCE: 53.70% BCM: 53.20% BCW: 56.10%
BlueCare and TennCare*Select*					
R1	C	*Improving Childhood and Adolescent Immunization Rates (CIS/IMA)* (BCE/BCM/BCW)	*Will targeted provider interventions result in increased influenza and HPV vaccination rates in children and adolescents over each remeasurement period?*	♦ Development of a Vaccination Hesitancy Educational Flyer for providers to use during clinical encounters ♦ Provider Incentive and Engagement Team began Quarterly reviews statewide with providers addressing child and adolescent immunizations targeting influenza and HPV.	**Performance Measure 1:** B BCE: 32.38% BCM: 33.14% BCW: 20.55% TCS: 20.33% R1 36.61% 38.83% 21.89% 25.73%

Table C-1. 2021 Performance Improvement Projects

Year	C/ NC	Topic	PIP Aim Statement	Improvement Strategies	Results
					Performance Measure 2 B BCE: 31.95% BCM: 33.51% BCW: 29.68% TCS: 30.44% R1 BCE: 33.28% BCM: 32.41% BCW: 29.33% TCS: 32.33%
R4	NC	*Improving Early and Periodic Screening, Diagnostic and Treatment (EPSDT)* (BCE/BCM/BCW)	*Do targeted provider engagement activities improve the EPSDT rates over each remeasurement period?*	♦ Provider education and partnerships through: provider educational email blasts**;** provider educational mass mailings**;** educational presentations at webinars, workshops, clinical advisory panel, meetings ♦ Implementation of an Integrated Appointment Scheduling Platform that allows health plan staff to directly access provider appointment inventory and schedule member appointments while on the phone with members. The platform also provides technology for appointment reminders that can be utilized by providers who may not otherwise have those capabilities. The platform also integrates transportation for appointments. ♦ Supersizing Provider Program to incentivize providers to capitalize on sick visits and covert them to an EPSDT visit to address preventive care. ♦ Embedded Member Resource Coordinator (MRC)—embedded within the ED to help address social determinants of health, assist with PCP follow-up, appointment scheduling, transportation assistance and other member needs.	B BCE: 72% BCM: 69% BCW: 70% TCS: 60% R1 BCE: 76% BCM: 76% BCW: 73% TCS: 66% R2 BCE: 81% BCM: 79% BCW: 79% TCS: 69% R3 BCE: 85% BCM: 82% BCW: 80% TCS: 71%

Table C-1. 2021 Performance Improvement Projects					
Year	**C/ NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**	**Results**
					R4 BCE: 78% BCM: 75% BCW: 67% TCS: 65%
TennCare*Select*					
R1	NC	*Improving Comprehensive Diabetes Care (Blood Pressure Control for SelectCommunity)*	*Does providing a tailored set of interventions and approaches improve the Comprehensive Diabetes Care: Blood Pressure Control (CDC BP) HEDIS rate for the TennCareSelect SelectCommunity population over each measurement year?*	♦ Agent Workspace technology implemented to be address gaps in care identified in the Agent Workspace application and address actions taken toward closing the gap. ♦ Training related to the CDC-BP HEDIS measure was developed to provide knowledge and technical specification updates; included information about open gap exploration and how to officially provide closure if the gap was identified as already closed	B 54.86% R1 75.78%
R1	NC	*Decreasing Plan All-Cause Readmissions*	*Do targeted interventions decrease the number of TennCareSelect acute inpatient and observation stays that are followed by an unplanned acute readmission for any diagnosis within 30 days over each measurement year?*	♦ Interactive calls made to all members statewide discharged from a facility for mental illness to provide education and support, confirm appointment scheduled during discharge, or assist scheduling an appointment. Identify and resolve any social determinants of health barriers to care such as transportation. An incentive offered to members who keep their appointment within 7 days of discharge. Follow up calls made one (1) day post appointment to ensure that member attended. ♦ Transition of Care (TOC) / Discharge Planning responsibility transferred statewide from Case Management to Utilization Management (UM). UM worked with Predictive Analytics to improve identification of members with high probability of readmission statewide. Members are discharge planned with the facility and documentation is completed on a new UM discharge planning template. Referrals made to Interdisciplinary care team as needed	B 9.72% R1 10.96%

Table C-1. 2021 Performance Improvement Projects

Year	C/ NC	Topic	PIP Aim Statement	Improvement Strategies	Results
				♦ Member Outreach Discharge calls made to members statewide with high probability of readmission (Asthma/Chronic Obstructive Pulmonary Disease) prior to discharge from hospital. A transition of care (TOC) template is completed, and members are educated on self-management and follow up appointments. ♦ UM evaluates members statewide for tele-monitoring referral to an external vendor using specific criteria for each diagnosis. Currently applies to only Medical members. ♦ Contracted with statewide vendor that utilizes providers to complete follow-up visits with members after hospitalization for mental illness	
R2	C	*Follow-Up After Hospitalization for Mental Illness—7 Day (FUH)*	*Do targeted interventions improve the rate of timely follow-up care for members age 6 and older who were hospitalized for treatment of mental illness over each remeasurement period?*	♦ Tennessee Health Link (THL) Provider incentivized measure, Quarterly education and support given to providers statewide. ♦ Member Outreach phone calls to members statewide for appointment scheduling assistance, with financial incentive for members who keep appointment. Follow up calls are made 1-day post appointment to ensure that member attended. Phone calls also include education on the importance of follow-up care. ♦ Incorporating behavioral health inpatient and outpatient practices statewide into the Integrated Appointment Scheduling Platform. ♦ Statewide vendor that utilizes providers to complete the 7-day follow-up visit after hospitalization for mental illness. ♦ Provider and Community Partner Education	B 39.27% R1 42.38% R2 41.75%
R2	NC	*Social Determinants of Health Data Collection Process*	*Will the development of a systematic process to collect SDoH information targeting the social determinants of health assessment in the internal documentation system of record on members with an open care management case in the Statewide TCS population, increase the number*	♦ Formation of the multi-disciplinary SDoH Workgroup and development of modified SDoH assessment tool to be completed in the internal documentation system of record. Internal education developed for all case	**Performance Measure 1:** B 11.43%

Table C-1. 2021 Performance Improvement Projects

Year	C/ NC	Topic	PIP Aim Statement	Improvement Strategies	Results
			of SDoH assessments completed, social determinants identified, and referral needs addressed, and improve member outcomes over each measurement year?	managers on the use/documentation of the new modified SDoH tool. ♦ Community Resource Tool – Repository of community resources identified by category needs, county, and ZIP code. This tool is for all staff to utilize for the member's needs ♦ Identification of process for collecting the SDoH Performance Measures data directly from the internal documentation system of record based on the assessment tool completed by the case managers ♦ Shift to new PH Model/Program, which included a focus on identifying social determinants and addressing through referral sources	R1 86.71% R2 63.30% **Performance Measure 2:** B 42.29% R1 42.56% R2 35.30% **Performance Measure 3:** B 28.97% R1 51.02% R2 68.60%
UnitedHealthcare					
B	C	*Increasing the Screening Rates of Child & Adolescent Well-Care Visits (WCV)* (UHCE/UHCM/UHCW)	*Will the use of targeted member outreach and incentives increase screening rates for children 18-21 years of age over each remeasurement year?*		B UHCE: 25.92% UHCM: 26.72% UHCW: 20.30%
R1	NC	*Increasing the Physical Health Provider Satisfaction Survey Engagement Rate* (UHCE/UHCM/UHCW)	*Can enhanced communication efforts to providers regarding the importance of their feedback increase the response rates for our Physical Health Provider Satisfaction Survey over each measurement period?*	♦ Formed a workgroup comprised of various provider-facing staff to evaluate current survey cover letter. Workgroup then worked with CMO to advise on content, as well as ways to address preferences and needs that have been identified in other provider communications that could be applicable here. After forming a draft Pre-Notification Letter including specific actions taken from our	B UHCE: 9.4% UHCM: 12.6% UHCW: 11.5% R1 UHCE: 8.8% UHCM: 11.8% UHCW: 11.2%

Table C-1. 2021 Performance Improvement Projects

Year	C/ NC	Topic	PIP Aim Statement	Improvement Strategies	Results
				previous year's survey, it was presented to those network providers that regularly participate in our Provider Affairs Subcommittee for a final review and to satisfy the 'study' step of our PDSA cycle. The survey cover letter will be updated annually to include specific impacts and actions taken based on the previous year's survey responses as decided upon and approved by the PAS each year	
R1	C	*Adherence to Antipsychotic Medications for Individuals w/ Schizophrenia (SAA)* (UHCW)	*Will targeted provider and member interventions increase adherence to antipsychotic medications for individuals diagnosed with schizophrenia over each measurement period?*	♦ Quality Analyst worked with UHCCP Data Analysts to run a monthly report via SMART. The Quality Analyst and provider reviewed the monthly report as needed to discuss progress and reconcile adherence data. Members identified on the provider's Pharmacy Gaps in Care Reports fall off the list, as providers outreach members to reconcile any medications issues. During this measurement cycle, the Quality Analyst collaborated with 6 identified providers to review, analyze, and make adjustments as needed. ♦ Developed and published an educational newsletter article for members titled The Importance of Taking Medication as Directed. The article was shared in a quarterly newsletter and with providers to discuss with members as needed. ♦ Developed and published a SAA education flyer ("Attention-Tips to Address the SAA Measure") to the Provider website and published an educational article for providers ("Antipsychotic Pharmacotherapy: TennCare Preferred Drug List & Appropriate Diagnosis for Prior Authorization Bypass").	B UHCW: 58.26% R1 UHCW: 64.27%
R2	NC	*Care Coordination* (UHCE/UHCM/UHCW)	*Can targeted provider outreach improve provider and member perception of coordination of care between health care practitioners as indicated by UnitedHealthcare Community Plan Provider*	♦ Creating a SDOH role within the health plan to assist providers with resource identification and linkage for patients with these non-medical risk factors to support overall care coordination activities	**Performance Measure 1:** B UHCE: 23.53% UHCM: 13.04%

Table C-1. 2021 Performance Improvement Projects

Year	C/ NC	Topic	PIP Aim Statement	Improvement Strategies	Results
			Satisfaction Survey and CAHPS® Survey responses over each measurement period?	♦ Moving CM team to sit within the Population Health structure to allow for central alignment of health plan goals for care coordination. Creating a total of 18 Community Care Teams (CCTs) comprised of one Registered Nurse and three Community Health Workers, for a total of six CCTs per region, each assigned to specific counties or geographical areas.	UHCW: 24.32% R1 UHCE: 34.78% UHCM: 47.37% UHCW: 13.33% R2 UHCE: 42.10% UHCM: 31.25% UHCW: 37.50% **Performance Measure 2:** B UHCE: 88.24% UHCM: 82.32% UHCW: 76.98% R1 UHCE: 91.33% UHCM: 83.20% UHCW: 80.33% R2 UHCE: 85.19% UHCM: 85.33% UHCW: 80.00% **Performance Measure 3**: B UHCE: 86.29% UHCM: 84.24% UHCW: 83.77% R1 UHCE: 87.80% UHCM: 84.17% UHCW: 86.89% R2 UHCE: 89.04% UHCM: 81.25% UHCW: 93.94%

Table C-1. 2021 Performance Improvement Projects

Year	C/ NC	Topic	PIP Aim Statement	Improvement Strategies	Results
R2	C	*Impact of Member and Provider Outreach on Immunization Rates for CIS Combo 10* (UHCE/UHCM/UHCW)	*Will targeted provider and member interventions increase the CIS Combo 10 immunization rate, for members, over each remeasurement period?*	♦ Utilize provider facing teams to educate, partner with, and regularly meet with our network providers participating in VBC. This education, combined with other efforts such as UHCOnAir, is used to support these providers in their efforts to incrementally improve their targeted quality metrics. Incentive amount for improvement associated with the CIS Combo 10 measure for our TennStar participating providers was increased. ♦ Clinical Practice Education Consultants met regularly with all TennStar providers to identify open gaps in care, established methods for closing those gaps in care, discuss their earning potential, as well as to review their current progress to date. ♦ National Member Engagement team identified a Pfizer affiliated outreach program based on the positive outcome rates shown in other participating health plans. ♦ Implemented an additional member outreach combining postcards and interactive voice response (IVR) calls to target members ages 6 months, 8 months, and 16 months with missed vaccines monthly.	B UHCE: 35.28% UHCM: 43.07% UHCW: 27.01% R1 UHCE: 37.23% UHCM: 43.07% UHCW: 27.74% R2 UHCE: 37.96% UHCM: 44.28% UHCW: 22.14%
R2	NC	*Transitions of CHOICES Individuals* (UHCE/UHCM/UHCW)	*Can utilizing innovative and transitional care interventions/methods result in a positive percentage ratio change in the number of Home and Community Based members versus Nursing Facility members over each measurement period?*	♦ NF Diversion Activities: Manager Review of all community persons requesting transition to Nursing Facility prior to approval and submission to state partner portal in all regions. ♦ NF Facility Screenings and Census Review: Review of all existing population at NF by Transition team with Assigned Facility CC for potential new transition referrals in all regions. ♦ Review of NF MDS 3.0 Section Q Discharge Individuals Identified Goals by assigned facility staff in all regions. ♦ NF Warning Report: Red Flags for Diagnosis and Claims Related to risk of NF Placement	**Performance Measure 1**: B UHCE: 57.49% UHCM: 53.64% UHCW: 52.36% R1 UHCE: 57.59% UHCM: 55.49% UHCW: 53.01% R2 UHCE: 47.51% UHCM: 47.92% UHCW: 45.87%

Table C-1. 2021 Performance Improvement Projects

Year	C/ NC	Topic	PIP Aim Statement	Improvement Strategies	Results
				for Group 1: Cases reviewed during Manager/ Coordinator meetings for high risk persons and plan of risk mitigation in all three regions. ♦ NCQA Inpatient and Readmission Report: Cases reviewed during MCM/ CC One on Ones for high risk and plan of risk mitigation in all regions. ♦ Housing Specialist and Member Advocacy collaboration during all regional transition grand rounds for consult and assistance. ♦ Collaboration with Provider Relations and Network Development for Community Based Residential Alternatives (CBRA) option for persons transitioning to community in all regions. ♦ Continuum of Care Grand Rounds with Medical Director for complex persons desiring to transition to community in all regions. ♦ Complete Comprehensive Interdisciplinary Rounds with Managers for All Individuals Prior to Return to the Nursing Facility. ♦ TCARE Assessment for Natural Supports and Caregivers. This program provides support to sustain individuals in the community by supporting those who provide the natural unpaid care to the LTSS HCBS Population. A Plan of Care is developed for the Caregiver directly to support their needs and resolve gaps.	**Performance Measure 2**: B UHCE: 42.51% UHCM: 46.36% UHCW: 47.64% R1 UHCE: 42.41% UHCM: 44.51% UHCW: 46.99% R2 UHCE: 52.49% UHCM: 52.08% UHCW: 54.13%
DentaQuest					
R3	C	*Increasing Provider Use of Silver Diamine Fluoride (SDF) as a Preventive Measure*	*Can the percentage of TennCare member utilizers 0-20 that receive an application of Silver Diamine Fluoride (SDF) be increased through targeted education to our providers over each remeasurement year?*	♦ SDF Provider Toolkit available on DQ Provider page ♦ The American Dental Association redefined CDT code D1354 from a full-mouth application to a per-tooth application state-wide. ♦ Provider utilization of SDF was added to the quarterly Provider Performance Report scorecard for provider behavior	B 0.20% of utilizers received SDF R1 0.50% R2 0.89%

Table C-1. 2021 Performance Improvement Projects

Year	C/ NC	Topic	PIP Aim Statement	Improvement Strategies	Results
				♦ Provider incentive payment was calculated based on number of SDF applications, along with other preventive measures ♦ Provider hospital readiness form was updated to clinically deny treatment in a hospital under general anesthesia unless the provider has tried SDF or explained why SDF is not an appropriate treatment. ♦ New Person-Centered Dental Home Program implemented for all TennCare network providers, emphasizing minimum expectation of SDF use and individual education and remediation for offices not using SDF	R3 1.55%
R3	NC	*Decreasing TennCare Enrollees Receiving Opioid Prescriptions*	*Can the percentage of TennCare member utilizers 0-20 that receive an opioid prescription be decreased through targeted education to TennCare dental providers over each remeasurement year?*	♦ Opioid Provider toolkit available on DentaQuest provider page. ♦ TennCare implemented an edit on opioid prescriptions for all outpatient, first-time prescription, non-chronic opioid users, such that: First fill prescriptions are limited to a 5-day supply (revised to 3-day supply on July 1st, 2018) at 60 MME per day; additional days' supply and higher MME limits require pre-authorization and ICD-10 codes containing diagnostic justification. ♦ DQ Dental Director presented dangers of and alternatives to opioids to dental students at Meharry and University of TN Dental Schools. ♦ Identified Dental Providers that are outliers amongst their peers, in terms of percentage of TennCare patients receiving an opioid prescription. These providers were targeted with a letter sent via mail and email calling attention to their prescriptive behaviors as well as providing education and alternative strategies for pain management.	B 4.77% R1 2.99% R2 2.96% R3 2.88%

Table C-1. 2021 Performance Improvement Projects					
Year	**C/ NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**	**Results**
OptumRx					
B	C	*Schizophrenia Medication Compliance Improvement Plan*	*Will the increased use of long-acting injectable antipsychotics reduce the frequency and costs associated with psychotic breaks (e.g., inpatient facility days and medical cost) in patients with schizophrenia who have been non-compliant with oral antipsychotics over each remeasurement year?*		**Performance Measure 1:** B 47.6 days **Performance Measure 2:** B $15,422.42 per patient
B	NC	*Usage of Diagnosis Code Override by Providers for Preferred Atypical Antipsychotics*	*Does targeted communication to providers about the diagnosis code override process for preferred atypical antipsychotics increase the use of appropriate diagnosis code overrides for TennCare members with at least one preferred atypical antipsychotic claim over each remeasurement year?*		B 6.06%