Tennessee External Quality Review Organization (EQRO)

Final November 2022

2022 Annual

EQRO Technical Report

TN Division of TennCare

Qsource

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Acknowledgements, Acronyms, and Initialisms[1]

A ..... Access, an aspect of care

ADD-E ..... Follow-Up Care for Children Prescribed ADHD Medication

ADHD ..... Attention Deficit Hyperactivity Disorder

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

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

AIS-E ..... Adult Immunization Status

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

B ..... Baseline

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

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

BESMART ..... Buprenorphine Enhanced and Supportive Medication-Assisted Recovery and Treatment

BH ..... Behavioral Health

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

C ..... Clinical

CAP ..... Corrective Action Plan

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*

CHCA ..... Certified HEDIS Compliance Auditor

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

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

CLS/CLS—FM ..... Community Living Supports, CLS—Family Model

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

CM ..... Clinical Modification

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

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

COE ..... Center of Excellence

CPT® ..... Current Procedural Terminology; a registered trademark of the American Medical Association

CRA ..... Contractor Risk Agreement

CSMD ..... Controlled Substance Monitoring Database

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

[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.*

EPSDT ..... Early and Periodic Screening, Diagnostic, and Treatment
EQR/EQRO ..... External Quality Review/EQR Organization
ESRD ..... End-Stage Renal Disease
FUH ..... Follow-Up After Hospitalization for Mental Illness (HEDIS measure)
FQHC ..... Federal Qualified Health Center
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.
ICD-10 ..... International Classification of Diseases, Tenth Revision
ICF ..... Intermediate Care Facility
I/DD ..... Intellectual/Developmental Disabilities
ID ..... Identification
IMA ..... Immunizations for Adolescents (HEDIS measure)
IS ..... Information System(s)
ISCAT ..... Information Systems Capabilities Assessment Tool
IT ..... Information technology
LOC ..... Level of Care
LTSS ..... Long-Term Services and Supports
LTSS-RAC ..... LTSS Reassessment (HEDIS measure)
LTSS-SCP ..... LTSS Shared Care Plan (HEDIS measure)
MAT ..... Medicated-Assisted Treatment
MCC ..... Managed Care Contractor
MCO ..... Managed Care Organization
MD ..... Doctor of Medicine
MME ..... Morphine milligram equivalent dose
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
NEMT ..... Non-Emergency Medical Transportation
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
PAS ..... Provider Affairs Subcommittee
PBM ..... Pharmacy Benefits Manager
PCP ..... Primary Care Provider/Practitioner
PCR ..... Plan All-Cause Readmissions (HEDIS measure)
PCS, HCPCS ..... Procedure Coding System, Healthcare PCS
PDV ..... Provider Data Validation
PH ..... Population Health
PIE ..... Provider Incentive Engagement
PIP ..... Performance Improvement Project
PMV ..... Performance Measure Validation
PPC ..... Prenatal and Postpartum Care (HEDIS measure)
PSS ..... Provider Satisfaction Survey
Q ..... Quality, an aspect of care

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
SFH ..... State Fair Hearing
SOP ..... Standard Operating Procedures
SSD ..... Diabetes and Cardiovascular Disease Screening and Monitoring for People with Schizophrenia or Bipolar Disorder (HEDIS measure)
T ..... Timeliness, an aspect of care
Td ..... Tetanus and Diphtheria vaccine
Tdap ..... Tetanus, Diphtheria, and Pertussis vaccine
TCA ..... Tennessee Code Annotated
TCS ..... TennCare*Select*, administered by BlueCare Tennessee
TDCI ..... Tennessee Department of Commerce and Insurance
TennCare ..... TN Division of TennCare
THL ..... Tennessee Health Link
TN ..... Tennessee
TOC ..... Transition of Care
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
UMP/UMPD ..... UM Program, UM Program Description
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 *2022 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 Centers for Medicare & Medicaid Services (CMS) EQR Protocols released in October 2019, which were current during 2021, 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 MY 2021, 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).

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 2022 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.

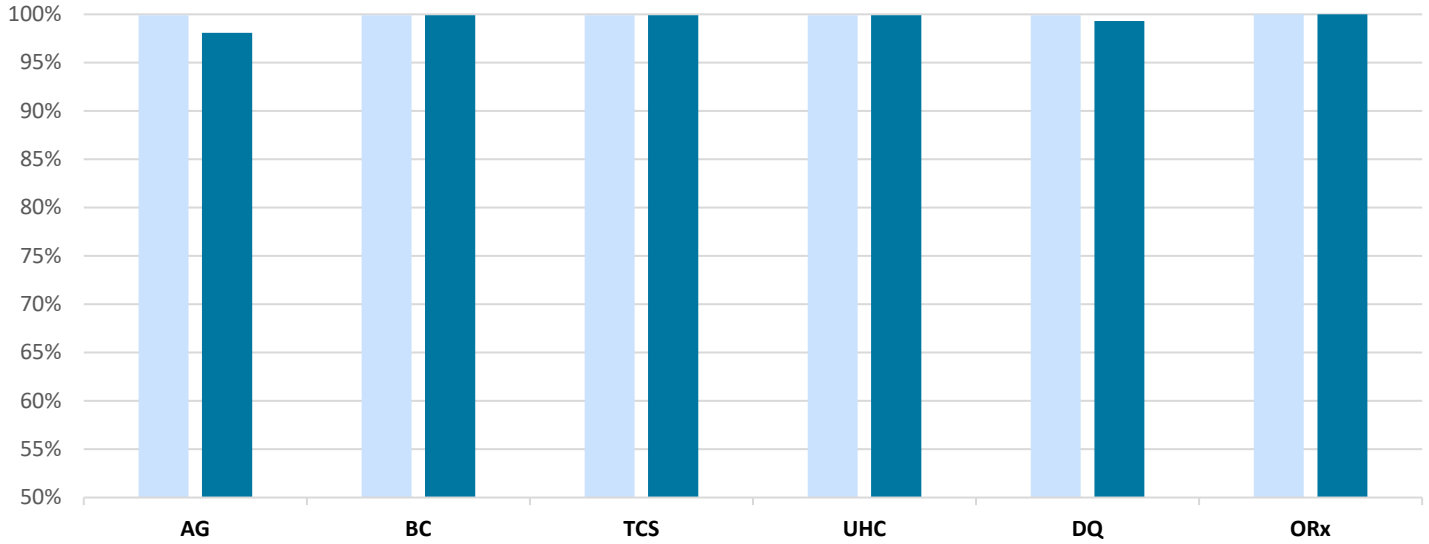
The TennCare plans are: Amerigroup (**AG**), BlueCare (**BC**), which also administers the statewide TennCare*Select* (**TCS**); UnitedHealthcare (**UHC**), DentaQuest (**DQ**), the statewide DBM; and OptumRx (**ORx**), the statewide PBM.

Access and Timeliness: ANA Review

Figure 1 shows each MCC's 2022 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 overall Network Adequacy and Benefit Delivery scores, all plans earned 99.9% or better except for **AG** and **DQ**'s Benefit Delivery scores, which were 98.1% and 99.3%, respectively.

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

Figure 1. 2022 ANA Review Results: Overall Network Adequacy and Benefit Delivery Scores



	AG	BC	TCS	UHC	DQ	ORx
Network Adequacy	>99.9%	99.9%	99.9%	>99.9%	>99.9%	100.0%
Benefit Delivery	98.1%	>99.9%	>99.9%	>99.9%	99.3%	100.0%

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 2022 ANA. Those results, as well as results for CHOICES credentialing and recredentialing file reviews, were included in detail in the *2022 AQS Technical Papers* and *2022 AQS Summary Report* and are included in the AQS section of this report.

As shown in Table 1, 2022 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 14 of 15 QP standards, while **AG** and **UHC** each scored 100% on 12 of 15 standards; **DQ** earned less than 100% on only 4 of 14 standards, while **ORx** earned less than 100% on 4 of its 13 standards. For the CHOICES credentialing and recredentialing file reviews, all applicable MCOs earned 100% for both quantity and quality ratings except **UHC** in credentialing quality and

recredentialing quality. PA file reviews were reported statewide for MCOs during the 2022 AQS. **TCS** achieved 100% compliance on all applicable PA file reviews, while **AG**, **BC**, and **UHC** were only slightly less than 100%. **DQ** earned 100% for all three applicable PAs. *Note: **ORx** is only assessed for QP standards.*

Table 1. 2022 AQS Summary Results

	AG	BC	TCS	UHC	DQ	ORx
QP Standards Range	84.0%–100%%	91.0%–100%	91.0%–100%	82.0%–100%	92.3%–100%	0.0%–100%
CHOICES Credentialing/ Recredentialing Range	100%	100%		80.3%–100%		
PA File Reviews Range	92.5%–100%	90.0%–100%	100%	95.0%-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 2022 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: Adult Immunization Status (AIS-E), and Follow-Up Care for Children Prescribed ADHD Medication (ADD-E). 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 MY2021 rates by MCO (three vaccines each) for AIS-E, and Figure 3 shows the HEDIS MY2021 rates for ADD-E by MCO.

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

Figure 2. HEDIS MY2021 Rates for AIS-E: Totals

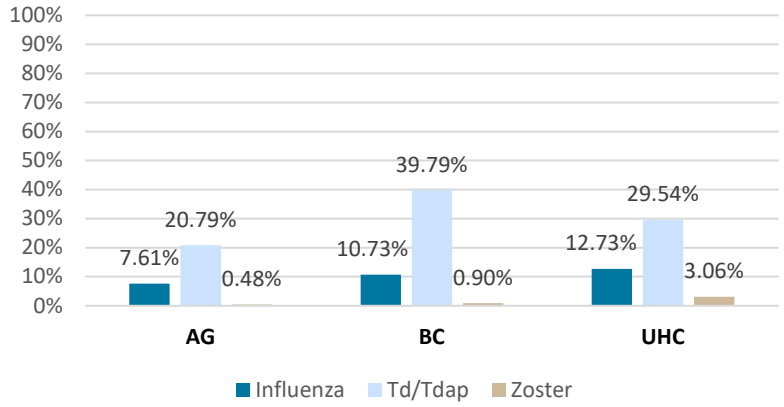
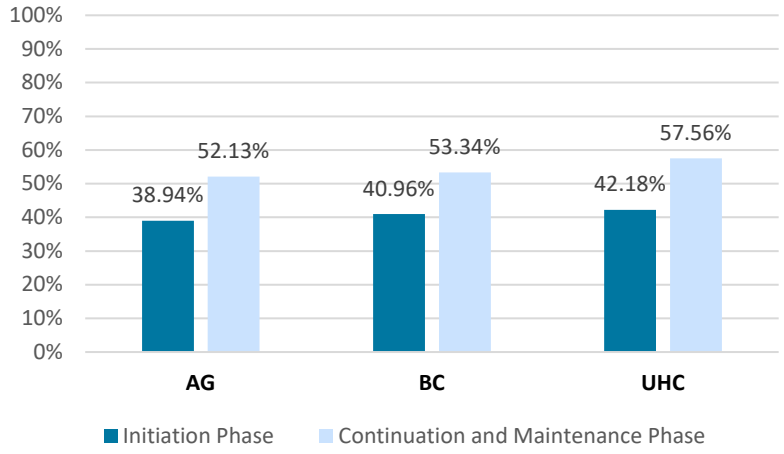


Figure 3. HEDIS MY2021 MCO Rates ADD-E



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 Contractor Risk Agreement (CRA) specifications were met this year in the 28 PIPs conducted by TennCare's plans and submitted for 2022 PIP validation.

This year's PIPs covered 28 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 5. Of the 28 PIPs, all earned a validation status of Met (**Table 2**), and 22 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. 2022 PIP Validation Statuses

MCC	PIPs Met/Submitted	MCC	PIPs Met/Submitted
AG	6/6	**TCS**	6/6
BC	6/6	**UHC**	6/6
DQ	2/2	**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 2022.

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 extended coverage to large numbers of uninsured/uninsurable people, the majority of benefits being delivered by TN's Managed Care Organizations (MCOs) operating at full risk. Enrollees under the program are eligible to receive only those medical items and services that are within the scope of defined benefits for which the enrollee is eligible and determined to be medically necessary.

The demonstration program's second waiver began on July 1, 2002. It contained revisions to the original structure and divided the program into TennCare Medicaid and TennCare Standard. TennCare Medicaid serves Medicaid eligibles, while TennCare Standard serves the demonstration population.

In 2004, state administration launched a reform package to "rightsize" program enrollment and establish goals to reduce the dramatic growth in pharmacy spending. With approval from the Centers for Medicare & Medicaid Services (CMS), the state began implementing these modifications in 2005.

On October 5, 2007, the waiver for the TennCare II extension was approved for three additional years. Subsequent extensions of the TennCare II managed care demonstration were approved in 2009 and 2013.

On July 22, 2009, TennCare received approval from CMS for a demonstration amendment to implement the CHOICES program outlined by the State's Long-Term Care Community Choices Act of 2008. Under the CHOICES program, the State provides Nursing Facility (NF) services, as well as community-based alternatives to people who would otherwise require Medicaid-reimbursed care in a NF, and to those at risk of NF placement. The CHOICES program utilizes the existing Medicaid MCOs to provide eligible individuals with NF services or home and community-based services (HCBS). Tennessee was one of the first states in the country to implement managed Medicaid long-term services and supports (LTSS) and in a manner that does not require enrollees to change their MCO.

With implementation of the CHOICES program, the MCOs became responsible for coordination of all covered medical,

behavioral, and LTSS provided to their members, age 65 and older and adults age 21 and older with physical disabilities enrolled in the program.

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 calendar year (CY) 2015. 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 July 1, 2016, the Employment and Community First (ECF) CHOICES program was added to the managed care demonstration. ECF CHOICES is a managed LTSS program that aligns incentives toward promoting and supporting integrated, competitive employment and independent community living as the first and preferred option for individuals with I/DD.

The newest iteration of the TennCare demonstration waiver was approved by CMS in January 2021, extending Tennessee's managed care program for 10 more years. Today, TennCare is a mature, data-driven managed care program with well-functioning component parts and a stable, established infrastructure that delivers high-quality care to many of the state's most vulnerable citizens. In its current approval period, TennCare retains its commitment to the program's core values, including broad access to care, improved health status of program participants, and cost-effective use of resources. All Medicaid and demonstration eligibles are enrolled in TennCare, including those full benefit dually eligible for TennCare and Medicare.

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. Ensure appropriate access to care
2. Provide high-quality, cost-effective care
3. Ensure 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
- Health and welfare
- 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 elected to have Qsource evaluate the effectiveness of its Quality Strategy via the *2022 Annual EQRO Technical Report*, which measures progress toward the strategy's primary goals and objectives. Prior assessment of the 2020 Quality Strategy was conducted in 2021 and published by Qsource in the *2020 TennCare Quality Strategy Evaluation.* The *2021 Update to the Quality Assessment and Performance Improvement 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 2022 evaluation found that 5 of the 11 objectives met or exceeded the Quality Strategy's physical and behavioral health goals set forth for 2021. **Table 3** contains the objectives not met (2.1), partially met (4.2), and off-target based on 2024 goals (2.4, 4.1), in addition to the EQRO suggestions for the State.

Table 3. 2021 Quality Strategy Evaluation Summary

Quality Strategy Objective	EQR Finding	Statewide Performance	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-416 screening rate decreased from 69% in FFY20 to 68% in FFY21. The decrease in screening rate is largely attributed to the continued impact of the Public Health Emergency during FFY21. The	FFY 2020: 69% FFY 2021: 68%	80%	As raising EPSDT screening rates have presented an ongoing challenge and focus for the MCOs, TennCare could monitor and evaluate successful MCO interventions to determine best practices and require that MCOs with

Table 3. 2021 Quality Strategy Evaluation Summary

Quality Strategy Objective	EQR Finding	Statewide Performance	Statewide Performance Target	EQRO Suggestions for the State
the CMS standard of 80% in the coming years. **2021 Goal**: Continued goal of reaching the 80% benchmark for the statewide rate, with an added focus of increasing the statewide participant ratio. The statewide participant ratio for FY19 is 61%.	statewide participant ratio remained at 56% in FFY21 compared to FFY20.			the lowest screening rates adopt and monitor those interventions.
Objective 2.1: By 2021, 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.	Not Met	Prenatal: ♦ MY2020: 81.92% Postpartum: ♦ MY2020: 72.67%	Prenatal: ♦ 87.38% Postpartum: ♦ 75.22%	TennCare could consider implementing a Performance Improvement Project for all MCO's to ensure targeted interventions and barrier analysis is conducted.
Objective 2.4: By 2024 statewide HEDIS rates for the following child and adolescent immunization measures will improve to the 66th percentile: ♦ Childhood Immunization Status (CIS) Combo 10 ♦ Immunizations for Adolescents (IMA) Combo 2	Off-target Did not meet 2021 Goals.	CIS-Combo 10: ♦ MY2020: 34.64% IMA Combo 2: ♦ MY2020: 32.74%	2021 Goals: CIS Combo 10: ♦ 39.17% IMA Combo 2: ♦ 34.43%	TennCare should continue monitoring results for the CIS and IMA measures. Potential opportunities include identifying alternative settings and sites for vaccine administration or routine care.
Objective 3.1: Through 2021, the number of TennCare enrollees who expressed satisfaction with TennCare will remain at least 95%.	TennCare goal for 2021 was to achieve 95% or higher satisfaction, however only 92% reported satisfaction with the program.	92% reported satisfaction with the program	TennCare enrollee satisfaction with TennCare will reach 95% or higher in the annual survey of TennCare recipients.	TennCare should continue to monitor results, primary dissatisfaction came from the quality of service provided from a TennCare provider and noted that respondents said that COVID-19 had impacted the quality of their healthcare, with nearly 72 percent of this group stating that the quality was worse during COVID-19.

Table 3. 2021 Quality Strategy Evaluation Summary

Quality Strategy Objective	EQR Finding	Statewide Performance	Statewide Performance Target	EQRO Suggestions for the State
Objective 4.1: By 2024, the statewide HEDIS rates related to child and adolescent weight management will improve to the 66th percentile.	Off-target Did not meet 2021 Goals.	MY2020: ♦ BMI percentile documentation: 79.82% ♦ Counseling for nutrition: 70.20% ♦ Counseling for physical activity: 65.65%	2021 Goals: ♦ BMI percentile documentation: 83.45% ♦ Counseling for nutrition 75.67% ♦ Counseling for physical activity: 71.53%	TennCare could conduct barrier analysis, assess highest performing plans to determine best practices to share with other MCOs.
Objective 4.2: TennCare members will show improvement across the 3 Population Health outcome measures.	Partially Met. Emergency Department visits per 1000 member months achieved goals, while 30-day readmission rate did not. The data source used to report these measures was updated in 2021, therefore the reported outcomes for 2021 should not be used for trending. End stage renal disease in members with diabetes is no longer captured in this data source.	♦ Emergency department visits per 1,000 member months in CY 2021 is 60.89. ♦ 30-day readmissions per 100 members in CY 2021 is 10.04.	♦ ED visits per 1000 members—582 ♦ 30-day readmissions per 100 members—10.7 ♦ ESRD per 100 members with diabetes—7.0	TennCare could conduct a barrier analysis, or disparity analysis among the population to determine possible interventions.

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 MY 2021, 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 *2022 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 2021. Applicable trending results are presented in the individual activity sections of this report.

Table 4. MY 2021 Audit Periods for EQR Activities

Activity	Audit Period
ANA Review	February–March 2022
AQS	February–May 2022
PMV	March–August 2022
PIP Validation	July–October 2022

The following reports were generated for each of the reviews:

- *2022 ANA Reports* for individual plans
- 2022 AQS Technical Papers for individual plans
- 2022 AQS Summary Report for all plans
- 2022 Annual PMV Reports for individual plans
- 2022 Annual PIP Validation Technical Papers for individual PIP topics, by plan
- 2022 Annual PIP Validation Summary Report for all plans

This *2022 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 was also obtained through NCQA accreditation, which had been earned by all TennCare MCOs by the end of CY 2009. 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: Adult Immunization Status (AIS-E) and Follow-Up Care for Children Prescribed ADHD Medication (ADD-E). 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 2022 PIP validation process evaluated 28 PIPs spread across 4 statewide MCOs, 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 Improvement 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 2022 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 2022 meetings featured presentations from experts on social determinants of health, health disparities, population health, Appalachian opioid response, long-term services and supports, updates in oral anticoagulation use in practice and reversal strategies, behavioral health, autism care and dentistry, breast and lung cancer screening, suicide prevention, and pediatric clinical services in rural communities, among others. (*Note: Due to the COVID-19 pandemic, the February and June meetings were held as live webinars.)*

Technical Report Guidelines

To assist both EQROs and state agencies, CMS supplemented the requirements of 42 CFR §438.364 and provided guidelines for this *2022 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's 2021 Update to State Quality Strategy helped determine the parameters of state Medicaid initiatives, of which Population Health (PH) 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 PH programs. TennCare's Quality Strategy measures improvement via three PH outcome measures: emergency department (ED) visits, readmissions, and end-stage renal disease.

In 2020, TennCare QI staff redesigned the PH program guidelines and reporting structure in a way that provides more actionable data to TennCare and more closely aligns with the NCQA PH Management standards. As a collaborative effort between all MCOs, the newly designed PH model includes the following advantages:

- Targeting all members' needs across the entire health care continuum, with all eligible populations being included;
- Providing both proactive and reactive interventions;
- Targeting interventions based on risk and lifestyle, not just disease;
- Addressing multiple risks and co-morbidities in a whole-person approach; and
- Addressing upstream causes of poor health (e.g., nutrition, physical inactivity, substance abuse, social determinants of health)

The redesigned PH model identifies/stratifies the entire TennCare population for each MCO into at least the following seven programs, most programs requiring specific minimum interventions:

- Wellness
- Low Risk Maternity
- Health Risk Management
- Care Coordination
- Chronic Care Management
- High Risk Maternity
- Complex Case Management

As part of the evaluation process, all MCOs annually report utilization, maternal health, and chronic/complex outcome metrics. They also report semi-annual PH program updates that detail updates to models of care, member engagement strategies, care management practices, as well as social determinants of health assessment and trends.

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, MCOs are required to complete a PIP in the area of EPSDT if its CMS-416 report rates were lower than 80%. All these specifications were met per CRA requirements in 2022.

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 2022.

Technical Methods of Data Collection and Analysis

ANA reviews include a desk audit of documents, administrative data analyses, and measure scoring. Portions of the ANA review are typically conducted onsite. However, in 2022 TennCare approved onsite reviews to be replaced by virtual reviews due to the COVID-19 pandemic. 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 the AQS technical papers at TennCare's request. Details on the ANA review process and results can be found in each MCC's *2022 Annual Network Adequacy Report*. ANA assessment tool templates can be found in Appendix B of this report.

Description of Data Obtained

The 2022 ANA measurement period was January 1 to December 31, 2021, 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 2022, 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. 2022 ANA Network Adequacy Scores: MCO Access/Availability

Measure	AG	BC	TCS	UHC
Primary Care Provider (PCP) Average	99.9%	>99.9%	>99.9%	>99.9%
Specialty Care Provider (SCP) Average	100%	100%	100%	100%
Behavioral Health (BH) Provider Average	100%	100%	100%	>99.9%
Opioid Use Disorder Treatment Providers	100%	100%	100%	100%
General Optometry and Hospitals Avg.	>99.9%	99.6%	99.6%	>99.9%
Special Programs Average	100%	100%	100%	100%
CHOICES HCBS Providers Average	100%	99.4%		>99.9%
ECF CHOICES Providers Average	100%	100%		100%
Overall Network Adequacy Score	**>99.9%**	**99.9%**	**99.9%**	**>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. 2022 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	>99.9%	
Orthodontic Services Distance	≤60 miles or ≤60 minutes	>99.9%	
Pediatric Dental Services Distance	≤70 miles or ≤70 minutes	>99.9%	
Dental Provider Distance (ECF CHOICES)[1]	Two: ≤30 miles or ≤45 min./ ≤60 or ≤60		99.9%[2]
Overall Network Adequacy Results: >99.9%			

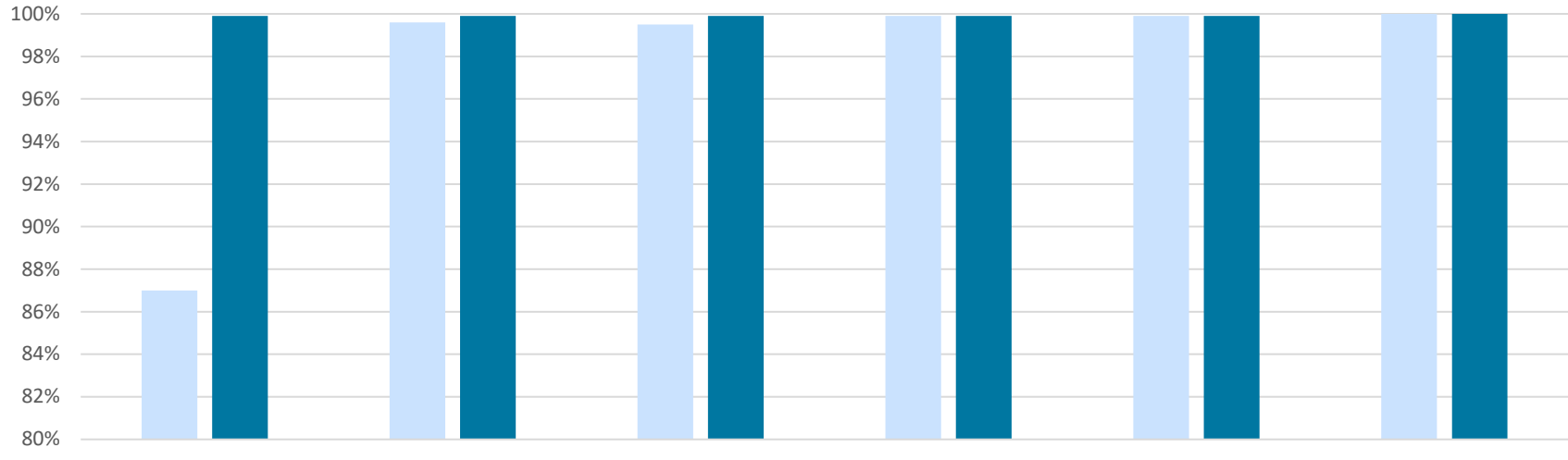
Note: Cells in gray are NA.
[1] The distance requirement is one provider within 30 miles travel distance or 45 minutes travel time for 75% of the members, and 60 miles travel distance or 60 minutes travel time for all ECF CHOICES members. The ECF CHOICES distance requirements were calculated using all ECF members selecting dental benefits.

[2] 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. 2022 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, the plans showed a slight increase in overall Network Adequacy scores in 2022. **AG**'s score increased from 87.0% to >99.9%. **BC**'s score increased from 99.6% to 99.9%. **TCS**'s score increased from 99.5% to 99.9%. **UHC**'s and **ORx**'s scores were high, yet static at >99.9% and 100%, respectively. (See **Figure 4**.)

Figure 4. 2021–2022 Overall Network Adequacy Scores



	AG	BC	TCS	UHC	DQ	ORx
2021	87.0%	99.6%	99.5%	>99.9%	>99.9%	100%
2022	>99.9%	99.9%	99.9%	>99.9%	>99.9%	100%

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 2022, ranging from 98.1% (**UHC** and **AG**) to 100% (**ORx**).

Table 8. 2022 ANA Benefit Delivery Scores: Plan Averages

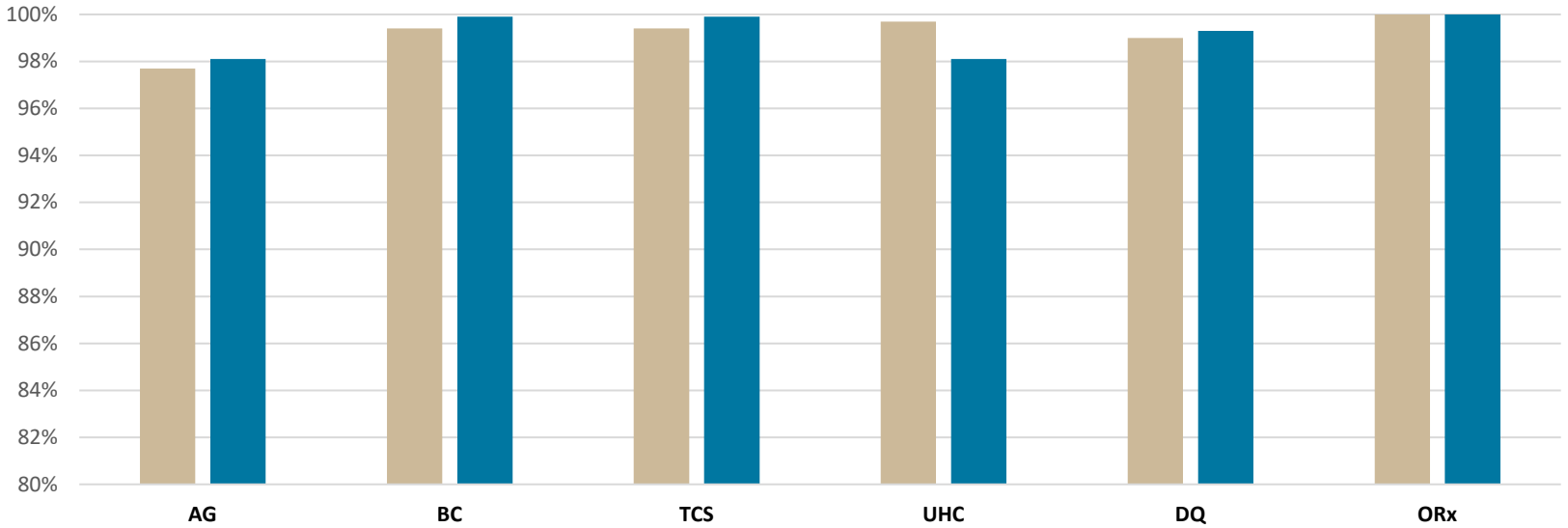
AG	BC	TCS	UHC	DQ	ORx[1]
Covered Benefits—Member Handbook					
100%	100%	100%	100%	100%	
Covered Benefits—Provider Manual					
98.6%	100%	100%	98.66%	100%	
Appointment Availability—Policies and Procedures					
100%	100%	100%	100%	100%	100%
Appointment Availability—Complaints					
99.9%	>99.9%	>99.9%	>99.9%	100%	100%
MCO Provider Contracts—Quantity					
95.0%	100%	100%	95.0%	100%	
MCO Provider Contracts—Quality					
95.0%	100%	100%	95.0%	95.7%	
Overall Benefit Delivery Results					
98.1%	**>99.9%**	**>99.9%**	**98.1%**	**99.3%**	**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%.

[1] *Gray-shaded cells indicate areas not assessed for the PBM.*

As shown in **Figure 5**, several plans raised their compliance percentages from 2021, with **BC** and **TCS** showing the most improvement (+0.5 percentage points) and **UHC** with the largest decline (-1.6 percentage points).

Figure 5. 2021–2022 Overall Benefit Delivery Scores



	AG	BC	TCS	UHC	DQ	ORx
2021	97.7%	99.4%	99.4%	99.7%	99.0%	100%
2022	98.1%	>99.9%	>99.9%	98.1%	99.3%	100%

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 2022 ANA review. All strengths and AONs for the ANA review are related to **Access** and **Timeliness** of care.

Table 9. 2022 ANA Review Strengths and AONs	
Amerigroup	
Strengths	
Benefit Delivery	**AG** developed the Updates to Your Benefits document, which was available to TennCare Medicaid members. The document included additional benefits and coverage information not included in the current **AG** Member Handbook as required by this element.
AONs	
Network Adequacy	**AG** achieved a score of 100% in 78 of 84 Network Adequacy measures. For performance improvement, **AG** should: ♦ ensure that female members older than 13 years of age have access to an OB/GYN within the TennCare required distance/time standards. ♦ ensure that all members have access to hospitals providers within the TennCare required distance/time standards. ♦ ensure that all members have access to general optometry providers within the TennCare required distance/time standards.
Benefit Delivery	For performance improvement in Benefit Delivery, **AG** should: ♦ inform providers about the CoverKids benefits for DME as described in the CRA.
File Review	**AG** presented 19 of the 20 files requested for the contract file review. One Specialty Care Provider's (SCP) contract could not be located. **AG** must ensure that it has executed a contract with every provider furnishing health care services to **AG** members.
BlueCare	
Strengths	
Benefit Delivery	Neither the **BC** Member Handbook nor the CoverKids Member Handbook addressed benefits and coverage for medically necessary second opinions; however, **BC** used the member newsletter to inform members about benefits and coverage related to second opinions. **BC** included additional information concerning required benefits and coverage not included in the current Member Handbooks on its member website. **BC** offered additional information to members related to benefits, coverage, and limitations for nursing facility care in the member newsletter.
AONs	
Network Adequacy	**BC** achieved a score of 100% in 76 of 84 Network Adequacy measures. For performance improvement, **BC** should: ♦ Availability and Accessibility of Primary Care Services: BC must ensure that female members older than 13 years of age have access to an OB/GYN provider within the distance/time standards. ♦ Availability and Accessibility of Specialty Services: **BC** must ensure that all members have access to providers within the distance/time standards for hospitals, ♦ ensure that CHOICES members have access to an adult day care provider within the distance/time standards

Table 9. 2022 ANA Review Strengths and AONs	
	♦ ensure that CHOICES members must have access to at least two inpatient respite care providers in each county ♦ ensure that CHOICES members must have access to at least two pest control providers in each county.
TennCare*Select*	
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 all members have access to providers within the distance/time standards for female members older than 13 years of age to ensure access to an OB/GYN provider. ♦ ensure that all members have access to providers within the distance/time standards for hospitals.
UnitedHealthcare	
Strengths	
Benefit Delivery	**UHC** developed a TennCare Medicaid Member Handbook Addendum, which listed required benefits and coverage information not included in the current **UHC** Member Handbook. The Member Handbook Addendum is available to all members on the **UHC** member website. New members are informed about the **UHC** Member Handbook and the Member Handbook Addendum upon enrollment.
AONs	
Network Adequacy	**UHC** achieved a score of achieved a score of 100% in 77 of 84 Network Adequacy measures. For performance improvement, **UHC** should: ♦ ensure that female members older than 13 years of age have access to an OB/GYN within the distance/time standards. ♦ ensure that all members have access to substance abuse outpatient treatment services within the TennCare required distance/time standards. ♦ ensure that all members have access to adult day care providers within the TennCare required distance/time standards.
Benefit Delivery	For performance improvement in Benefit Delivery, **UHC** should: ♦ ensure it informs providers about the limitations and restrictions for inpatient/residential and outpatient substance abuse benefits described in the CRA.
File Review	**UHC** presented 19 of the 20 files requested for the contract file review. The sample list for the provider file review included one PCP who was retroactively terminated in February 2022, with a termination date of October 2021. Because this provider was not an actively participating provider on **UHC**'s network as of November 2021, this provider was excluded from the review.

Table 9. 2022 ANA Review Strengths and AONs	
DentaQuest	
Strengths	
Benefit Delivery	**DQ** added benefits and coverage information related to the application of silver diamine fluoride to its member website. **DQ** developed a Member Dental Benefits document for TennCare Medicaid members, available on its website, which offered additional benefits information not included in the current Member Handbook.
AONs	
Network Adequacy	DQ achieved a score of >99.9% in the Dental Provider Distance for the ECF CHOICES members network adequacy evaluation area. Availability and Accessibility of Covered Services. For performance improvement, **DQ** should: ♦ ensure that all ECF CHOICES members have access to a dental provider within the distance/time standards. ♦ ensure that all members have access to oral surgery within the distance/time standards. ♦ ensure that all members have access to orthodontic services within the distance/time standards. ♦ ensure that all members have access to pediatric dental services within the distance/time standards.
File Review	**DQ** must ensure that all CoverKids provider contracts include the requirement to ensure 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.
OptumRx	

Qsource did not identify any strengths or AONs for ORx in the 2022 ANA review.

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 Health Plan Accreditation Standards and Guidelines for Credentialing*; and (3) additional state and federal regulations. The 2021 AQS was conducted from February through May 2022. 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 2022, 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 14—July 1, 2021 (**AG**, **BC**, and **UHC**)
- Statewide Contract with Amendment 50—July 1, 2021 (**TCS**)
- 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 to developing assessment tools and evaluating MCCs' planned improvements. AQS tools assess QP standards for MCC P&Ps and 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. 2022 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, DBM, and PBM: Availability of Services	42 CFR 438.228 Grievance and Appeal System	♦ MCO, DBM, and PBM: Grievance and Appeal Systems
42 CFR 438.207: Assurances of adequate capacity and services	♦ MCO, DBM, and PBM: Assurances of Adequate Capacity and Services	42 CFR 438.230: Subcontractual relationships and delegation	♦ MCO, DBM, and PBM: Subcontractual relationships and Delegation
42 CFR 438.208: Coordination and continuity of care	♦ MCO, DBM, and PBM: Coordination and Continuity of Care	42 CFR 438.236: Practice guidelines	♦ MCO, DBM, and PBM: Practice Guidelines
42 CFR 438.210: Coverage and authorization of services	♦ MCO, DBM, and PBM: Coverage and Authorization of Services	42 CFR 438.242: Health information systems	♦ MCO, DBM, and PBM: Health Information Systems
42 CFR 438.214: Provider selection	♦ MCO, DBM, and PBM: Availability of Services ♦ MCO, DBM, and PBM: Provider Selection	42 CFR 438.330 Quality assessment and performance improvement program	♦ MCO, DBM, and PBM: Quality Assessment and Performance Improvement (QAPI) Program
42 CFR 438.224: Confidentiality	♦ MCO, DBM, and PBM: Confidentiality		

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 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 *2022 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 *2022 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 2022 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. 2022 AQS Documentation Reviewed

All MCCs	MCOs only
♦ Member Handbooks in English and Spanish ♦ Provider Manual ♦ Quality Improvement Program (QIP) Description (QIPD) ♦ Provider and Member Newsletters ♦ Quarterly EPSDT reports ♦ Utilization Management (UM) Program Description (UMPD) ♦ UM Program Evaluation of 2020 Activities ♦ 2021 Population Health (PH) Satisfaction Surveys ♦ Policies that define the MCC's time standards for handling all denials, complaints, and appeals ♦ 2021 corrective action plans and related documentation, if applicable ♦ All additional policies, procedures, and other documentation needed to answer survey tool elements	♦ Complete National Committee for Quality Assurance (NCQA) Accreditation Report ♦ Provider and Member Satisfaction Surveys
DBM only	
♦ 2021 TennCare Kids Outreach Plan ♦ 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 ♦ PBM Web Address ♦ Quarterly Non-Discrimination Compliance Report	

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, PA file reviews, and CHOICES credentialing/recredentialing file reviews in 2022, including performance improvements in several categories. Updates to the 2022 QP standards and elements limit the ability to compare year to year results, however, only the EPSDT QP standard showed a decline in individual MCO compliance scores from 2021 to 2022. Compliance scores also fell from 100% for the quality rating of both the CHOICES Credentialing and Recredentialing file review.

Table 12. 2022 AQS Compliance: MCO QP Standard and Credentialing/Recredentialing Results

QP Standards	AG 2022	BC 2022	TCS 2022	UHC 2022
Availability of Services	100%	100%	100%	100%
Assurances of Adequate Capacity and Services	84.0%	100%	100%	100%
Coordination and Continuity of Care	91.0%	91.0%	91.0%	82.0%
Coverage and Authorization of Services	100%	100%	100%	100%
Provider Selection	100%	100%	100%	88.0%
Confidentiality	100%	100%	100%	100%
Grievance and Appeal Systems	98.3%	100%	100%	100%
Subcontractual Relationships and Delegation	100%	100%	100%	100%
Practice Guidelines	100%	100%	100%	100%
Health Information Systems	100%	100%	100%	100%
Quality Assessment and Performance Improvement (QAPI) Program	100%	100%	100%	100%
BESMART Program	100%	100%	100%	100%
EPSDT	100%	100%	100%	96.0%
Non-Discrimination Compliance	100%	100%	100%	100%
Credentialing/Recredentialing P&Ps	100%	100%	100%	100%

Table 12. 2022 AQS Compliance: MCO QP Standard and Credentialing/Recredentialing Results					
CHOICES Credentialing/Recredentialing File Reviews[1]					
CHOICES Credentialing Files[1]	Quantity[2]	100%	100%		100%
	Quality[2]	100%	100%		93.3%
CHOICES Recredentialing Files[1]	Quantity[2]	100%	100%		100%
	Quality[2]	100%	100%		80.3%

[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 statewide in **Table 13**. Once again, MCOs achieved 100% compliance with the majority of measures, falling short in four PAs: Appeals, for which **AG** achieved 92.5%; CHOICES Annual LOC Assessment, for which **BC** achieved 90.0%, and **UHC** achieved 95.0%; and Transition of CHOICES Members Between MCOs, for which **UHC** achieved 96.4%.

Table 13. 2021–2022 AQS Compliance: MCO PA File Review Results								
PAs	**AG**		**BC**		**TCS**		**UHC**	
	2021	**2022**	**2021**	**2022**	**2021**	**2022**	**2021**	**2022**
UM Denials (ages 20 and younger)	100%	**100%**	100%	**100%**	100%	**100%**	100%	**100%**
Complaints[1]		100%		100%		100%		100%
Appeals	97.5%	**92.5%**	100%	**100%**	100%	**100%**	94.9%	**100%**
EPSDT Information System Tracking	100%	**100%**	100%	**100%**	100%	**100%**	100%	**100%**
CHOICES Annual LOC Assessment[2]	95.0%	**100%**	100%	**90.0%**			95.0%	**95.0%**
Transition of CHOICES Members Between MCOs[3]	100%	**100%**	100%	**100%**			96.3%	**96.4%**

Scores in red indicate a decline for the 2022 review, while scores in green indicate increased or maintained scores compared to 2021. Cells in gray indicate that a measure was not assessed.
[1] *PA File Review first assessed in 2022.*
[2] *Not assessed in 2021-2022 for TCS due to its small number of CHOICES members.*
[3] *Not assessed in 2021-2022 for TCS due to its small number of CHOICES members.*

As shown in **Table 14,** DQ continued its high performance in the 2022 AQS. The DBM fell short of 100% compliance in four QP measures: Availability of Services (92.3%), Coordination and Continuity of Care (90.0%), Coverage and Authorization of Services (95.7%), and Credentialing/Recredentialing P&Ps (96.4%). The DBM had 100% compliance in all PA file reviews.

Table 14. 2022 AQS Compliance: DBM Results

QP Standards	2022	QP Standards	2022
Availability of Services	92.3%	Health Information Systems	100%
Assurances of Adequate Capacity and Services	100%	Quality Assessment and Performance Improvement (QAPI) Program	100%
Coordination and Continuity of Care	90.0%	EPSDT	100%
Coverage and Authorization of Services	95.7%	Non-Discrimination Compliance	100%
Provider Selection	100%	Credentialing/Recredentialing P&Ps	96.4%
Confidentiality	100%	**PA File Reviews**	**2022**
Grievance and Appeal Systems	100%	Appeals	100%
Subcontractual Relationships and Delegation	100%	Complaints	100%
Practice Guidelines	100%	UM Denials (ages 20 years and younger)	100%

Table 15 displays ORx's scores. The PBM earned 100% compliance for all QP standards except Availability of Services (80.0%), Assurances of Adequate Capacity and Services (0.0%), Coverage and Authorization of Services (81.8%), Grievance and Appeal Systems (91.2%), and QAPI Program (90.0%). *Note: File reviews are not required for the PBM.*

Table 15. 2022 AQS Compliance: PBM Results

QP Standards	2022	QP Standards	2022
Availability of Services	80.0%	Subcontractual Relationships and Delegation	100%
Assurances of Adequate Capacity and Services	0.0%	Practice Guidelines	100%
Coordination and Continuity of Care	100%	Health Information Systems	100%
Coverage and Authorization of Services	81.8%	Quality Assessment and Performance Improvement (QAPI) Program	90.0%
Provider Selection	100%	Non-Discrimination Compliance	100%
Confidentiality	100%	Credentialing/Recredentialing P&Ps	100%
Grievance and Appeal Systems	91.2%		

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 Medicated-Assisted Treatment (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 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. 2022 AQS Strengths and AONs

Amerigroup		
AONs		**Q/A/T**
Assurances of Adequate Capacity and Services	**Element #1—**Appropriate Range of Services and Providers: The MCO should ensure it maintains a sufficient provider network.	Q/A/T
Coordination and Continuity of Care	**Element #10—**Disenrollment by MCO Prohibited**:** The MCO should maintain a P&P that ensures that it does not request disenrollment for any member for any reason, and that it promptly informs TennCare if it believes that a member satisfies the conditions for termination, as described in TennCare rules and regulations.	Q/A/T
Grievance and Appeal Systems	**Element #24—**Requirements Following Extension: The MCO should ensure that it sends written notice to members within two calendar days of the decision to extend the timeframe, and informs them of their right to file a grievance if they disagree with the decision.	A
Appeals File Review	The MCO should ensure that members are notified timely regarding a resolution; this issue was noted in one file. The MCO should also ensure that the correct member letter templates are used; this issue was noted in two files.	A/T

No strengths were identified for AG in 2022.

Table 16. 2022 AQS Strengths and AONs		
BlueCare		
AONs		
Coordination and Continuity of Care	**Element #10—**Disenrollment by MCO Prohibited: The MCO should maintain a policy and procedure for ensuring that it does not request disenrollment for any member for any reason and that it promptly informs TennCare if it believes that a member satisfies the conditions for termination as described in TennCare rules and regulations.	Q/A/T
CHOICES Annual LOC	The MCO should ensure that reassessments are completed timely; this issue was noted in one file.	Q/T
No strengths were identified for BC in 2022.		
TennCare*Select*		
AONs		
Coordination and Continuity of Care	**Element #10—**Disenrollment by MCO Prohibited: The MCO should maintain a policy and procedure for ensuring that it does not request disenrollment for any member for any reason and that it promptly informs TennCare if it believes that a member satisfies the conditions for termination as described in TennCare rules and regulations.	Q/A/T
No strengths were identified for TCS in 2022.		
UnitedHealthcare		
AONs		
Provider Selection	**Element #4—**Provider Visits: The MCO should ensure that semiannual contacts are made with all contract providers.	Q
Coordination and Continuity of Care	**Element #9**—Direct Access to Specialists: The MCO should ensure that it has a mechanism in place that allows members with identified special healthcare needs direct access to a specialist to obtain a needed course of treatment or regular care monitoring, as appropriate for the member's condition.	Q/A/T
	Element #10—Disenrollment by MCO Prohibited: The MCO should maintain a P&P for ensuring that it does not request disenrollment for any member for any reason, and that it promptly informsTennCare if it believes that a member satisfies the conditions for termination as described in TennCare rules and regulations.	Q/A/T
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	**Element #7—**Prenatal Appointment Assistance: The MCO should ensure that pregnant women past their first trimester are offered individual assistance in making a first prenatal appointment that occurs within 15 calendar days of becoming eligible for coverage.	Q/A/T
	Element #12—Referral Providers List: The MCO should ensure that providers are aware of their right to request a hard copy of the referral providers list at least 30 calendar days prior to their start date of operations.	Q/A/T
CHOICES Credentialing File Review (Quality)	The MCO should ensure that provider Medicare/Medicaid participation is verified in CHOICES credentialing files.	Q
No strengths were identified for UHC in 2022.		

Table 16. 2022 AQS Strengths and AONs		
DentaQuest		
AONs		
Availability of Services	**Element #13—**Provider Directory Availability: The DBM should develop a Policy and Procedure that specifies how often the hardcopy and electronic versions of the Provider Directory are updated.	A/T
Coordination and Continuity of Care	**Element #9—**Disenrollment by DBM Prohibited: The DBM should have a P&P that states no member shall be disenrolled by the plan.	Q/A/T
Coverage and Authorization of Services	**Element #21—**Provider Termination: The DBM should ensure that member notification of provider departure or termination fully aligns with the CRA (which also includes 30 calendar days prior to the effective date of the termination).	A/T
Non-Discrimination Compliance	**Element #4—**Written P&P: The DBM should ensure that its helpline processes function to address the member's needs.	A
No strengths were identified for DQ in 2022.		
OptumRx		
AONs		
Availability of Services	**Element #3—**Out-of-Network Costs: The PBM should ensure that a policy or procedure is in place that documents how the coordination of payment for out-of-network services occur and that the cost is no greater than that for an in-network provider. **Element #10—**Provider Directory Availability: The PBM should develop a P&P that addresses updates to the Provider Directory and the required timeframes.	A/T
Assurances of Adequate Capacity and Services	**Element #1—**Appropriate Provider Network: The PBM should have a policy and procedure to detail when and how its provider network is maintained, in addition to its expected reporting to TennCare. **Element #2—**Timely Documentation: The PBM should have a policy and procedure to detail when and how its provider network is maintained, in addition to its expected reporting to TennCare.	Q/A/T
Coverage and Authorization of Services	**Element #4—**Processing Authorizations: The PBM should develop mechanisms to ensure consistent application of review criteria for authorization decisions. **Element #9—**Member Rights: The PBM should ensure that it guarantees member rights. The PBM should include them in a policy, on its website, in provider materials, and/or through other available mechanisms.	A/T

Table 16. 2022 AQS Strengths and AONs		
OptumRx		
Grievances and Appeals	**Element #14—**Reviewer Requirements: The PBM should maintain a policy which states that those who make decisions should neither be involved in any previous level of review or decision making, nor should they be a subordinate of any such individual. **Element #28—**Punitive Action Prohibited: The PBM should maintain a P&P against punitive action in response to a request for an expedited resolution. **Element #37—**Services Not Furnished During Pending Appeal: The PBM should develop a P&P that specifically states the actions done by the PBM if they reverse a decision to deny, limit, or delay services and the services were not furnished. **Element #38—**Services Furnished During Pending Appeal: The PBM should develop a P&P that specifically states that the PBM or TennCare will pay for services furnished during a pending appeal if the PBM or State Fair Hearing (SFH) officer reverse the decision to deny authorization of services.	A

No strengths were identified for ORx in 2022.

Improvements Since the 2021 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: **BC** and **TCS** were not required to submit a CAP for the 2021 AQS, and 2021 was the first year **ORx** was required to complete the AQS.*

Table 17. 2022 AQS: Improvements Since the 2021 AQS	
2021 AON	**Improvements**
Amerigroup	
Network: Contracting, Availability, Access, and Documentation: Element #10— Quarterly MAT Network Quality Metrics Reports: The MCO 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.	The MCO ensured that the correct process will be followed to provide quarterly MAT Network Quality Metrics Reports to all contracted MAT providers. The MCO worked with the Information Technology (IT) Data Management teams to ensure that files are dropped and received as expected. The MCO also implemented an additional step in which two staff members monitor report uploads. **These actions satisfy the 2021 CAP.**

Table 17. 2022 AQS: Improvements Since the 2021 AQS	
2021 AON	**Improvements**
Credentialing/Recredentialing P&Ps: Element #22, Unlicensed BH Providers: The MCO 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.	The MCO will revise the processes used to ensure oversight of unlicensed BH practitioners to meet the requirements of this AON. The MCO submitted the timeframe for completing the updates to its P&Ps and defined the corrective actions developed to ensure compliance with this element. **These actions satisfy the 2021 CAP.**
CHOICES Credentialing (Quantity): The MCO should ensure that the initial credentialing file sample includes only initial provider credentialing records.	The MCO identified the root cause of the error and is developing procedures to ensure that only initially credentialed providers are included in the initial credentialing file sample. The MCO is designing process revisions and reporting logic revisions to its automated systems to ensure compliance with the AON. The MCO included the timeframe and the employee responsible for implementing the activities. **These actions satisfy the 2021 CAP.**
UM Denials: The MCO should ensure that expedited requests are processed within 72 hours. The issue was noted in one file.	The MCO identified the root cause as a miscalculation of the timeframe, and the utilization management staff received a refresher training. The MCO updated its procedure to state that the Medical Director will be notified by email and by phone regarding urgent pre-service requests. Finally, the Utilization Management Manager will review the outcome of pre-service urgent requests using a denied authorization report. **These actions satisfy the 2021 CAP.**
Appeals: The MCO should ensure that member notifications are sent timely. The issue was noted in one AGW file. The MCO 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.	The MCO coached the staff on the importance of timeliness of member notifications, which included a policy review. The MCO's Grievances and Appeals Manager monitors the cases dashboard daily to meet the turnaround times. The Team Lead now reviews the letters to ensure usage of the correct template and information. **These actions satisfy the 2021 CAP.** The MCO 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. **These actions satisfy the 2021 CAP.**
CHOICES LOC Assessment: The MCO should ensure that the date of the LOC reassessment is documented in each member's file. The issue was noted in one file. The MCO should ensure that LOC assessment is conducted timely, and all documentation is appropriately retained.	The MCO updated CHOICES SOP: Level of Care Reassessment to indicate that the date of the LOC reassessment must be documented in the member file. The MCO further stated it would revise the LOC assessment tracking to ensure compliance. **These actions satisfy the 2021 CAP.** The MCO updated CHOICES SOP: Level of Care Reassessment to indicate that the date of the LOC reassessment must be documented in the member file. The MCO further stated it will revise the LOC assessment tracking to ensure compliance. **These actions satisfy the 2021 CAP.**
UnitedHealthcare	
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT): Element #2—Member Outreach Contacts: The MCO should ensure that all members	The MCO provided documentation confirming that the existing P&P HS PWE 01: TennCare Kids EPSDT aligned with the CRA requirement and created a new SOP HP_MH_001: Member Handbook. The MCO initiated the process of updating the Annual Member Mailer, which included information on how to access the Member Handbook on the website or by calling customer service. The MCO also

Table 17. 2022 AQS: Improvements Since the 2021 AQS	
2021 AON	**Improvements**
receive a separate reminder for the Member Handbook to achieve the specified six outreach attempts per year.	submitted the English version of the Member Handbook to TennCare and, upon approval, intends to translate it to Spanish, obtain approval, and proceed with the annual notification mailing. **These actions satisfy the 2021 CAP.**
Credentialing/Recredentialing P&Ps: Element #12—Delegated Credentialing Reporting: The MCO should ensure that all annual reviews for delegated entities are presented to the appropriate committee for review and approval.	The SOP submitted for this AON addressed the requirement to ensure that UHC presents annual reviews for delegated entities to the Provider Affairs Subcommittee (PAS) and that the PAS committee minutes reflect the review and approval of those annual reviews. UHC included the timeframe and the employees responsible to implement the Standard Operating Procedure (SOP). **These actions satisfy the 2021 CAP**.
CHOICES Credentialing (Quantity): The MCO should ensure that the initial credentialing file sample includes only initial provider credentialing records.	The revised processes, oversight, and monitoring procedures identified by UHC addressed the deficiency of ensuring that UHC submits only initial provider credentialing records for the initial credentialing file reviews. UHC included the timeframe and the employees responsible to implement the activities. **These actions satisfy the 2021 CAP**.
CHOICES Credentialing (Quality): The MCO should ensure that recredentialing provider records include a valid license or certification.	UHC implemented revised procedures with the NCC to ensure that out-of-state providers have a valid license or certification at the time of recredentialing. Retraining of staff members occurred, and the NCC incorporated a review of the AON in its quality audit program. UHC included the timeframe and the employees responsible to implement the activities. **These actions satisfy the 2021 CAP**.
UM Denials: The MCO should ensure that notifications about UM denial decisions are sent timely.	Since the noncompliant record was from January 2020, the MCO provided the same actions that were a part of last year's CAP, which was implemented by May 2020. **These actions satisfy the 2021 CAP.**
Appeals: The MCO 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.	Qsource confirmed that the MCO update was per TennCare's expectations. The updated language in the policy regarding member notification for expedited appeal cases meets the intent of the AON. **These actions satisfy the 2021 CAP.**
CHOICES Annual LOC Assessment: The MCO should ensure that the LOC reassessment is conducted timely.	The MCO noted that it would update the SCM tool that generated LOC reassessments and reinstate the internal review. The MCO further noted that it will also implement an ECF CHOICES oversight tool to monitor timely LOC reassessment dates. **These actions satisfy the 2021 CAP.**
Transition of CHOICES Members Between MCOs: The MCO should ensure that the face-to-face assessment for transitioning CHOICES members is conducted within 30 days.	The MCO updated the procedure to include the assignment of a secondary owner when the individual care coordinator is assigned to a case to trigger a manager response and monitoring, and ensure face-to-face assessments for CHOICES members are conducted within 30 days of the transition. **These actions satisfy the 2021 CAP.**

Table 17. 2022 AQS: Improvements Since the 2021 AQS	
2021 AON	**Improvements**
DentaQuest	
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.	The DBM indicated plans to distribute annual dental appointment notices to all members who did not receive dental services in the previous 12 months, beginning in January 2022 with completion in March 2022. As per TennCare's guidance, the DBM should consider sending the annual notices earlier in the contract year (May 1–April 30) to allow members who receive an annual notice sufficient time to see their dentist prior to the end of the contract year. The DBM could provide copies of the staff training, new process implemented, and meeting minutes referenced in the CAP. **This CAP satisfies the AON.**

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, information systems (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. Since 2021, the onsite visits have been replaced by virtual visits using online meeting software due to the COVID-19 pandemic.

Technical Methods of Data Collection and Analysis

For MCOs, the PMV process includes an assessment of 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:

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.

Virtual Reviews lasted up to 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

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 *2022 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 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 MY2021, TennCare MCOs were required to report a full set of HEDIS measures for NCQA-accreditation purposes, two of which were validated by Qsource in 2022—Adult Immunization Status (AIS-E), and Follow-Up Care for Children Prescribed ADHD Medication (ADD-E).

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 2021 & Measurement Year 2022 Volume 2: Technical Specifications for Health Plans* and other descriptions of the measure data obtained are presented in Table 18.

Table 18. 2022 PMV Audit Measures—MCOs			
Measure Name	**Measure Definitions**	**Measure Steward**	**Data Collection Method**
Adult Immunization Status (AIS-E)	The percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus, and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal.	NCQA	Administrative
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	The percentage of children newly prescribed attention deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. ♦ Initiation Phase ♦ Continuation and Maintenance (C&M) Phase	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 MY2021 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. HEDIS MY2021 PMV Measure Rates—MCOs			
	AG	**BC**	**UHC**
Electronic Clinical Data Systems			
Adult Immunization Status (AIS-E)			
Influenza	7.61%	10.73%	12.73%
Td or Tdap	20.79%	39.79%	29.54%
Zoster	0.48%	0.9%	3.06%
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)			
Initiation Phase	38.94%	40.96%	42.18%
Continuation and Maintenance (C&M) Phase	52.13%	53.34%	57.56%

Note: BC results include the statewide TCS.

Findings and Conclusions—MCOs

All MCOs passed the 2022 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 MY2021 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 2021 and 2022 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 2022 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, 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 MY 2021, 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. HEDIS MY2021 PMV Audit Measures—PBM			
Measure Name	**Measure Definitions**	**Measure Steward**	**Data Collection Method**
Concurrent Use of Opioids and Benzodiazepines (COB-AD)	Percentage of beneficiaries ages 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 ♦ Methadone ♦ Long-acting, injectable naltrexone	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. Qsource noted several strengths exhibited during the 2022 PMV. **ORx** was well prepared for the review, as evidenced both by ISCAT and the PBM's subject-matter experts for each of the areas contributing to PM data reporting. Additionally, it dedicated key leadership and resources to the TennCare contract, had a high level of engagement to the Medicaid program, and showed particular strengths with RxTrack, its integrated data warehouse system.

Table 21 displays the PBM's actual reported measure rates for the two audited measures, COB-AD and OUD-AD.

Table 21. HEDIS MY2021 PMV Measure Rates—PBM	
Measure	**Rate (%)**
Concurrent Use of Opioids and Benzodiazepines-AD: 18-64 years*	10.99%
Use of Pharmacotherapy for Opioid Use Disorder-AD: 18-64 years	
Buprenorphine	86.61%
Oral naltrexone	3.12%
Long-acting, injectable naltrexone	7.20%
Methadone	0.04%
Total	**93.09%**

** 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 and CoverKids members combined was 975,273 in MY2021. This represents a 6.23% growth compared to the combined member totals for MY2020 of 913,800. 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 2022 PIP validation, 28 PIPs (24 unique topics) were conducted by four MCOs, 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 2022.

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 2022 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 *2022 PIP Validation Technical Papers* as well as the *2022 PIP Validation Summary Report*.

Comparative Findings

TennCare plans achieved a Met validation status for all PIPs submitted in 2022. Of the 28 PIPs validated, 22 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]; Remeasurement 5 [R5]) and classification as clinical (C) or non-clinical (NC).

Table 23. 2022 PIP Validation Results

PIP Study Title	PIP Year	C/NC	Element Scores		Overall PIP Validation Status
			# Met/ Assessed	%	
Amerigroup					
Improve Childhood Immunization Status (CIS) Combination 10 Rates—East, Middle, and West Regions	R1	C	46/47	97.87%	**Met**
Increase Eye Exam Screening Rates for Members with Diabetes	R1	NC	51/51	100%	**Met**
Increase Statewide the % of Members with Documented LTSS Reassessment and Care Plan Update, Including Nine Core Elements, within 30 Days of Inpatient Discharge	B	NC	30/32	93.75%	**Met**
Increase Well Child Visit (WCV) HEDIS Rate in West TN Region	B	C	29/29	100%	**Met**
Improve East Grand Region Member Satisfaction with the Health Plan	R2	NC	51/51	100%	**Met**
Improving Diabetic Screening Compliance for Members with Schizophrenia or Bipolar Disorder Using Antipsychotic Medication (SSD)	R2	C	46/46	100%	**Met**
BlueCare					
Long-Term Services and Supports Reassessment/Care Plan Update After Inpatient Discharge (RAC)	B	NC	28/28	100%	**Met**
Improving Antidepressant Medication Management (AMM)	R2	C	46/46	100%	**Met**
Decrease the Use of Opioids in High Dosages (HDO)	R2	NC	46/46	100%	**Met**
Social Determinants of Health Data Collection Process	R2	NC	46/46	100%	**Met**
Improving Childhood and Adolescent Immunization Rates (CIS/IMA)	R2	C	46/46	100%	**Met**
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	R5	NC	44/44	100%	**Met**
TennCare*Select*					
Improving Comprehensive Diabetes Care (Blood Pressure Control for SelectCommunity)	R2	NC	47/47	100%	**Met**
Decreasing Plan All-Cause Readmissions	R2	NC	46/47	97.87%	**Met**
*Follow-Up after Hospitalization for Mental Illness—7 Day—TennCare*Select	R3	C	47/47	100%	**Met**
Social Determinants of Health Data Collection Process	R3	NC	44/45	97.78%	**Met**
Improving Childhood and Adolescents Immunization Rates (CIS/IMA)	R2	C	47/47	100%	**Met**
Improving Early Periodic Screening Diagnosis & Treatment (EPSDT) – BlueCareTennCareSelect	R5	NC	43/43	100%	**Met**
UnitedHealthcare					
Increasing the Screening Rates of Child and Adolescent Well-Care Visits (WCV)	R1	C	46/46	100%	**Met**
Increasing the Physical Health Provider Satisfaction Survey Engagement Rate	R2	NC	47/47	100%	**Met**

Table 23. 2022 PIP Validation Results					
PIP Study Title	PIP Year	C/NC	Element Scores		Overall PIP Validation Status
			# Met/ Assessed	%	
Care Coordination	R3	NC	48/48	100%	**Met**
Impact of Member and Provider Outreach on Immunization Rates for CIS Combo 10	R3	C	49/49	100%	**Met**
UnitedHealthcare Long Term Services and Supports (LTSS) HEDIS Process Improvement for Reassessment and Care Plan Updates Within 30 days After Inpatient Discharge for LTSS Eligible Populations	B	NC	30/32	93.75%	**Met**
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	R2	C	47/47	100%	**Met**
DentaQuest					
Increasing Provider Use of Silver Diamine Fluoride (SDF) as a Preventive Measure	R4	C	47/47	100%	**Met**
Decreasing TennCare Enrollees Receiving Opioid Prescriptions	R4	NC	43/43	100%	**Met**
OptumRx					
Schizophrenia Medication Compliance Improvement Plan	B	C	26/26	100%	**Met**
Usage of Diagnosis Code Override by Providers for Preferred Atypical Antipsychotics	R1	NC	34/44	77.27%	**Met**

Conclusions

Strengths and Weaknesses

To help improve PIP performance, Qsource identified strengths and/or AONs (weaknesses) in 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. 2022 PIP Validation Strengths and AONs		
Amerigroup		
Q/A/T	**Strengths**	
Q/A	*Increase Well Child Visit (WCV) HEDIS Rate in West TN Region*	**Step 6:** The MCO provided a thorough and detailed analysis of its data collection process for ensuring the validity and reliability of its internal data for this performance project.
	AONs	
Q/A/T	*Improve Childhood Immunization Status (CIS) Combination 10 Rates*	**Step 7: Element 4—**The MCO should specifically identify any factors that may influence comparability of initial Baseline Year and repeat measurement, specific to each region for the Baseline Year to Remeasurement Year 1 or state that no factors affected the ability to make the comparison.
Q/A	*Increase Statewide the % of Members with Documented LTSS Reassessment and Care Plan Update, Including Nine Core Elements, within 30 Days of Inpatient Discharge*	**Step 5: Element 5—**The MCO should clearly state how the performance measure addresses performance at a point in time and tracks performance over time. The MCO should include a second performance measure as specified by HEDIS Technical Specifications (LTSS-RAC Reassessment). **Step 6: Element 4—**The MCO should clearly specify the data elements to be collected for each performance measure.
BlueCare		
	Strengths	
Q	*Decrease the Use of Opioids in High Dosages (HDO)*	**Step 1**: The MCO addressed each element of this step in comprehensive detail.
Q	*Social Determinants of Health Data Collection Process*	**Step 1:** The MCO included an exceptionally detailed analysis of and justification for the PIP topic. **Step 5:** The MCO conducted an extensive literature review on the PIP topic and data collection.
No AONs were identified for any BC PIPs in 2022.		
TennCare*Select*		
	Strengths	
Q/T	*Decreasing Plan All-Cause Readmissions*	**Step 1:** The MCO included an exceptionally thorough analysis of how the PIP topic is relevant to TennCare member needs, care, and services.
Q	*Social Determinants of Health Data Collection Process*	**Step 1:** The MCO included an exceptionally detailed analysis of and justification for the PIP topic. **Step 5:** The MCO conducted an extensive literature review on the PIP topic and data collection.
	AONs	
Q	*Decreasing Plan All-Cause Readmissions*	**Step 8: Element 2—**The MCO should ensure that the barrier analysis aligns with the improvement strategies selected.
Q	*Social Determinants of Health Data Collection Process*	**Step 8: Element 5—**The MCO should address how improvement strategies were designed/modified to account for major confounding variables that could impact PIP outcomes.

Table 24. 2022 PIP Validation Strengths and AONs		
UnitedHealthcare		
AONs		
Q/A/T	*UnitedHealthcare Long Term Services and Supports (LTSS) HEDIS Process Improvement for Reassessment and Care Plan Updates Within 30 days After Inpatient Discharge for LTSS Eligible Populations*	**Step 2: Element 1—**The MCO should ensure that the PIP improvement strategy is clear and easily interpreted. **Step 2: Element 3—**The MCO's aim statement should specify the PIP time period, such as "over each remeasurement period." The PIP aim statement should also make clear that the reassessment and reassessment with care plan update include the nine core elements for each.
No strengths were identified for any UHC PIPs in 2022.		
DentaQuest		
No strengths or AONs were identified for any DQ PIPs in 2022.		
OptumRx		
AONs		
Q/A/T	*Usage of Diagnosis Code Override by Providers for Preferred Atypical Antipsychotics*	**Step 1: Element 4**—The PBM should explicitly state how the PIP topic addresses a special population and/or high priority services. **Step 5: Element 5**—The PBM should address how the performance measure informs the selection and evaluation of quality improvement strategies. **Step 7: Elements 1 & 3–5**—The PBM should address the elements which had no information provided. **Step 8: Element 1—**The PBM should describe how the improvement strategies are evidence-based. **Step 8: Element 2—**The PBM should address any causes or barriers identified through data analysis and quality improvement processes. **Step 8: Element 3—**The PBM should document the implementation of the interventions for each step in the PDSA process. **Step 8: Element 5—**The PBM should include documentation identifying how the improvement strategy accounts for variables that could make an impact on outcomes. **Step 8: Element 6—**The PBM should include a detailed discussion of the success of the interventions and any follow-up activities identified.
No strengths were identified for ORx PIPs in 2022.		

Improvements Since the 2021 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. 2022 PIP Validation: Improvements Since the 2021 PIP Validation

PIP Topic	2021 AON	2022 Improvements
Improve Childhood Immunization Status (CIS) Combination 10 Rates—East, Middle, and West Regions	**Step 2: Element 3—AG** should ensure that the aim statement clearly specifies the PIP time period. **Step 5: Element 1(a)—AG** should correctly define the variable according to HEDIS Technical Specifications	**AG** added the phrase "over each measurement year" to the aim statement to clearly specify the PIP time period, and provided a copy of the updated PIP Summary Form. **The CAP satisfied the 2021 AON.** **AG** revised the variable to ensure alignment with HEDIS Technical Specifications and provided a copy of the updated PIP Summary Form. **The CAP satisfied the 2021 AON.**
Increase Percentage of CHOICES Members Who Had LTSS Assessment with Nine Core Elements	**Step 2: Element 3—AG** should ensure that the aim statement clearly specifies the PIP time period.	The CAP response and an updated PIP Summary Form reflected the revised aim statement that specified the PIP time period as "over each measurement year." **The CAP satisfied the 2021 AON**.
Improve East Grand Region Member Satisfaction with the Health Plan	**Step 2: Element 3—AG** should ensure that the aim statement clearly specifies the PIP time period.	**AG** submitted the revised PIP Summary form and added the missing information to the aim statement. **The CAP satisfied the 2021 AON**.
Improve Diabetic Screening Compliance for Members with Schizophrenia or Bipolar Disorder using Antipsychotic Medication	**Step 2: Element 3—AG** should clearly specify the time period being measured in the PIP aim statement.	**AG** submitted the revised PIP Summary form and added the missing information to the aim statement. **The CAP satisfied the 2021 AON.**

Table 25. 2022 PIP Validation: Improvements Since the 2021 PIP Validation		
PIP Topic	**2021 AON**	**2022 Improvements**
Improving Childhood and Adolescent Immunization Rates (CIS/IMA)	**Step 7: Element 4-5—BC** 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, Element 1—BC** should identify the change made to the numerator calculations for CIS Combination 10 as it pertains to "before exclusions" or "after exclusions."	**BC** provided documentation showing corrections to this PIP that addressed comparability of results and validity of findings, as well as actions taken to improve internal processes to avoid these errors in future submissions. The attendee lists and discussion topics from two meeting dates were provided. For future remeasurement calculations "before exclusions," **BC** will need to provide calculations showing no statistical difference to the current baseline rate calculated "after exclusions" or recalculate the baseline rate "before exclusions." **The CAP satisfied the 2021 AON.** **BC** provided documentation showing corrections to this PIP that addressed comparability of results, as well as actions taken to improve internal processes to avoid these errors in future submissions. The attendee lists and discussion topics from two meeting dates were provided. **The CAP satisfied the 2021 AON.**
Improving Early Periodic Screening Diagnosis and Treatment (EPSDT)	**Step 2, Element 2—BC** should ensure that the PIP population is specified in the PIP aim statement.	**BC** addressed the CAP through actions that focused on staff training and procedural updates. **BC** also indicated that it would explore consultation with the statistical analysis department, or other department as applicable, of a local university to assist the Clinical Strategy & Evaluation Team with PIP review and internal validation. **The CAP satisfied the 2021 AON.**
Decrease the Use of Opioids at High Dosage (HDO)	**Step 2, Element 1—BC** should, at a minimum, identify the focus of the targeted interventions (e.g., providers or members) in the PIP aim statement.	**BC** provided its PIP internal validation tool, updated PIP procedure, PIP summary form with a revised aim statement, and documentation to support staff training. **BC** also indicated that it would explore consultation with the statistical analysis department, or other department as applicable, of a local university to assist the Clinical Strategy & Evaluation Team with PIP review and internal validation. **The CAP satisfied the 2021 AON.**

Table 25. 2022 PIP Validation: Improvements Since the 2021 PIP Validation

PIP Topic	2021 AON	2022 Improvements
LTSS Shared Care Plan with Primary Care Practitioner (LTSS-SCP)	**Step 1, Element 3—BC** 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, Element 1—BC** should, at a minimum, identify the focus of the targeted interventions (e.g., providers or members) in the PIP aim statement.	**BC**'s action plan addressed convening a Clinical Advisory Panel meeting to seek provider input on PIP topics. Other actions focused revisions to the PIP internal validation tool, updates to the PIP procedure document (Development and Submission of Performance Improvement Project Procedure Reference # QI.SGMM.104B), and staff education to ensure that input from members and/or providers was considered when devising the PIP topic or that an explanation was provided when this was not possible. **BC** indicated that based on TennCare direction and the CRA requirement, this PIP study topic would not be utilized for the 2022 PIP submission. **The CAP satisfied the 2021 AON.** **BC**'s corrective actions focused on staff training, revisions to the PIP internal validation tool (which was used to ensure all components of the PIP were addressed), updates to the PIP procedure document (Development and Submission of Performance Improvement Project Procedure Reference # QI.SGMM.104B), and submission of the updated PIP Summary Form aim statement that specified member-, provider-, and or data-targeted interventions as the general improvement strategy focus. **BC** also indicated that it would explore consultation with the statistical analysis department, or other department as applicable, of a local university to assist the Clinical Strategy & Evaluation Team with PIP review and internal validation. **The CAP satisfied the 2021 AON.**
Improving Comprehensive Diabetes Care (Blood Pressure Control for SelectCommunity)	**Step 2, Element 1—TCS** should provide the general focus of the improvement strategies used in the PIP. **Step 6, Element 6—TCS** should ensure that the PIP design allows for consistent data collection over PIP time periods and adjust goal accordingly. **Step 7, Elements 4-5—TCS** should address the break in trending identified by NCQA for the Comprehensive Diabetes Care (CDC) measure between MY2019 and MY2020, its influence on comparability of Baseline to Remeasurement 1 findings, and its threat to validity. **Step 9, Elements 1, 3, and 4—**When assessing for real improvement, **TCS** should acknowledge that there was a change in methodology between measurement years. Due to this change, **TCS** should not attribute the reported improvement in performance or the statistical evidence of observed improvement to the improvement strategies.	**TCS** provided a revised PIP Summary Form with the corrected PIP Aim Statement, as well as documentation from the training meeting showing attendees and topics covered. **The CAP satisfied the 2021 AON.** **TCS** provided a revised PIP Summary Form that included a discussion regarding the break in trending, recalculated goal rate, and plans for future remeasurements, as well as a documentation from the training session showing topics covered and attendees. **The CAP satisfied the 2021 AON.** **TCS** provided a revised PIP Summary Form addressing the impact of the break in trending on validity and comparability of results, as well as a documentation from the training session showing topics covered and attendees. **The CAP satisfied the 2021 AON.** **TCS** provided a PIP Summary Form with revisions addressing the impact of the change in methodology on interpreting results, as well as a documentation from the training session showing topics covered and attendees. **The CAP satisfied the 2021 AON.**

Table 25. 2022 PIP Validation: Improvements Since the 2021 PIP Validation		
PIP Topic	**2021 AON**	**2022 Improvements**
Decreasing Plan All-Cause Readmissions (PCR)	**Step 2, Element 1—TCS** should provide the focus of targeted interventions (e.g., providers, members).	**TCS** provided its PIP internal validation tool, updated PIP procedure, PIP summary form with a revised aim statement, and documentation to support staff training. **TCS** also indicated that it would explore consultation with the statistical analysis department, or other department as applicable, of a local university to assist the Clinical Strategy & Evaluation Team with PIP review and internal validation. **The CAP satisfied the 2021 AON.**
Impact of Member and Provider Outreach on Immunization Rates for CIS Combo 10	**Step 6, Element 4—UHC** should ensure the accuracy of the data source and data elements collected.	**UHC** initial data collection plan specified an inaccurate data element for the PIP and indicated that this occurrence was the result of the same staff working simultaneously on two different PIPs. Training was scheduled to address PIP form completion and the importance of separating work streams for individual PIP form completion activities. An updated PIP Summary Form included a revision that specified hybrid review of administrative and medical record data for the CIS Combo 10 HEDIS® measure, according to the HEDIS® Technical Specifications. **The CAP satisfied the 2021 AON.**

For the 2022 PIP validation, TennCare required MCCs to submit a CAP for any AONs via a similar evaluation and monitoring process to the AQS CAP process. Six PIP topics received an AON and required CAPs in 2022; the results of these CAP evaluations will be reported next year.

Summary and Conclusions

The results of 2022 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 2022 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 measurement 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. 2022 Results, Recommendations, and Strengths by Plan

Amerigroup			
Results	**A/T**	**ANA Review**	**AG** earned an overall Network Adequacy score of >99.9% and an overall Benefit Delivery score of 98.1%.
	Q/A/T	**AQS**	**AG** earned 100% compliance with all QP standards except Assurance of Adequate Capacity and Services (84.0%), Coordination and Continuity of Care (91.0%), and Grievance and Appeal Systems (98.3%). **AG** earned 100% in all Credentialing and Recredentialing File Reviews. AG earned 100% in all PA file reviews except Appeals, for which it earned 92.5%.
	Q	**PMV**	**AG** passed the 2022 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**	**AG** earned a Met validation status for all submitted PIPs, earning a 100% element score in four of six PIPs.
Recommendations	**A/T**	**ANA Review**	**Network Adequacy**: **AG** must ensure that female members older than 13 years of age have access to an OB/GYN within the TennCare required distance/time standards; **AG** must ensure that all members have access to hospitals providers within the TennCare required distance/time standards; **AG** must ensure that all members have access to general optometry providers within the TennCare required distance/time standards; **Benefit Delivery: AG** must inform providers about the CoverKids benefits for DME as described in the CRA. **File Review: AG** presented 19 of the 20 files requested for the contract file review. One SCP's contract could not be located. **AG** must ensure that it has executed a contract with every provider furnishing health care services to **AG** members.

Table 26. 2022 Results, Recommendations, and Strengths by Plan			
	Q/A/T	**AQS**	**AG** should ensure that it maintains a sufficient provider network; **AG** should maintain a P&P that ensures that it does not request disenrollment for any member for any reason, and that it promptly informs TennCare if it believes that a member satisfies the conditions for termination, as described in TennCare rules and regulations; **AG** should ensure that it sends written notice to members within two calendar days of the decision to extend the timeframe, and informs them of their right to file a grievance if they disagree with the decision; **AG** should ensure that members are notified timely regarding a resolution; this issue was noted in one file. **AG** should also ensure that the correct member letter templates are used.
	Q	**PMV**	No deficiencies or recommendations for improvement were identified.
	Q	**PIP Validation**	**AG** should specifically identify any factors that may influence comparability of initial Baseline Year and repeat measurement, specific to each region for the Baseline Year to Remeasurement Year 1 or state that no factors affected the ability to make the comparison in the *Improve Childhood Immunization Status (CIS) Combination 10 Rates—East, Middle, and West Regions* PIP. The MCO should clearly state how the performance measure addresses performance at a point in time and tracks performance over time. **AG** should include a second performance measure as specified by HEDIS Technical Specifications (LTSS-RAC Reassessment), and clearly specify the data elements to be collected for each performance measure in the *Increase Statewide the % of Members with Documented LTSS Reassessment and Care Plan Update, Including Nine Core Elements, within 30 Days of Inpatient Discharge* PIP.
Strengths & Improvements	**A/T**	**ANA Review**	**AG** was commended for developing the Updates to Your Benefits document, which was available to TennCare Medicaid members. The document included additional benefits and coverage information not included in the current **AG** Member Handbook as required by this element.
	Q/A/T	**AQS**	No particular strengths were identified. Since the 2021 AQS, **AG** revised the processes used to ensure oversight of unlicensed BH practitioners to meet the requirements of this AON. **AG** submitted the timeframe for completing the updates to its P&Ps and defined the corrective actions developed to ensure compliance; **AG** identified the root cause of errors and developed procedures to ensure that only initially credentialed providers are included in the initial credentialing file sample; **AG** designed process revisions and reporting logic revisions to its automated systems to ensure compliance; **AG** included the timeframe and the employee responsible for implementing the activities; **AG** identified the root cause as a miscalculation of the timeframe, and the utilization management staff received a refresher training; **AG** updated its procedure to state that the Medical Director will be notified by email and by phone regarding urgent pre-service requests. Finally, the Utilization Management Manager will review the outcome of pre-service urgent requests using a denied authorization report; **AG** coached the staff on the importance of timeliness of member notifications, which included a policy review. **AG**'s Grievances and Appeals Manager monitors the cases dashboard daily to meet the turnaround times. The Team Lead now reviews the letters to ensure usage of the correct template and information; **AG** 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; **AG** updated CHOICES SOP: Level of Care Reassessment to indicate that the date of the LOC reassessment must be documented in the member file. **AG** further stated it would revise the LOC assessment tracking to ensure compliance; and finally, **AG** updated CHOICES SOP: Level of Care Reassessment to indicate that the date of the LOC reassessment must be documented in the member file. **AG** further stated it will revise the LOC assessment tracking to ensure compliance.
	Q	**PMV**	No particular strengths or improvements were identified.
	Q	**PIP Validation**	**AG** was lauded for providing a thorough and detailed analysis of its data collection process for ensuring the validity and reliability of its internal data for this performance project in the *Increase Well Child Visit (WCV) HEDIS Rate in West TN Region* PIP. **AG** added the phrase "over each measurement year" to the aim statement to clearly specify the PIP time period, and provided a copy of the updated PIP Summary Form to address the AON in the *Improve Childhood Immunization Status (CIS) Combination 10 Rates—East, Middle, and West Regions* PIP; **AG** revised the variable to ensure alignment with HEDIS Technical Specifications and provided a copy of the updated PIP Summary Form to address the AON in the PIP**;** The CAP

Table 26. 2022 Results, Recommendations, and Strengths by Plan			
			response and an updated PIP Summary Form reflected the revised aim statement that specified the PIP time period as "over each measurement year." **The CAP satisfied the 2021 AON**. *Increase Percentage of CHOICES Members Who Had LTSS Assessment with Nine Core Elements* **AG** submitted the revised PIP Summary form and added the missing information to the aim statement to address the AON in the *Improve East Grand Region Member Satisfaction with the Health Plan* PIP; **AG** submitted the revised PIP Summary form and added the missing information to the aim statement to address the AON in the *Improve Diabetic Screening Compliance for Members with Schizophrenia or Bipolar Disorder using Antipsychotic Medication* PIP.
BlueCare			
Results	**A/T**	**ANA Review**	**BC** earned an overall Network Adequacy score of >99.9% and an overall Benefit Delivery score of >99.9%.
	Q/A/T	**AQS**	**BC** achieved 100% compliance with all QP standards except Coordination and Continuity of Care, for which it earned 91.0%. BC earned 100% compliance with all Credentialing and Recredentialing file reviews. BC earned 100% compliance for all PA file reviews except CHOICES Annual LOC Assessment, for which it earned 90.0%.
	Q	**PMV**	**BC** passed the 2022 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**	BC earned a Met validation status for all submitted PIPs, earning a 100% element score in six of six PIPs.
Recommendations	**A/T**	**ANA Review**	**Network Adequacy**: **BC** must ensure that female members older than 13 years of age have access to an OB/GYN provider within the distance/time standards; **BC** must ensure that all members have access to providers within the distance/time standards for hospitals; **BC** must ensure that CHOICES members have access to an adult day care provider within the distance/time standards; **BC** must ensure that CHOICES members must have access to at least two inpatient respite care providers in each county; **BC** must ensure that CHOICES members must have access to at least two pest control providers in each county.
	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**	No AONs or recommendations for improvement were identified.
Strengths & Improvements	**A/T**	**ANA Review**	**BC** was commended for using the member newsletter to inform members about benefits and coverage related to second opinions; including additional information concerning required benefits and coverage not included in the current Member Handbooks on its member website; and offering additional information to members related to benefits, coverage, and limitations for nursing facility care in the member newsletter.
	Q/A/T	**AQS**	No particular strengths or improvements were identified.
	Q	**PMV**	No particular strengths or improvements were identified.
	Q	**PIP Validation**	**BC** addressed each element of Step 1 in comprehensive detail in the *Decrease the Use of Opioids at High Dosage (HDO)* PIP. **BC** The MCO included an exceptionally detailed analysis of and justification for the PIP topic, in addition to conducting. The MCO conducted an extensive literature review on the PIP topic and data collection in the *Social Determinants of Health Data Collection Process* PIP. Since the 2021 PIP Validation, **BC** provided documentation showing corrections to this PIP that addressed comparability of results and validity of findings, as well as actions taken to improve internal processes to avoid these errors in future submissions. The attendee lists and discussion topics from two meeting dates were provided. For future remeasurement

Table 26. 2022 Results, Recommendations, and Strengths by Plan			
			calculations "before exclusions," **BC** will need to provide calculations showing no statistical difference to the current baseline rate calculated "after exclusions" or recalculate the baseline rate "before exclusions" to address the AON in the *Improving Childhood and Adolescent Immunization Rates (CIS/IMA)* PIP; **BC** provided documentation showing corrections to this PIP that addressed comparability of results, as well as actions taken to improve internal processes to avoid these errors in future submissions. The attendee lists and discussion topics from two meeting dates were provided to address the AON in the *Improving Childhood and Adolescent Immunization Rates (CIS/IMA)* PIP; **BC** addressed the CAP through actions that focused on staff training and procedural updates. **BC** also indicated that it would explore consultation with the statistical analysis department, or other department as applicable, of a local university to assist the Clinical Strategy & Evaluation Team with PIP review and internal validation to address the AON in the *Improving Early Periodic Screening Diagnosis and Treatment (EPSDT)* PIP; **BC** provided its PIP internal validation tool, updated PIP procedure, PIP summary form with a revised aim statement, and documentation to support staff training. **BC** also indicated that it would explore consultation with the statistical analysis department, or other department as applicable, of a local university to assist the Clinical Strategy & Evaluation Team with PIP review and internal validation to address the AON in the *Decrease the Use of Opioids at High Dosage (HDO)* PIP; **BC**'s action plan addressed convening a Clinical Advisory Panel meeting to seek provider input on PIP topics. Other actions focused revisions to the PIP internal validation tool, updates to the PIP procedure document (Development and Submission of Performance Improvement Project Procedure Reference # QI.SGMM.104B), and staff education to ensure that input from members and/or providers was considered when devising the PIP topic or that an explanation was provided when this was not possible. **BC** indicated that based on TennCare direction and the CRA requirement, this PIP study topic would not be utilized for the 2022 PIP submission to address the AON in the *LTSS Shared Care Plan with Primary Care Practitioner (LTSS-SCP)* PIP; and finally, **BC**'s corrective actions focused on staff training, revisions to the PIP internal validation tool (which was used to ensure all components of the PIP were addressed), updates to the PIP procedure document (Development and Submission of Performance Improvement Project Procedure Reference # QI.SGMM.104B), and submission of the updated PIP Summary Form aim statement that specified member-, provider-, and or data-targeted interventions as the general improvement strategy focus. **BC** also indicated that it would explore consultation with the statistical analysis department, or other department as applicable, of a local university to assist the Clinical Strategy & Evaluation Team with PIP review and internal validation to address the AON in the *LTSS Shared Care Plan with Primary Care Practitioner (LTSS-SCP)* PIP.
TennCare*Select*			
Results	**A/T**	**ANA Review**	**TCS** earned an overall Network Adequacy score of 99.9% and an overall Benefit Delivery score of >99.9%.
	Q/A/T	**AQS**	**TCS** achieved 100% compliance with all QP standards except Coordination and Continuity of Care, for which it earned 91.0%. TCS earned 100% compliance with all Credentialing and Recredentialing file reviews. TCS earned 100% compliance for all applicable PA file reviews.
	Q	**PMV**	**TCS** (reported with **BC** results) passed the 2022 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** earned a Met validation status for all submitted PIPs, earning a 100% element score in four of six PIPs.
Recommendations	**A/T**	**ANA Review**	**Network Adequacy**: **TCS** should ensure that all members have access to providers within the distance/time standards for female members older than 13 years of age to ensure access to an OB/GYN provider; **TCS** should ensure that all members have access to providers within the distance/time standards for hospitals.
	Q/A/T	**AQS**	**TCS** should maintain a policy and procedure for ensuring that it does not request disenrollment for any member for any reason and that it promptly informs TennCare if it believes that a member satisfies the conditions for termination as described in TennCare rules and regulations.
	Q	**PMV**	No deficiencies or recommendations for improvement were identified.

Table 26. 2022 Results, Recommendations, and Strengths by Plan			
	Q	**PIP Validation**	**TCS** should ensure that the barrier analysis aligns with the improvement strategies selected in the *All Cause Readmissions* PIP. **TCS** should address how improvement strategies were designed/modified to account for major confounding variables that could impact PIP outcomes in the *Social Determinants of Health Data Collection Process* PIP.
Strengths & Improvements	**A/T**	**ANA Review**	As **TCS** is administered by **BC**, its strengths are the same.
	Q/A/T	**AQS**	No particular strengths or improvements were identified.
	Q	**PMV**	No particular strengths or improvements were identified.
	Q	**PIP Validation**	**TCS** was lauded for including an exceptionally thorough analysis of how the PIP topic is relevant to TennCare member needs, care, and services in the *All Cause Readmissions* PIP. **TCS** was additionally praised for including an exceptionally detailed analysis of and justification for the PIP topic, and conducting an extensive literature review on the PIP topic and data collection in the *Social Determinants of Health Data Collection Process* PIP. Since the 2021 validation, **TCS** provided a revised PIP Summary Form with the corrected PIP Aim Statement, as well as documentation from the training meeting showing attendees and topics covered to address the AON in the *Improving Comprehensive Diabetes Care (Blood Pressure Control for SelectCommunity)* PIP; **TCS** provided a revised PIP Summary Form that included a discussion regarding the break in trending, recalculated goal rate, and plans for future remeasurements, as well as a documentation from the training session showing topics covered and attendees to address the AON in the *Improving Comprehensive Diabetes Care (Blood Pressure Control for SelectCommunity)* PIP; **TCS** provided a revised PIP Summary Form addressing the impact of the break in trending on validity and comparability of results, as well as a documentation from the training session showing topics covered and attendees to address the AON in the *Improving Comprehensive Diabetes Care (Blood Pressure Control for SelectCommunity)* PIP; **TCS** provided a PIP Summary Form with revisions addressing the impact of the change in methodology on interpreting results, as well as a documentation from the training session showing topics covered and attendees to address the AON in the *Improving Comprehensive Diabetes Care (Blood Pressure Control for SelectCommunity)* PIP; and finally, **TCS** provided its PIP internal validation tool, updated PIP procedure, PIP summary form with a revised aim statement, and documentation to support staff training. **TCS** also indicated that it would explore consultation with the statistical analysis department, or other department as applicable, of a local university to assist the Clinical Strategy & Evaluation Team with PIP review and internal validation to address the AON in the *Decreasing Plan All-Cause Readmissions (PCR)* PIP.
UnitedHealthcare			
Results	**A/T**	**ANA Review**	**UHC** earned an overall Network Adequacy score of >99.9% and an overall Benefit Delivery score of >99.9%.
	Q/A/T	**AQS**	**UHC** earned 100% compliance with all QP standards except Coordination and Continuity of Care (82.0%), Provider Selection (88.0%), and EPSDT (96.0%). UHC earned a 100% with CHOICES Credentialing file review–quantity rating and 100% with CHOICES Recredentialing file review–quantity rating. For the quality rating, UHC scored 93.3% in the Credentialing file review, and 80.3% in the Recredentialing file review. UHC earned 100% in all PA file reviews except CHOICES Annual LOC Assessment (95.0%) and Transition of CHOICES Members Between MCOs (96.4%).
	Q	**PMV**	**UHC** passed the 2022 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**	**UHC** earned a Met validation status for all submitted PIPs, earning a 100% element score in five of six PIPs.
Recommendations	**A/T**	**ANA Review**	**Network Adequacy**: **UHC** should ensure that female members older than 13 years of age have access to an OB/GYN within the distance/time standards; **UHC** must ensure that all members have access to substance abuse outpatient treatment services within the TennCare required distance/time standards; **UHC** must ensure that all members have access to hospitals

Table 26. 2022 Results, Recommendations, and Strengths by Plan			
			within the TennCare required distance/time standards; **UHC** must ensure that all members have access to adult day care providers within the TennCare required distance/time standards **Benefit Delivery**: **UHC** should inform providers about the limitations and restrictions for inpatient/residential and outpatient substance abuse benefits described in the CRA. **File Review**: **UHC** presented 19 of the 20 files requested for the contract file review. The sample list for the provider file review included one PCP who was retroactively terminated in February 2022, with a termination date of October 2021. Because this provider was not an actively participating provider on **UHC**'s network as of November 2021, this provider was excluded from the review.
	Q/A/T	**AQS**	**UHC** should ensure that that semiannual contacts are made with all contract providers; **UHC** should ensure that it has a mechanism in place that allows members with identified special healthcare needs direct access to a specialist to obtain a needed course of treatment or regular care monitoring, as appropriate for the member's condition; **UHC** should maintain a P&P for ensuring that it does not request disenrollment for any member for any reason, and that it promptly informs TennCare if it believes that a member satisfies the conditions for termination as described in TennCare rules and regulations; **UHC** should ensure that pregnant women past their first trimester are offered individual assistance in making a first prenatal appointment that occurs within 15 calendar days of becoming eligible for coverage; **UHC** should ensure that providers are aware of their right to request a hard copy of the referral providers list at least 30 calendar days prior to their start date of operations; **UHC** should ensure that provider Medicare/Medicaid participation is verified in CHOICES credentialing files.
	Q	**PMV**	No deficiencies or recommendations for improvement were identified.
	Q	**PIP Validation**	**UHC** should ensure that the PIP improvement strategy is clear and easily interpreted, specify if the strategy is member or provider focused. Additionally, it should specify the PIP time period, such as "over each remeasurement period." The PIP aim statement should also make clear that the reassessment and reassessment with care plan update include the nine core elements for each in the *UnitedHealthcare Long Term Services and Supports (LTSS) HEDIS Process Improvement for Reassessment and Care Plan Updates Within 30 days After Inpatient Discharge for LTSS Eligible Populations* PIP.
Strengths & Improvements	**A/T**	**ANA Review**	**UHC** was commended for developing a TennCare Medicaid Member Handbook Addendum, which listed required benefits and coverage information not included in the current **UHC** Member Handbook. The Member Handbook Addendum is available to all members on the **UHC** member website. New members are informed about the **UHC** Member Handbook and the Member Handbook Addendum upon enrollment.
	Q/A/T	**AQS**	No particular strengths were identified. **UHC** provided documentation confirming that the existing P&P HS PWE 01: TennCare Kids EPSDT aligned with the CRA requirement and created a new SOP HP_MH_001: Member Handbook. **UHC** initiated the process of updating the Annual Member Mailer, which included information on how to access the Member Handbook on the website or by calling customer service. **UHC** also submitted the English version of the Member Handbook to TennCare and, upon approval, intends to translate it to Spanish, obtain approval, and proceed with the annual notification mailing; The SOP submitted addressed the requirement to ensure that **UHC** presents annual reviews for delegated entities to the Provider Affairs Subcommittee (PAS) and that the PAS committee minutes reflect the review and approval of those annual reviews. **UHC** included the timeframe and the employees responsible to implement the SOP; The revised processes, oversight, and monitoring procedures identified by **UHC** addressed the deficiency of ensuring that **UHC** submits only initial provider credentialing records for the initial credentialing file reviews. **UHC** included the timeframe and the employees responsible to implement the activities; **UHC** implemented revised procedures with the NCC to ensure that out-of-state providers have a valid license or certification at the time of recredentialing. Retraining of staff members occurred, and the NCC incorporated a review of the AON in its quality audit program. **UHC** included the timeframe and the employees responsible to implement the activities; Since a noncompliant record was from January 2020, **UHC** provided the same actions that were a part of last year's CAP, which was implemented by May 2020; Qsource confirmed that an MCO update was per TennCare's expectations. The updated language in the policy regarding member notification for expedited appeal

Table 26. 2022 Results, Recommendations, and Strengths by Plan			
			cases meets the intent of the AON; **UHC** noted that it would update the SCM tool that generated LOC reassessments and reinstate the internal review. **UHC** further noted that it will also implement an ECF CHOICES oversight tool to monitor timely LOC reassessment dates; and finally, **UHC** updated the procedure to include the assignment of a secondary owner when the individual care coordinator is assigned to a case to trigger a manager response and monitoring, and ensure face-to-face assessments for CHOICES members are conducted within 30 days of the transition.
	Q	**PMV**	No particular strengths or improvements were identified.
	Q	**PIP Validation**	No particular strengths or improvements were identified in the 2022 PIP Validation. Since the 2021 validation, **UHC** initial data collection plan specified an inaccurate data element for the PIP and indicated that this occurrence was the result of the same staff working simultaneously on two different PIPs. Training was scheduled to address PIP form completion and the importance of separating work streams for individual PIP form completion activities. An updated PIP Summary Form included a revision that specified hybrid review of administrative and medical record data for the CIS Combo 10 HEDIS® measure, according to the HEDIS® Technical Specifications to address the AON in the *Impact of Member and Provider Outreach on Immunization Rates for CIS Combo 10* PIP.
DentaQuest			
Results	**A/T**	**ANA Review**	**DQ** earned an overall Network Adequacy score of >99.9% and an overall Benefit Delivery score of 99.3%.
	Q/A/T	**AQS**	**DQ** earned 100% compliance with all QP standards except Availability of Services (92.3%), Coordination and Continuity of Care (90.0%), Coverage and Authorization of Services (95.7%), and Non-Discrimination Compliance (96.4%). DQ earned 100% on all 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 a Met validation status for all submitted PIPs, earning a 100% element score in two of two PIPs.
Recommendations	**A/T**	**ANA Review**	**Network Adequacy**: **DQ** should ensure that all ECF CHOICES members have access to a dental provider within the distance/time standards; **DQ** must ensure that all members have access to oral surgery within the distance/time standards; **DQ** must ensure that all members have access to orthodontic services within the distance/time standards; **DQ** must ensure that all members have access to pediatric dental services within the distance/time standards. **File Review**: DQ must ensure that all CoverKids provider contracts include the requirement to ensure 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.
	Q/A/T	**AQS**	**DQ** should develop a Policy and Procedure that specifies how often the hardcopy and electronic versions of the Provider Directory are updated; **DQ** should have a P&P that states no member shall be disenrolled by the plan; **DQ** should ensure that member notification of provider departure or termination fully aligns with the CRA (which also includes 30 calendar days prior to the effective date of the termination); **DQ** should ensure that its helpline processes function to address the member's needs.
	Q	**PMV**	No deficiencies or recommendations for improvement were identified.
	Q	**PIP Validation**	No deficiencies or recommendations for improvement were identified.
Strengths & Improvements	**A/T**	**ANA Review**	**DQ** was commended for adding benefits and coverage information related to the application of silver diamine fluoride to its member website, and for developing a Member Dental Benefits document for TennCare Medicaid members, available on its website, which offered additional benefits information not included in the current Member Handbook.

Table 26. 2022 Results, Recommendations, and Strengths by Plan			
	Q/A/T	AQS	No particular strengths were noted. Since the 2021 AQS, DQ indicated plans to distribute annual dental appointment notices to all members who did not receive dental services in the previous 12 months, beginning in January 2022 with completion in March 2022. As per TennCare's guidance, DQ should consider sending the annual notices earlier in the contract year (May 1–April 30) to allow members who receive an annual notice sufficient time to see their dentist prior to the end of the contract year. DQ should provide copies of the staff training, new process implemented, and meeting minutes referenced in the CAP.
	Q	PMV	No particular strengths or improvements were identified.
	Q	PIP Validation	No particular strengths or improvements were identified in the 2022 PIP Validation.
OptumRx			
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 Availability of Services (80.0%), Assurances of Adequate Capacity and Services (0.0%), Coverage and Authorization of Services (81.8%), and Grievance and Appeal Systems (91.2%). The PBM has no file reviews.
	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 a Met validation status for all submitted PIPs, earning a 100% element score in one of two 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 PBM should ensure that a policy or procedure is in place that documents how the coordination of payment for out-of-network services occur and that the cost is no greater than that for an in-network provider; ORx should develop a P&P that addresses updates to the Provider Directory and the required timeframes; ORx should have a policy and procedure to detail when and how its provider network is maintained, in addition to its expected reporting to TennCare; ORx should have a policy and procedure to detail when and how its provider network is maintained, in addition to its expected reporting to TennCare; ORx should develop mechanisms to ensure consistent application of review criteria for authorization decisions; PBM should ensure that it guarantees member rights. ORx should include them in a policy, on its website, in provider materials, and/or through other available mechanisms; ORx should maintain a policy which states that those who make decisions should neither be involved in any previous level of review or decision making, nor should they be a subordinate of any such individual; ORx should maintain a P&P against punitive action in response to a request for an expedited resolution; ORx should develop a P&P that specifically states the actions done by ORx if they reverse a decision to deny, limit, or delay services and the services were not furnished; ORx should develop a P&P that specifically states that ORx or TennCare will pay for services furnished during a pending appeal if ORx or SFH officer reverse the decision to deny authorization of services.
	Q	PMV	No deficiencies or recommendations for improvement were identified.
	Q	PIP Validation	In the *Usage of Diagnosis Code Override by Providers for Preferred Atypical Antipsychotics* PIP, ORx should describe how the improvement strategies are evidence-based. ORx should address any causes or barriers identified through data analysis and quality improvement processes. ORx should document the implementation of the interventions for each step in the PDSA process. ORx should include documentation identifying how the improvement strategy accounts for variables that could make an impact on outcomes. Finally, ORx should include a detailed discussion of the success of the interventions and any follow-up activities identified.
	A/T	ANA Review	No particular strengths were identified for ORx.

Table 26. 2022 Results, Recommendations, and Strengths by Plan			
Strengths & Improvements	**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** was well prepared for the review, as evidenced both by ISCAT and the PBM's subject-matter experts for each of the areas contributing to PM data reporting. Additionally, it dedicated key leadership and resources to the TennCare contract, had a high level of engagement to the Medicaid program, and showed particular strengths with RxTrack, its integrated data warehouse system.
	Q	**PIP Validation**	No particular strengths or improvements 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, DBM, & PBM tool: Standards for Availability and Accessibility
		AQS	♦ MCO: Availability of Services • #1: Adequate Access for All Members • #2: Women's Health Specialists • #3: Second Opinion • #4: Out-of-Services Network • #5: Out-of-Network Costs • #6: Credentialing and Recredentialing Policy • #7: Family Planning • #8: Timely Access • #9: Hours of Operation and Access • #10: Compliance • #11: Cultural Competency • #12: Accessibility for Members with Disabilities ♦ MCO: Credentialing/Recredentialing P&Ps • #34: Site Visits for CHOICES and ECF CHOICES Providers ♦ DBM: Availability of Services • #1: Adequate Access for All Members • #2: Second Opinion • #3: Out-of-Services Network • #4: Out-of-Network Costs • #5: Credentialing and Recredentialing Policy • #6: Timely Access • #7: Hours of Operation and Access • #8: Compliance • #9: Cultural Competency • #10: Accessibility for Members with Disabilities ♦ DBM: Credentialing/Recredentialing P&Ps • #1: Initial Credentialing P&Ps

Table A-1. CFR-Tool Crosswalk

#	CFR Standards	Tool	Standards/Elements
			• #2: Recredentialing P&Ps ♦ PBM: Availability of Services • #1: Adequate Access for All Members • #2: Out-of-Services Network • #3: Out-of-Network Costs • #4: Timely Access • #5: Hours of Operation and Access • #6: Compliance • #7: Cultural Competency • #8: Accessibility for Members with Disabilities
2	**42 CFR 438.207: Assurances of adequate capacity and services**	**ANA**	♦ MCO, DBM, & PBM: Standards for Availability and Accessibility
		AQS	♦ MCO, DBM, & PBM: Assurances of Adequate Capacity and Services • #1: Appropriate Range of Services and Providers • #2: Timely Documentation
3	**42 CFR 438.208: Coordination and continuity of care**	**AQS**	♦ MCO: Coordination and Continuity of Care • #1: Primary Care • #2: Coordination of Services • #3: Initial Screening • #4: Prevent Duplication of Services • #5: Medical Records • #6: Protected Health Information • #7: Comprehensive Assessment Mechanisms • #8: Treatment and Service Plans • #9: Direct Access to Specialists ♦ DBM: Coordination and Continuity of Care • #1: Primary Care • #2: Coordination of Services • #3: Prevent Duplication of Services • #4: Medical Records • #5 Protected Health Information • #6: Comprehensive Assessment Mechanisms • #7: Treatment and Service Plans • #8: Direct Access to Specialists

Table A-1. CFR-Tool Crosswalk

#	CFR Standards	Tool	Standards/Elements
			♦ PBM: Coordination and Continuity of Care • #1: Protected Health Information
4	**42 CFR 438.210: Coverage and authorization of services**	**AQS**	♦ MCO & DBM: Coverage and Authorization of Services • #1: Sufficient Services • #2: Arbitrary Limitations Prohibited • #3: Service Limitations • #4: Utilization Control • #5: Medically Necessary Definition • #6: Medically Necessary Services • #7: Service Authorization P&Ps • #8: Processing Authorizations • #9: Appropriate Expertise • #10: Notice of Adverse Benefit Determination (NABD) • #11: Notification Timeframes • #12: Compensation for Utilization Management (UM) ♦ DBM: Credentialing/Recredentialing P&Ps • #18: Non-discrimination • #19: Providers Excluded from Participation in Federal Health Care Programs ♦ PBM: Coverage and Authorization of Services • #1: Service Limitations • #2: Medically Necessary Definition • #3: Service Authorization P&Ps • #4: Processing Authorizations • #5: Appropriate Expertise • #6: Notice of Adverse Benefit Determination (NABD) • #7: Notification Timeframes ♦ #8: Compensation for Utilization Management (UM)
		AQS	♦ MCO: Availability of Services • #6: Credentialing and Recredentialing Policy ♦ MCO, DBM, & PBM: Provider Selection • #1: Credentialing and Recredentialing Process • #2: Provider Selection P&Ps • #3: Excluded Providers

Table A-1. CFR-Tool Crosswalk

#	CFR Standards	Tool	Standards/Elements
			♦ MCO: Credentialing/Recredentialing P&Ps • #1: Written P&Ps for Credentialing: Contracted/ Employed Providers • #13: Nondiscrimination in Credentialing and Recredentialing • #35: Monthly Verification of CHOICES and ECF CHOICES Providers ♦ DBM: Availability of Services • #5: Credentialing and Recredentialing Policy ♦ DBM: Credentialing/Recredentialing P&Ps • #1: Initial Credentialing P&Ps • #2: Recredentialing P&Ps ♦ PBM: Credentialing/Recredentialing P&Ps • #1: Initial Credentialing P&Ps • #2: Recredentialing P&Ps • #8: Non-discrimination • #10: Providers Excluded from Participation in Federal Health Care Programs
5	**42 CFR 438.214: Provider selection**	**AQS**	• MCO, DBM, & PBM: Standards for Confidentiality
6	**42 CFR 438.224: Confidentiality**	**AQS**	♦ MCO, DBM, & PBM: Grievance and Appeal Systems
7	**42 CFR 428.228: Grievance and appeal systems**	**AQS**	♦ MCO & DBM: Subcontractual Relationships and Delegation • #1: Delegated Activities • #2: Remedies for Unsatisfactory Performance • #3: Compliance Laws and Regulations • #4: Annual Review Requirements • #5: Annual Review Provisions • #6: Annual Review Timeframes ♦ #7: Suspicion of Fraud
8	**42 CFR 438.230: Subcontractual relationships and delegation**	**AQS**	♦ MCO & DBM: Practice Guidelines • #1: Requirements • #2: Dissemination of Guidelines • #3: Consistency with Guidelines ♦ PBM: Practice Guidelines • #1: Requirements

Table A-1. CFR-Tool Crosswalk

#	CFR Standards	Tool	Standards/Elements
9	**42 CFR 438.236: Practice guidelines**	**AQS**	♦ MCO, DBM, & PBM: Health Information Systems • #1: System Requirements • #2: Data Collection • #3: Data Accuracy and Completeness • #4: Data Availability
10	**42 CFR 438.242 Health information systems**	**PIP**	• Information on PIP methodology and results in the PIP section, with tool in Appendix B and MCC improvement strategies in Appendix C
11	**42 CFR 438.330 Quality assessment and performance improvement program**	**PMV**	♦ Information on methodology and results in the PMV section, with tool in Appendix B
		AQS	♦ MCO: Quality Assessment and Performance Improvement (QAPI) Program • #1: Program in Place • #2: Program Components • #3: Under-/Over-Utilization • #4: LTSS Requirements • #5: Annual Evaluation • #6: PIPs • #7: Quality Indicators • #8: Interventions • #9: Intervention Effectiveness • #10: Activities for Increasing or Sustaining Improvement • #11: Reporting PIP Results ♦ DBM & PBM: Quality Assessment and Performance Improvement (QAPI) Program • #1: Program in Place • #2: Program Components • #3: Under-/Over-Utilization • #4: Annual Evaluation • #5: PIPs • #6: Quality Indicators • #7: Interventions • #8: Intervention Effectiveness • #9: Activities for Increasing or Sustaining Improvement ♦ #10: Reporting PIP Results

APPENDIX B | 2022 EQR Tool Templates

ANA Review

ANA Standards Tools—MCOs

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
1. Informing Members of Emergency Medical Services *CRA A.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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
2. Informing Providers of Emergency Medical Services *CRA A.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 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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
3. Maximum Members per Provider	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**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
CRA Attachment IV *TCA 56-7-2356(a)(1)(A)* *42 CFR § 438.206(a)* *42 CFR § 438.207(a)*	**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			

Comment:

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
Strengths:				
Suggestions:				
AONs:				
4. Appointment/Wait Times for PCPs *CRA Attachment III* *TCA 56-7-2356(e)* *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**	**1.0**
Comment:				
Strengths: None were identified.				
Suggestions: None were identified.				
AONs: None were identified.				
5. Appointment/Wait Times for SCPs *CRA Attachment III* *TCA 56-7-2356(e)* *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 SCPs: 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**	**1.0**
Comment:				
Strengths:				
Suggestions:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
AONs:				
6. Appointment/Wait Times for Optometry *CRA Attachment III* *TCA 56-7-2356(e)* *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 optometry wait times: 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	a) ☒ Met ☐ Not Met b) ☒ Met ☐ Not Met c) ☒ Met ☐ Not Met Variables a & b = .33 Variable c = .34	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
7. Second Opinions *CRA A.2.6.4* *42 CFR § 438.206(b)(3)*	The MCO provides for a second opinion in any situation where there is a question 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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
8. Direct Access to Women's Health Specialist *CRA A.2.14.4.3* *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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
9. Essential Hospital Services *CRA A 2.11.3.1.1* *CRA Attachment VII - #12*	The MCO has a contract with at least one tertiary care center in each Grand Region for essential hospital service (i.e., neonatal, perinatal, pediatric, trauma, and burn services).	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
10. Center of Excellence (COE) for People with HIV/AIDS *CRA A.2.11.3.1.2* *CRA Attachment VII - #12*	The MCO has a contract with at least two COEs for human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) in each Grand Region.	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
11. Center of Excellence for BH *CRA A.2.11.3.1.3*	The MCO has a contract with all Centers of Excellence (COE) for BH with each Grand Region.	☒ Met	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
CRA Attachment VII - #12		☐ Not Met		
Comment: **Strengths**: **Suggestions**: **AONs**:				
12. Timeliness Standards for Access to BH Services *CRA Attachment V* *TCA 56-7-2356(e)* *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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
13. Standards for Timely Access to Psychiatric Inpatient Hospital Services *CRA Attachment V* *TCA 56-7-2356(e)* *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**	**1.0**
Comment:				

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

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
Strengths: **Suggestions**: **AONs**:				
14. Standards for Timely Access to 24-Hour Psychiatric Residential Treatment *CRA Attachment V* *TCA 56-7-2356(e)* *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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
15. Standards for Timely Access to Outpatient (Non-Medical Doctor [MD]) and Intensive Outpatient Services *CRA Attachment V* *TCA 56-7-2356(e)* *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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
16. Standards for Timely Access to Inpatient Substance Abuse Services	The BH standards include access standards for inpatient substance abuse services: a) Within 2 calendar days for detoxification	a) ☒ Met ☐ Not Met b) ☒ Met	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
CRA Attachment V *TCA 56-7-2356(e)* *42 CFR § 438.206(c)(1)(i)*	b) Within 4 hours in an emergency c) Within 24 hours for a nonemergency	☐ Not Met c) ☒ Met ☐ Not Met Variables a & b = .33 Variable c = .34		
Comment: **Strengths**: **Suggestions**: **AONs**:				
17. Access Standards for Timely Access to 24-Hour Residential Substance Abuse Services *CRA Attachment V* *TCA 56-7-2356(e)* *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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
18. Access Standards for Timely Access to Outpatient Substance Abuse Services *CRA Attachment V* *TCA 56-7-2356(e)* *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**	**1.0**
Comment: **Strengths**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
Suggestions:				
AONs:				
19. Access Standards for Timely Access to Intensive Community-Based Treatment Services *CRA Attachment V* *TCA 56-7-2356(e)* *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**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
20. Access Standards for Timely Access to Tennessee Health Link Services *CRA Attachment V* *TCA 56-7-2356(e)* *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**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
21. Access Standards for Timely Access to Psychosocial Rehabilitation *CRA Attachment V* *TCA 56-7-2356(e)*	The BH standards include access standards for psychosocial rehabilitation within 10 business days.	☒ Met ☐ Not Met	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
42 CFR § 438.206(c)(1)(i)				
Comment:				
Strengths:				
Suggestions:				
AONs:				
22. Access Standards for Timely Access to Supported Employment *CRA Attachment V* *TCA 56-7-2356(e)* *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**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
23. Access Standards for Timely Access to Peer Recovery Services or Family Support Services *CRA Attachment V* *TCA 56-7-2356(e)* *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**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
24. Access Standards for Timely Access to Illness Management and Recovery	The BH standards include access standards for illness management and recovery within 10 business days.	☒ Met ☐ Not Met	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
CRA Attachment V *TCA 56-7-2356(e)* *42 CFR § 438.206(c)(1)(i)*				
Comment: **Strengths**: **Suggestions**: **AONs**:				
25. Standards for Timely Access to Mobile Crisis Services *CRA Attachment V* *TCA 56-7-2356(e)* *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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
26. Standards for Timely Access to Crisis Stabilization *CRA Attachment V* *TCA 56-7-2356(e)* *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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
27. Standards for Timely Access to Supported Housing *CRA Attachment V* *TCA 56-7-2356(e)* *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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
28. Geographic Access Requirements *CRA Attachments III, IV, & V* *TCA 56-7-2356(a)(1)(B)* *42 CFR § 438.206(c)(1)(iv–vi)*	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 and takes corrective action as necessary.	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
29. Geographic Access Requirements for Primary Care Physician or Extenders *CRA Attachment III* *TCA 56-7-2356(a)(1)(B)* *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 and ≤ 45 minutes travel for all members b) Urban: ≤ 20 miles and ≤ 30 minutes travel for all members	☒ Met ☐ Not Met ☒ Met ☐ Not Met Each Variable = .50	**1.0**	**1.0**
Comment: **Strengths**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
Suggestions:				
AONs:				
30. Geographic Access for Hospitals *CRA Attachment III* *TCA 56-7-2356(a)(1)(B)* *TCA 56-7-2356(b)(1)* *42 CFR § 438.206(c)(1)(i)* *42 CFR § 438.207(b)(2)*	♦ 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**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
31. Geographic Access for Optometry *CRA Attachment III* *TCA 56-7-2356(a)(1)(B)* *42 CFR § 438.206(c)(1)(i)* *42 CFR § 438.207(b)(2)*	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**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
32. Geographic Access Requirements for Psychiatric Inpatient Hospital Services *CRA Attachment V* *TCA 56-7-2356(a)(1)(B)* *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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
33. Geographic Access Requirements for Outpatient Non-MD BH Services *CRA Attachment V* *TCA 56-7-2356(a)(1)(B)* *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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
34. Geographic Access Requirements for Intensive Outpatient BH Services *CRA Attachment V* *TCA 56-7-2356(a)(1)(B)* *42 CFR § 438.206(c)(1)(i)*	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**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
42 CFR § 438.207(b)(2)				
Comment:				
Strengths:				
Suggestions:				
AONs:				
35. Geographic Access Requirements for Inpatient Substance Abuse Services *CRA Attachment V* *TCA 56-7-2356(a)(1)(B)* *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**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
36. Geographic Access Requirements for Outpatient Treatment for Substance Abuse *CRA Attachment V* *TCA 56-7-2356(a)(1)(B)* *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**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
37. Geographic Access Requirements for Opioid Use Disorder Treatment Providers *CRA Attachment IV* *TCA 56-7-2356(a)(1)(B)* *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 who treat with buprenorphine: ♦ 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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
38. Electronic Provider Information *CRA A.2.17.8.3*	The MCO furnishes an online searchable electronic provider directory.	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
39. Provider Directory *CRA A.2.17.8.5* *42 CFR 438.10(h)(1)(vii)*	The provider directory includes: a) name and specialty b) locations c) telephone numbers d) website e) office hours f) non-English languages spoken g) handicap accessible h) group affiliation	a) ☒ Met ☐ Not Met ☐ NA b) ☒ Met ☐ Not Met ☐ NA c) ☒ Met ☐ Not Met	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
	i) hospital privileges j) cultural competency training	☐ NA d) ☒ Met ☐ Not Met ☐ NA e) ☒ Met ☐ Not Met ☐ NA f) ☒ Met ☐ Not Met ☐ NA g) ☒ Met ☐ Not Met ☐ NA h) ☒ Met ☐ Not Met ☐ NA i) ☒ Met ☐ Not Met ☐ NA j) ☒ Met ☐ Not Met ☐ NA Each Variable= .10		

Comment:

Strengths:

Suggestions:

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
AONs:				
40. Monthly Provider Enrollment File *CRA A.2.30.8.1*	The MCO submits a monthly Provider Enrollment File.	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
41. Quarterly Reporting Requirements *CRA A.2.30.8.3* *CRA A.2.30.8.6* *CRA A.2.30.8.8* *CRA A.2.30.8.9* *CRA A.2.30.14.1* *CRA A.2.30.13.4* *42 CFR § 438.206(c)(1)(v)*	The MCO submits the following required quarterly reports: a) PCP Assignment Report b) BH Appointment Timeliness Summary Report c) CHOICES and ECF CHOICES Provider Criminal Background Check and Registry Check Report d) CHOICES, ECF CHOICES, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), and 1915(c) Waiver, Member Complaints Reports e) HCBS Settings Report f) Provider Complaints and Appeals Report	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	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
		Variable a–d = .167 Variable e & f = .166		
Comment: **Strengths**: **Suggestions**: **AONs**:				
42. Annual Reporting Requirements *CRA A.2.30.8.2* *CRA A.2.30.8.4* *CRA A.2.30.8.7* *42 CFR § 438.206(c)(1)(v)*	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 by January 1 of each year	a) ☒ Met ☐ Not Met b) ☒ Met ☐ Not Met c) ☒ Met ☐ Not Met Variables a & b = .33 Variable c = .34	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
43. Annual Plan for Monitoring BH Appointment Timeliness *CRA A.2.30.8.5* *42 CFR § 438.206(c)(1)(v)*	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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
44. Provider Satisfaction Survey Report: Medicaid *CRA A.2.30.13.3*	A Provider Satisfaction Survey Report that includes stratification by physical health providers, behavioral health providers, CHOICES (nursing facility and HCBS) providers, and ECF CHOICES providers, and is submitted to TennCare by January 30 each year.	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
45. Appointments Scheduling *CRA 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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
46. Exchange of Information *CRA 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) furnishes health care.	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
47. PCP Selection *CRA A.2.11.2.6*	The MCO establishes P&Ps to enable members the opportunity to change PCPs at least every 12 months. If the	☒ Met ☐ Not Met	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
	ability to change PCPs is limited, the MCO includes provisions for more frequent PCP changes with good cause.			
Comment:				
Strengths: None were identified.				
Suggestions: None were identified.				
AONs: None were identified.				
48. Family Planning Providers *CRA 2.17.4.6.10* *42 CFR § 438.206(b)(7)*	The MCO does not require a referral before a member visits a family planning provider.	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
49. Out-of-Network Providers *CRA 2.11.1.9* *TCA 56-7-2356(c)* *42 CFR § 438.206(b)(4–5)*	If the MCO's network is unable to provide necessary, covered services to a particular enrollee, the MCO adequately and timely covers these services out-of-network for as long as the MCO provider network is unable to provide the services. The MCO ensures that 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**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
	Network Adequacy: Availability and Accessibility Score	**100%**	**49.0**	**49.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—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*	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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
2. Outpatient Hospital Services *CRA A.2.6.1.3*	As medically necessary	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
3. Physician Inpatient Services *CRA A.2.6.1.3*	As medically necessary	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**

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

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
Comment: **Strengths**: **Suggestions**: **AONs**:				
4. Physician Outpatient Services/Community Health Clinic Services/ Other Clinic Services *CRA A.2.6.1.3*	As medically necessary	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
5. Lab and X-Ray Services *CRA A.2.6.1.3*	As medically necessary	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
6. Maternity/Postpartum Services *TCA 56-7-2350*	As medically necessary	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
Comment: **Strengths**: **Suggestions**: **AONs**:				
7. Hospice Care *CRA A.2.6.1.3*	As medically necessary (must be provided by a Medicare-Certified Hospice)	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
8. Vision Services *CRA A.2.6.1.3*	TENNCARE MEDICAID: ♦ 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. COVERKIDS: Annual vision exam including refractive exam and glaucoma screening; prescription eyeglass lenses: one pair per calendar year with $85 maximum benefit per pair; eyeglass frames: replacement frames limited to once every two calendar years with $100 maximum benefit per pair.	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
	COVERKIDS MOTHERS (AGE 19 AND OVER) OF ELIGIBLE UNBORN CHILDREN: 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.			
Comment: **Strengths**: **Suggestions**: **AONs**:				
9. Home Healthcare *CRA A.2.6.1.3*	TENNCARE MEDICAID: 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. COVERKIDS: Prior approval required with visits limited to 125 visits per enrollee per calendar year	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
10. Durable Medical Equipment (DME) *CRA A.2.6.1.3*	TENNCARE MEDICAID: As medically necessary and covered in accordance with TennCare rules and regulations COVERKIDS: As medically necessary with DME and other medically-related or remedial devices being limited to the most basic equipment that will provide the needed care. Hearing aids limited to one per year per calendar year up to age 5, and limited to one per ear every two years thereafter. Specified DME services covered/non-covered in accordance with TennCare	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
	rules and regulations			
Comment: **Strengths**: **Suggestions**: **AONs**:				
11. Medical Supplies *CRA A.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**	**1.0**
Comment: Strengths: **Suggestions**: **AONs**:				
12. Emergency Air and Ground Ambulance Transportation *CRA A.2.6.1.3*	As medically necessary	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
13. Nonemergency Medical Transportation, Including Nonemergency Ambulance Transportation *CRA A.2.6.1.3*	TENNCARE MEDICAID: Nonemergency medical 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**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
	Not applicable for CoverKids			
Comment: **Strengths**: **Suggestions**: **AONs**:				
14. Renal Dialysis Services *CRA A.2.6.1.3*	As medically necessary	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
15. TennCare Kids Services/Health Screenings *CRA A.2.6.1.3*	Services for members younger than 21 years of age: ♦ As medically necessary, except that screenings do not have to be medically necessary ♦ 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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
16. Preventive Care Services *CRA A.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	☒ Member Handbook ☐ Explanation of	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
	in accordance with TennCare rules and regulations.	Benefits ☐ Other (Describe)		
Comment: **Strengths**: **Suggestions**: **AONs**:				
17. Occupational Therapy *CRA A.2.6.1.3*	**Occupational Therapy:** TENNCARE MEDICAID: ♦ Age 21 and older, as medically necessary, when provided by a licensed occupational therapist to restore, improve, or stabilize impaired functions ♦ Younger than age 21, as medically necessary, in accordance with TennCare Kids requirements COVERKIDS: Limited to 52 visits per calendar year	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
18. Physical Therapy *CRA A.2.6.1.3*	**Physical Therapy:** TENNCARE MEDICAID: ♦ Age 21 and older, as medically necessary, when provided by a licensed physical therapist to restore, improve, or stabilize impaired functions ♦ Younger than age 21, as medically necessary, in accordance with TennCare Kids requirements	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
	COVERKIDS: Limited to 52 visits per calendar year			
Comment: **Strengths**: **Suggestions**: **AONs**:				
19. Chiropractic Services *CRA A.2.6.1.3*	**Chiropractic Services:** TENNCARE MEDICAID: ♦ Age 21 and older, covered when determined to be a cost-effective alternative by the MCO ♦ Younger than age 21, covered as medically necessary in accordance with TennCare Kids requirements COVERKIDS: Children under age 19: Maintenance visits not covered when no additional progress is apparent or expected to occur; Mothers (age 19 and over) not covered	☒ Member Handbook ☐ Explanation of Benefits ☒ Other ♦ Updates to Your Benefits	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
20. Private Duty Nursing *CRA A.2.6.1.3*	TENNCARE MEDICAID: Private duty nursing is covered as medically necessary in accordance with the definition of private duty nursing in the Tennessee rules. Not applicable for CoverKids	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
Suggestions: **AONs**:				
21. Speech Therapy *CRA A.2.6.1.3*	**Speech Therapy:** TENNCARE MEDICAID: ♦ 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. ♦ Younger than age 21, as medically necessary in accordance with TennCare Kids requirements COVERKIDS: Limited to 52 visits per calendar year	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
22. Organ and Tissue Transplants and Donor Organ Procurement *CRA A.2.6.1.3*	**Organ and Tissue Transplants and Donor Organ Procurement:** ♦ Age 21 and older, all medically necessary and non-investigational/experimental organ and tissue transplants, as covered by Medicare ♦ Younger than age 21, covered as medically necessary in accordance with TennCare Kids requirements	☒ Member Handbook ☐ Explanation of Benefits ☒ Other ♦ Updates to Your Benefits document	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
AONs:				
23. Reconstructive Breast Surgery *CRA A.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 date the reconstructive breast surgery was performed on a diseased breast.	☒ Member Handbook ☐ Explanation of Benefits ☒ Other ♦ Updates to Your Benefits document	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
24. Mammography Screening *TCA 56-7-2502*	TENNCARE MEDICAID: 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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
25. Phenylketonuria (PKU) *TCA 56-7-2505*	TENNCARE MEDICAID: The MCO provides coverage for the treatment of PKU, including licensed professional medical services and special dietary formulas.	☒ Member Handbook ☐ Explanation of Benefits	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
	Not applicable for CoverKids	☒ Other ♦ 2022 Benefit Delivery Review Questionnaire		
Comment: **Strengths**: **Suggestions**: **AONs**:				
26. Diabetic Services *TCA 56-7-2605*	TENNCARE MEDICAID: The MCO provides coverage for diabetic equipment, supplies, and outpatient self-management training and education, including medical nutrition counseling, when medically necessary. Not applicable for CoverKids	☒ Member Handbook ☐ Explanation of Benefits ☒ Other ♦ 2022 Benefit Delivery Review Questionnaire	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
27. Chlamydia Screens *TCA 56-7-2606*	TENNCARE MEDICAID: The MCO provides for one annual chlamydia screening test in conjunction with an annual Pap smear for females who are not more than 29 years of age, if deemed medically necessary. Not covered for CoverKids	☒ Member Handbook ☐ Explanation of Benefits ☒ Other ♦ 2022 Benefit Delivery Review Questionnaire	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	Criteria	Criteria Met*	Element	
			Value	Score
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
Comment:				
Strengths:				
Suggestions:				
AONs:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
28. Psychiatric Inpatient Hospital Services (Including Physician Services) *CRA A.2.6.1.4*	As medically necessary	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
29. Outpatient Mental Health Services (Including Physician Services) *CRA A.2.6.1.4*	As medically necessary	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
30. Inpatient/Residential and Outpatient Substance Abuse Benefits *CRA A.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.	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
AONs:				
31. 24-Hour Psychiatric Residential Treatment *CRA A.2.6.1.4*	As medically necessary	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
32. BH Crisis Services *CRA A.2.6.1.4*	As necessary	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
33. BH Intensive Community Based Treatment *CRA A.2.6.1.4*	As medically necessary	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
AONs:				
34. Psychiatric Rehabilitation Services *CRA A.2.6.1.4*	As medically necessary	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
35. Nursing Facility Care *CRA A.2.6.1.5.3* *CRA A.2.6.1.6.4*	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 Groups 4, 5, and 6 may receive short-term nursing facility care, without being required to disenroll from their ECF CHOICES group until such time that it is determined that transition back to HCBS in ECF CHOICES will not occur within 90 days from admission.	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA*	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
36. Community-Based Residential Alternatives *CRA A.2.6.1.5.3*	As medically necessary for CHOICES members in Group 2. For CHOICES members in Group 3, specified services and	☒ Member Handbook ☐ Explanation of	**1.0**	**1.0**

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

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
	levels of reimbursement only (i.e., assisted care living facility, community living supports [CLS1]), and community living supports—family model (CLS-FM1).	Benefits ☐ Other (Describe) ☐ NA		
Comment: **Strengths**: **Suggestions**: **AONs**:				
37. Personal Care Visits *CRA A.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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
38. Attendant Care *CRA A.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**	**1.0**
Comment: **Strengths**: **Suggestions**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
AONs:				
39. Home-Delivered Meals *CRA A.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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
40. PERS *CRA A.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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
41. Adult Day Care *CRA A.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**	**1.0**
Comment: **Strengths**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
Suggestions: **AONs**:				
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.	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
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 ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
44. Assistive Technology *CRA A.2.6.1.5.3* *CRA A.2.6.1.6.3*	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 members (for assistive technology and enabling technology combined) in Groups 4, 5, 6, 7, and 8.	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
		☐ NA		
Comment: **Strengths**: **Suggestions**: **AONs**:				
45. Minor Home Modifications *CRA A.2.6.1.5.3* *CRA A.2.6.1.6.3*	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 members in Groups 4, 5, 6, 7, and 8.	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
46. Pest Control *CRA A.2.6.1.5.3*	As medically necessary (up to nine units per calendar year) for CHOICES members in Groups 2 and 3.	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
47. ECF CHOICES: 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	☒ Member Handbook ☐ Explanation of	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
	unpaid family caregivers) for ECF CHOICES members in Groups 4, 5, and 6.	Benefits ☐ Other (Describe) ☐ NA		
Comment: **Strengths**: **Suggestions**: **AONs**:				
48. Supportive Home Care (SHC) *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES members in Group 4.	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
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 members in Group 4.	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, 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 members in Groups 4, 5, 6, and 7.	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
51. Community Transportation *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES members in Groups 4, 5, 6, and 7.	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
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 members in Groups 4, 5, 6, and 7.	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
Strengths: **Suggestions**: **AONs**:				
53. Community Support *CRA A.2.6.1.6.3*	As medically necessary for community support development, organization, and navigation for ECF CHOICES members in Groups 4 and 7.	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
54. Family Caregiver Education and Training *CRA A.2.6.1.6.3*	As medically necessary (up $500 per calendar year) for ECF CHOICES members in Group 4 and 7.	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
55. Family-to-Family Support *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES members in Groups 4 and 7.	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
56. Decision-making Supports *CRA A.2.6.1.6.3*	As medically necessary (up to $500 per lifetime) for ECF CHOICES members in Groups 4, 5, 6, 7, and 8.	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
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 members in Groups 4 and 7.	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
Strengths: **Suggestions**: **AONs**:				
58. Personal Assistance *CRA A.2.6.1.6.3*	As medically necessary (up to 215 hours per month) for ECF CHOICES members in Groups 5 and 6.	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
59. Community Living Supports (CLS) *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES members in Groups 5 and 6.	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
60. CLS-Family Model (CLS-FM) *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES members in Groups 5 and 6.	☒ Member Handbook ☐ Explanation of Benefits	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
		☐ Other (Describe) ☐ NA		
Comment: **Strengths**: **Suggestions**: **AONs**:				
61. Individual Education and Training *CRA A.2.6.1.6.3*	As medically necessary (up to $500 per calendar year) for ECF CHOICES members in Groups 5, 6, and 8.	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
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 members in Groups 5, 6, and 8.	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
AONs:				
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 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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
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 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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
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 members in Groups 4, 5, 6, 7, and 8: ♦ Exploration ♦ Discovery	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
	♦ 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 ♦ Career advancement			
Comment: **Strengths**: **Suggestions**: **AONs**:				
66. Intensive Behavioral Family-centered Treatment, Stabilization and Supports (IBFCTSS) *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES members in Group 7.	☒ Met ☐ Not Met ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
67. Intensive Behavioral Community Transition and Stabilization Services (IBCTSS) *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES members in Group 8.	☒ Met ☐ Not Met ☐ NA	**1.0**	**1.0**
Comment: **Strengths**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
Suggestions:				
AONs:				
68. Non-pharmacy Copayment Schedule *Attachment II*	The MCO informs CoverKids members of the non-pharmacy copayment schedule that applies to them for the following services: ♦ Hospital emergency room ♦ Primary care providers and Community Mental Health Agency Services for services other than preventive care ♦ Physician specialists ♦ Inpatient hospital admissions	☒ Met ☐ Not Met ☐ NA	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
69. Cost Sharing *Attachment II*	The MCO informs CoverKids members of the cost-sharing requirements for the following services: ♦ Chiropractic care ♦ Emergency room services ♦ Inpatient physical health admissions and services ♦ Inpatient mental health and substance abuse treatment services ♦ Outpatient mental health and substance abuse treatment services ♦ Physical, speech, and occupational therapy ♦ Physician office visits ♦ Prescription drugs ♦ Vision services	☒ Met ☐ Not Met	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)				
Comment:				
Strengths:				
Suggestions:				
AONs:				
70. Regulator Approval: TennCare Medicaid Handbook *CRA A.2.17.1.1*	The MCO's TennCare Medicaid Member Handbook was approved by TennCare. Date of Approval: <MM/DD/YY>	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
71. Regulator Approval: CoverKids Handbook *CRA A.2.17.1.1*	The MCO's CoverKids Member Handbook was approved by TennCare. Date of Approval: 5/24/21 and 6/24/21	☒ Met ☐ Not Met ☐ NA	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
	Benefit Delivery: Accessibility—Member Score	**100%**	**71.0**	**71.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
1. Inpatient Hospital Services *CRA A.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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
2. Outpatient Hospital Services *CRA A.2.6.1.3*	As medically necessary	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
3. Physician Inpatient Services *CRA A.2.6.1.3*	As medically necessary	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				

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

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
4. Physician Outpatient Services/Community Health Clinic Services/ Other Clinic Services *CRA A.2.6.1.3*	As medically necessary	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
5. Lab and X-Ray Services *CRA A.2.6.1.3*	As medically necessary	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
6. Maternity/Postpartum Services *TCA 56-7-2350*	As medically necessary	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
7. Hospice Care *CRA A.2.6.1.3*	As medically necessary (must be provided by a Medicare-Certified Hospice)	☒ Provider Manual	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
		☐ Contract ☐ Other (Describe)		
Comment: **Strengths**: **Suggestions**: **AONs**:				
8. Vision Services *CRA A.2.6.1.3* *CRA 2.6.1.9*	TENNCARE MEDICAID: ♦ 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. COVERKIDS: Annual vision exam including refractive exam and glaucoma screening; prescription eyeglass lenses: one pair per calendar year with $85 maximum benefit per pair; eyeglass frames: replacement frames limited to once every two calendar years with $100 maximum benefit per pair. COVERKIDS MOTHERS (AGE 19 AND OVER) OF ELIGIBLE UNBORN CHILDREN: 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.	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
Suggestions:				
AONs:				
9. Home Healthcare *CRA A.2.6.1.3* *CRA 2.6.1.9*	TENNCARE MEDICAID: 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. COVERKIDS: Prior approval required with visits limited to 125 visits per enrollee per calendar year	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
10. Durable Medical Equipment (DME) *CRA A.2.6.1.3* *CRA 2.6.1.9*	TENNCARE MEDICAID: As medically necessary and covered in accordance with TennCare rules and regulations COVERKIDS: As medically necessary with DME and other medically-related or remedial devices being limited to the most basic equipment that will provide the needed care. Hearing aids limited to one per year per calendar year up to age 5, and limited to one per ear every two years thereafter. Specified DME services covered/non-covered in accordance with TennCare rules and regulations	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
11. Medical Supplies *CRA A.2.6.1.3*	As medically necessary and covered in accordance with TennCare rules and regulations	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
12. Emergency Air and Ground Ambulance Transportation *CRA A.2.6.1.3*	As medically necessary	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
13. Nonemergency Medical Transportation, Including Nonemergency Ambulance Transportation *CRA A.2.6.1.3*	TENNCARE MEDICAID: Nonemergency medical 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. Not applicable for CoverKids	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
AONs:				
14. Renal Dialysis Services *CRA A.2.6.1.3*	As medically necessary	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
15. TennCare Kids Services/Health Screenings *CRA A.2.6.1.3*	Services for members younger than 21 years of age: ♦ As medically necessary, except that screenings do not have to be medically necessary ♦ 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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
16. Preventive Care Services *CRA A.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**	**1.0**
Comment: **Strengths**: **Suggestions**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
AONs:				
17. Occupational Therapy *CRA A.2.6.1.3* *CRA 2.6.1.9*	**Occupational Therapy:** TENNCARE MEDICAID: ♦ Age 21 and older, as medically necessary, when provided by a licensed occupational therapist to restore, improve, or stabilize impaired functions ♦ Younger than age 21, as medically necessary, in accordance with TennCare Kids requirements COVERKIDS: Limited to 52 visits per calendar year	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
18. Physical Therapy *CRA A.2.6.1.3* *CRA 2.6.1.9*	**Physical Therapy:** TENNCARE MEDICAID: ♦ Age 21 and older, as medically necessary, when provided by a licensed physical therapist to restore, improve, or stabilize impaired functions ♦ Younger than age 21, as medically necessary, in accordance with TennCare Kids requirements COVERKIDS: Limited to 52 visits per calendar year	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
19. Chiropractic Services *CRA A.2.6.1.3* *CRA 2.6.1.9*	**Chiropractic Services:** TENNCARE MEDICAID: ♦ Age 21 and older, covered when determined to be a cost-effective alternative by the MCO ♦ Younger than age 21, covered as medically necessary in accordance with TennCare Kids requirements COVERKIDS: Children under age 19: Maintenance visits not covered when no additional progress is apparent or expected to occur; Mothers (age 19 and over) not covered	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
20. Private Duty Nursing- *CRA A.2.6.1.3*	TENNCARE MEDICAID: Private duty nursing is covered as medically necessary in accordance with the definition of private duty nursing in the Tennessee rules. Not applicable for CoverKids	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
21. Speech Therapy *CRA A.2.6.1.3* *CRA 2.6.1.9*	**Speech Therapy:** TENNCARE MEDICAID: ♦ Age 21 and older, as medically necessary, when provided by a licensed speech therapist to restore	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
	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. ♦ Younger than age 21, as medically necessary in accordance with TennCare Kids requirements COVERKIDS: Limited to 52 visits per calendar year			
Comment: **Strengths**: **Suggestions**: **AONs**:				
22. Organ and Tissue Transplants and Donor Organ Procurement *CRA A.2.6.1.3*	**Organ and Tissue Transplants and Donor Organ Procurement:** ♦ Age 21 and older, all medically necessary and non-investigational/experimental organ and tissue transplants, as covered by Medicare ♦ Younger than age 21, covered as medically necessary in accordance with TennCare Kids requirements	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
23. Reconstructive Breast Surgery *CRA A.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	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
	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 date the reconstructive breast surgery was performed on a diseased breast.			
Comment: **Strengths**: **Suggestions**: **AONs**:				
24. Mammography Screening *TCA 56-7-2502*	TENNCARE MEDICAID: 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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
25. Phenylketonuria (PKU) *TCA 56-7-2505*	TENNCARE MEDICAID: The MCO provides coverage for the treatment of PKU, including licensed professional medical services and special dietary formulas. Not applicable for CoverKids	☒ Provider Manual ☐ Contract ☒ Other ♦ 2022 Benefit Delivery Review Questionnaire	**1.0**	**1.0**
Comment:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
Strengths: **Suggestions**: **AONs**:				
26. Diabetic Services *TCA 56-7-2605*	TENNCARE MEDICAID: The MCO provides coverage for diabetic equipment, supplies, and outpatient self-management training and education, including medical nutrition counseling, when medically necessary. Not applicable for CoverKids	☒ Provider Manual ☐ Contract ☒ Other ♦ 2022 Benefit Delivery Review Questionnaire	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
27. Chlamydia Screens *TCA 56-7-2606*	TENNCARE MEDICAID: The MCO provides for one annual chlamydia screening test in conjunction with an annual Pap smear for females who are not more than 29 years of age, if deemed medically necessary. Not covered for CoverKids	☒ Provider Manual ☐ Contract ☒ Other ♦ 2022 Benefit Delivery Review Questionnaire	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
28. Psychiatric Inpatient Hospital Services (Including Physician Services)	As medically necessary	☒ Provider Manual ☐ Contract	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
CRA A.2.6.1.4		☐ Other (Describe)		
Comment: **Strengths**: **Suggestions**: **AONs**:				
29. Outpatient Mental Health Services (Including Physician Services) *CRA A.2.6.1.4*	As medically necessary	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
30. Inpatient/Residential and Outpatient Substance Abuse Benefits *CRA A.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.	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
31. 24-Hour Psychiatric Residential Treatment *CRA A.2.6.1.4*	As medically necessary	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
Comment: **Strengths**: **Suggestions**: **AONs**:				
32. BH Crisis Services *CRA A.2.6.1.4*	As necessary	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
33. BH Intensive Community Based Treatment *CRA A.2.6.1.4*	As medically necessary	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
34. Psychiatric Rehabilitation Services *CRA A.2.6.1.4*	As medically necessary	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
Strengths:				
Suggestions:				
AONs:				
35. Nursing Facility Care *CRA A.2.6.1.5.3* *CRA A.2.6.1.6.4*	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 Groups 4, 5, and 6 may receive short-term nursing facility care, without being required to disenroll from their ECF CHOICES group until such time that it is determined that transition back to HCBS in ECF CHOICES will not occur within 90 days from admission.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA*	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
36. Community-Based Residential Alternatives *CRA A.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**	**1.0**
Comment:				
Strengths:				
Suggestions:				

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

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
AONs:				
37. Personal Care Visits *CRA A.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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
38. Attendant Care *CRA A.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.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
39. Home-Delivered Meals *CRA A.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**	**1.0**
Comment: **Strengths**: **Suggestions**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
AONs:				
40. PERS *CRA A.2.6.1.5.3*	As medically necessary for CHOICES members in Groups 2 and 3.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
41. Adult Day Care *CRA A.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**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
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 ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
AONs:				
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.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
44. Assistive Technology *CRA A.2.6.1.5.3* *CRA A.2.6.1.6.3*	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 members (for assistive technology and enabling technology combined) in Groups 4, 5, 6, 7, and 8.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
45. Minor Home Modifications *CRA A.2.6.1.5.3* *CRA A.2.6.1.6.3*	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 members in Groups 4, 5, 6, 7, and 8.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
AONs:				
46. Pest Control *CRA A.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 ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
47. ECF CHOICES: 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 members in Groups 4, 5, and 6.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
48. Supportive Home Care (SHC) *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES members in Group 4.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
AONs:				
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 members in Group 4.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
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 members in Groups 4, 5, 6, and 7.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
51. Community Transportation *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES members in Groups 4, 5, 6, and 7.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
AONs:				
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 members in Groups 4, 5, 6, and 7.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
53. Community Support *CRA A.2.6.1.6.3*	As medically necessary for community support development, organization, and navigation for ECF CHOICES members in Groups 4 and 7.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
54. Family Caregiver Education and Training *CRA A.2.6.1.6.3*	As medically necessary (up to $500 per calendar year) for ECF CHOICES members in Group 4 and 7.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
AONs:				
55. Family-to-Family Support *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES members in Groups 4 and 7.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
56. Decision-making Supports *CRA A.2.6.1.6.3*	As medically necessary (up to $500 per lifetime) for ECF CHOICES members in Groups 4, 5, 6, 7, and 8.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
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 members in Groups 4 and 7.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
AONs:				
58. Personal Assistance *CRA A.2.6.1.6.3*	As medically necessary (up to 215 hours per month) for ECF CHOICES members in Groups 5 and 6.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
59. Community Living Supports (CLS) *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES members in Groups 5 and 6.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
60. CLS-Family Model (CLS-FM) *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES members in Groups 5 and 6.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
AONs:				
61. Individual Education and Training *CRA A.2.6.1.6.3*	As medically necessary (up to $500 per calendar year) for ECF CHOICES members in Groups 5, 6, and 8.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
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 members in Groups 5, 6, and 8.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
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 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.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
Strengths:				
Suggestions:				
AONs:				
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 members in Groups 4, 5, 6, and 8. Group 4 benefits limited to adults age 21 and older	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
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 members in Groups 4, 5, 6, 7, and 8: ♦ Exploration ♦ 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 ♦ Career advancement	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment:				
Strengths:				

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
Suggestions:				
AONs:				
66. Intensive Behavioral Family-centered Treatment, Stabilization and Supports (IBFCTSS) *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES members in Group 7.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
67. Intensive Behavioral Community Transition and Stabilization Services (IBCTSS) *CRA A.2.6.1.6.3*	As medically necessary for ECF CHOICES members in Group 8.	☒ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
68. Non-Pharmacy Copayment Schedule *Attachment II*	The MCO informs CoverKids members of the non-pharmacy copayment schedule that applies to them for the following services: ♦ Hospital emergency room ♦ Primary care providers and Community Mental Health Agency Services for services other than preventive care	☒ Met ☐ Not Met ☐ NA	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
	♦ Physician specialists ♦ Inpatient hospital admissions			
Comment: **Strengths**: **Suggestions**: **AONs**:				
69. Cost Sharing *Attachment II*	The MCO informs CoverKids members of the cost-sharing requirements for the following services: ♦ Chiropractic care ♦ Emergency room services ♦ Inpatient physical health admissions and services ♦ Inpatient mental health and substance abuse treatment services ♦ Outpatient mental health and substance abuse treatment services ♦ Physical, speech, and occupational therapy ♦ Physician office visits ♦ Prescription drugs ♦ Vision services	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment: **Strengths**: **Suggestions**: **AONs**:				
70. Regulator Approval: Provider Manual CRA A.2.18.5.1	The MCO's Provider Manual was approved by TennCare. Date of Approval: 12/03/21, CHOICES 10/22/21, ECF CHOICES 10/29/21	☒ Met ☐ Not Met ☐ NA	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <MCO>				
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)				
Comment:				
Strengths:				
Suggestions:				
AONs:				
	Benefit Delivery: Accessibility—Provider Score	**100.0%**	**70.0**	**70.0**

ANA Standards Tools—DBM

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
1. Statewide Network *TennCare Dental Benefits Manager Contract (TDC) A.19.*	The DBM has a statewide provider network, including general dentists and dental specialists.	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
2. Anticipated Enrollment *TDC A.20.a.*	The DBM considers the anticipated Medicaid and CoverKids enrollment when developing and maintaining the provider network.	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
AONs:				
3. Expected Utilization *TDC A.20.b.*	In developing and maintaining the provider network, the DBM considers the expected utilization of services, taking into consideration the characteristics and health care needs of the Medicaid and CoverKids population.	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
4. Number and Type of Providers *TDC A.20. c.*	In developing and maintaining the provider network, the DBM considers the number and type (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid and CoverKids services.	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
5. 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 monitored by the DBM.	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
6. Contracted Dental Specialists *TDC A.46.*	Specialists include: Oral Surgeons Endodontists Orthodontists Periodontists Prosthodontists	☒ Met ☐ Not Met ☒ Met ☐ Not Met ☒ Met ☐ Not Met ☒ Met ☐ Not Met ☒ Met ☐ Not Met Each Variable = .20	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
7. 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**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
8. 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	☒ Met ☐ Not Met ☒ Met	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
	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 b) Appointment wait times do not exceed 48 hours for urgent care	☐ Not Met Each Variable = 0.50		
Comment: **Strengths:** **Suggestions:** **AONs:**				
9. 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**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
10. 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: 30 miles or 45 minutes for general dental services 60 miles or 60 minutes for oral surgery services 60 miles or 60 minutes for orthodontic services 70 miles or 70 minutes for pediatric dental services 30 miles or 45 minutes for 75%, and 60 miles or 60 minutes for 100% of ECF CHOICES DBM providers	☒ Met ☐ Not Met ☐ NA ☒ Met ☐ Not Met ☐ NA ☒ Met ☐ Not Met	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
		☐ NA ☒ Met ☐ Not Met ☐ NA ☒ Met ☐ Not Met ☐ NA Each Variable = 0.20		
Comment: **Strengths:** **Suggestions:** **AONs:**				
11. 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**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
12. 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**	**1.0**
Comment: **Strengths:** **Suggestions:**				

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
AONs:				
13. 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, primary care provider, or triage nurse who is trained in dental care and oral healthcare.	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:**				
AONs:				
14. Out-of-Network Providers *TDC A.26.* *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**	**1.0**
Comment: **Strengths:** **Suggestions:**				
AONs:				
15. Charges for Out-of-Network Services *TDC A.46.* *42 CFR § 438.206(b)(5)*	The DBM ensures that the cost to the member is no greater for an out-of-network provider than the cost would have been if the services were provided within the network.	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:**				

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
AONs:				
16. Mobile Dental Clinics *TDC A.20.f.*	Mobile dental clinics are not considered in determining sufficient network access.	☒ Met ☐ Not Met ☐ NA*	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
17. 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**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
18. Dental Referrals *TDC A.46.*	The general dentist or pediatric dentist: ♦ 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 ♦ Does not need to provide separate referrals for subsequent visits to the same specialist in a course of treatment.	☒ Met ☐ Not Met ☒ Met ☐ Not Met Each Variable = 0.50	**1.0**	**1.0**

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

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
Comment: **Strengths:** **Suggestions:** **AONs:**				
19. 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 cost to the member.	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
20. 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**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
21. Non-Traditional Fluoride Varnish and Dental Screening Program *TDC A.5.a.4.*	TENNCARE MEDICAID: The DBM implements a program that allows non-traditional providers (such as primary care providers, 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**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
Comment: **Strengths:** **Suggestions:** **AONs:**				
22. Notification to New Members: Distributing the Member Handbook *TDC A.10.a.1.*	The DBM distributes the Member Handbooks and provider network directories to members within 30 days of receipt of notice of enrollment in a State DBM Program.	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
23. Notification to New Members: Accessing the Provider Directory *TDC A.10.c.*	The DBM provides information concerning how to access the provider directory, including the right to request a hard copy, how to contact member services, and how to access the searchable version of the provider directory on the DBM's website within 30 calendar days of receipt of notification of enrollment in the DBM.	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
24. Updating Provider Information *TDC A.10.c.*	The DBM is responsible for redistribution of updated provider information on a regular basis and makes available a complete and updated provider directory at least on an annual basis.	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment:				

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
Strengths: **Suggestions:** **AONs:**				
25. Requirements of the Provider Directory *TDC A.10.c.1,*	The provider directory includes: a) name and specialty b) locations c) telephone numbers d) website e) office hours f) non-English languages spoken g) handicap accessible h) group affiliation i) hospital privileges cultural competency training	☒ Met ☐ Not Met ☒ Met ☐ Not Met ☒ Met ☐ Not Met ☒ Met ☐ Not Met ☒ Met ☐ Not Met ☒ Met ☐ Not Met ☒ Met ☐ Not Met Variable a–f = .143 Variable g = .142	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
26. Provider Satisfaction Survey *TDC A. 37.*	The DBM conducts a provider satisfaction survey of the participating network dentists and dental specialists, following approval by the State of the form, content, and proposed administration of the survey, each October or November and reports the results to the State by March 30 of each year	☒ Met ☐ Not Met	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
Comment:				
Strengths:				
Suggestions:				
AONs:				
27. Provider Informational Sessions *TDC A.52.a.*	The DBM holds at least two informational sessions per year for each Grand Region in the state.	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
	Network Adequacy: Availability and Accessibility Score	**100%**	**27.0**	**27.0**

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)				
1. Member Education *TDC A.115.*	The DBM conducts regularly scheduled outreach activities designed to educate enrollees about the availability of EPSDT services to increase the number of children receiving services	☒ Member Handbook ☐ Explanation of Benefits ☒ Other ♦ 2021 Community Outreach Plan	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
2. Preventive Treatment: Dental Cleanings TDC A.5.a.1. *TDC A.5.d*	Dental cleanings TENNCARE MEDICAID: As medically necessary COVERKIDS: Coverage for two cleanings per calendar year	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
3. Non-Traditional Fluoride Varnish and Dental Screening Program TDC A.5.a.4.	Fluoride treatments TENNCARE MEDICAID: Two visits per year	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths:**				

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)				
Suggestions:				
AONs:				
4. Preventive Treatment: Dental Sealants TDC A.5.a.1. *TDC A.5.d.*	Dental Sealants TENNCARE MEDICAID: As medically necessary COVERKIDS: Coverage for permanent molars-One per tooth per lifetime	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
5. Preventive Treatment: Application of Silver Diamine Fluoride *TDC A.5.a.1.* *TDC A.5.d.*	Silver Diamine Fluoride TENNCARE MEDICAID: As medically necessary COVERKIDS: Four applications per tooth per lifetime	☒ Member Handbook ☐ Explanation of Benefits ☒ Other ♦ **DQ** website	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
6. Preventive Treatment: Diagnostic Services TDC A.5.a.1. *TDC A.5.d*	Diagnostic Services TENNCARE MEDICAID: As medically necessary	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)				
	COVERKIDS: Coverage for two oral exams per calendar year			
Comment: **Strengths:** **Suggestions:** **AONs:**				
7. Laboratory Services: Oral Pathology *TDC A.5.a.1.* *TDC A.5.d.*	Laboratory services TENNCARE MEDICAID: AS medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☒ Other ♦ Member Dental Benefits document	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
8. Emergency Services *TDC A.5.a.1.* *TDC A.5.d.*	Emergency services TENNCARE MEDICAID: As medically necessary COVERKIDS: Two visits per calendar year during office hours; two visits per calendar year after office hours	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:**				

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)				
AONs:				
9. Restorative Services *TDC A.5.a.1.* *TDC A.5.d.*	Restorative services TENNCARE MEDICAID: As medically necessary COVERKIDS: Stainless steel crowns; routine fillings (silver or tooth colored)	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
10. Extractions *TDC A.5.a.1.* *TDC A.5.d.*	Extractions TENNCARE MEDICAID: As medically necessary COVERKIDS: As medically necessary	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
11. Radiographs *TDC A.5.a.1.* *TDC A.5.d.*	X-rays TENNCARE MEDICAID: As medically necessary COVERKIDS:	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)				
	♦ Bitewing X-rays: No more frequently than once per calendar year for members 2 years of age and older. ♦ Full mouth X-rays: No more frequently than once every three calendar years			
Comment: **Strengths:** **Suggestions:** **AONs:**				
12. Therapeutic Pulpotomy *TDC A.5.a.1.* *TDC A.5.d.*	Therapeutic Pulpotomy TENNCARE MEDICAID: As medically necessary COVERKIDS: As medically necessary	☒ Member Handbook ☐ Explanation of Benefits ☒ Other ♦ Member Dental Benefits document	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
13. Anesthesia *TDC A.5.a.1.* *TDC A.5.d.*	Anesthesia TENNCARE MEDICAID: As medically necessary COVERKIDS: As medically necessary	☒ Member Handbook ☐ Explanation of Benefits ☒ Other ♦ Member Dental Benefits document	**1.0**	**1.0**
Comment: **Strengths:**				

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)				
Suggestions:				
AONs:				
14. Orthodontics *TDC A.5.a.2.* *TDC A.5.d.*	Orthodontics TENNCARE MEDICAID: As medically necessary for members under age 21 in accordance with TennCare Rules COVERKIDS: As medically necessary with a maximum limit of $1,250 per member	☒ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
15. Periodontic Services *TDC A.46.*	Periodontic services REGULAR MEDICAID: As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☒ Other ♦ Member Dental Benefits document	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
16. Annual Benefit Maximum TDC 5.d.	COVERKIDS ONLY: Members are informed of their annual benefit maximum	☒ Member Handbook ☐ Explanation of Benefits	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)				
		☐ Other (Describe)		
Comment:				
Strengths:				
Suggestions:				
AONs:				
17. Member Handbook Approval *TDC A.10.*	The Member Handbooks were approved by TennCare prior to distribution. TENNCARE STANDARD MEDICAID: Date of Approval: 9/30/21 COVERKIDS: Date of Approval: 9/30/21	☒ Met ☐ Not Met ☐ NA	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
	Benefit Delivery: Accessibility—Member Score	**100%**	**17.0**	**17.0**

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)				
1. Member Education *TDC A.115.*	The DBM conducts regularly scheduled outreach activities designed to educate providers about the availability of EPSDT services to increase the number of children receiving services	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
2. Preventive Treatment: Dental Cleanings TDC A.5.a.1. *TDC A.5.d*	Dental cleanings TENNCARE MEDICAID: As medically necessary COVERKIDS: Coverage for two cleanings per calendar year	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
3. Non-Traditional Fluoride Varnish and Dental Screening Program TDC A.5.a.4.	Fluoride treatments TENNCARE MEDICAID: Two visits per year	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment:				

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)				
Strengths:				
Suggestions:				
AONs:				
4. Preventive Treatment: Dental Sealants TDC A.5.a.1. *TDC A.5.d.*	Dental Sealants TENNCARE MEDICAID: As medically necessary COVERKIDS: Coverage for permanent molars-One per tooth per lifetime	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
5. Preventive Treatment: Application of Silver Diamine Fluoride *TDC A.5.a.1.* *TDC A.5.d.*	Silver Diamine Fluoride TENNCARE MEDICAID: As medically necessary COVERKIDS: Four application per tooth per lifetime	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
6. Preventive Treatment: Diagnostic Services TDC A.5.a.1. *TDC A.5.d*	Diagnostic Services TENNCARE MEDICAID: As medically necessary	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)				
	COVERKIDS: Coverage for two oral exams per calendar year			
Comment: **Strengths:** **Suggestions:** **AONs:**				
7. Laboratory Services: Oral Pathology *TDC A.5.a.1.* *TDC A.5.d.*	Laboratory services TENNCARE MEDICAID: AS medically necessary	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
8. Emergency Services *TDC A.5.a.1.* *TDC A.5.d.*	Emergency services TENNCARE MEDICAID: As medically necessary COVERKIDS: Two visits per calendar year during office hours; two visits per calendar year after office hours	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)				
9. Restorative Services *TDC A.5.a.1.* *TDC A.5.d.*	Restorative services TENNCARE MEDICAID: As medically necessary COVERKIDS: Stainless steel crowns; routine fillings (silver or tooth colored)	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
10. Extractions *TDC A.5.a.1.* *TDC A.5.d.*	Extractions TENNCARE MEDICAID: As medically necessary COVERKIDS: As medically necessary	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
11. Radiographs *TDC A.5.a.1.* *TDC A.5.d.*	X-rays TENNCARE MEDICAID: As medically necessary COVERKIDS:	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)				
	♦ Bitewing X-rays: No more frequently than once per calendar year for members 2 years of age and older. ♦ Full mouth X-rays: No more frequently than once every three calendar years			
Comment: **Strengths:** **Suggestions:** **AONs:**				
12. Therapeutic Pulpotomy *TDC A.5.a.1.* *TDC A.5.d.*	Therapeutic Pulpotomy TENNCARE MEDICAID: As medically necessary COVERKIDS: As medically necessary	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
13. Anesthesia *TDC A.5.a.1.* *TDC A.5.d.*	Anesthesia TENNCARE MEDICAID: As medically necessary COVERKIDS: As medically necessary	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths:**				

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)				
Suggestions:				
AONs:				
14. Orthodontics *TDC A.5.a.2.* *TDC A.5.d.*	Orthodontics TENNCARE MEDICAID: As medically necessary for members under age 21 in accordance with TennCare Rules COVERKIDS: As medically necessary with a maximum limit of $1,250 per member	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
15. Periodontic Services *TDC A.46.*	Periodontic services REGULAR MEDICAID: As medically necessary	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
16. Annual Benefit Maximum *TDC 5.d.*	COVERKIDS ONLY: Members are informed of their annual benefit maximum	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)				
Comment: **Strengths:** **Suggestions:** **AONs:**				
17. ECF CHOICES DBM: Preventive Services *TDC A.5.b.2.(a)*	ECF CHOICES DBM Services: Preventive Dental Services	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
18. ECF CHOICES DBM: Fillings *TDC A.5.b.2.(a)*	ECF CHOICES DBM Services: Fillings	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
19. ECF CHOICES DBM: Root Canals *TDC A.5.b.2.(a)*	ECF CHOICES DBM Services: Root Canals	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths:**				

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)				
Suggestions:				
AONs:				
20. ECF CHOICES DBM: Extractions *TDC A.5.b.2.(a)*	ECF CHOICES DBM Services: Extractions	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
21. ECF CHOICES DBM: Periodontics *TDC A.5.b.2.(a)*	ECF CHOICES DBM Services: Periodontics	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
22. ECF CHOICES DBM: Dentures *TDC A.5.b.2.(a)*	ECF CHOICES DBM Services: Dentures	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)				
23. ECF CHOICES DBM: Sedation Services *TDC A.5.b.2.(a)*	ECF CHOICES DBM Services: Sedation Services—may include medically necessary and appropriate deep sedation or general anesthesia	☒Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
24. ECF CHOICES DBM: Benefit Maximums *TDC A.5.b.4.*	ECF CHOICES DBM Services: The Provider Manual includes the benefit maximum amount per member per calendar year, and the amount per member across three consecutive calendar years	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
25. ECF CHOICES: Provider Training *TDC A.53.*	ECF CHOICES Provider Training: Furnishes educational training/webinars and best practices information to contracted ECF CHOICES dental providers	☒ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				

2022 Annual Network Adequacy Review Standards Tool: <DBM>				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)				
26. Revisions to the Provider Manual *TDC A.55.*	Participating dental providers are apprised of revisions to the manual by means of written or electronic notice to be sent 30 days in advance of the implementation of a new policy or procedure.	☐ Provider Manual ☐ Contract ☒ Other ♦ Change Notice	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
27. 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 ORM: 7/29/21 CoverKids ORM: 7/29/20 ECF ORM: 8/26/21	☐ Provider Manual ☐ Contract ☒ Other ♦ Approval Notices	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
	Benefit Delivery: Accessibility—Provider Score	**100%**	**27.0**	**27.0**

ANA Standards Tools—PBM

2022 Annual Network Adequacy Review Standards Tool: PBM				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
1. Statewide Network *PBMC A.10.* *TCA 56-7-2356(a)(1)* *42 CFR § 438.207(b)(2)*	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**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
2. Statewide Network of Pharmacy Providers *PBMC A.49.a* *TCA 56-7-2356(a)(1)* *42 CFR § 438.207(b)(2)*	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**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				

2022 Annual Network Adequacy Review Standards Tool: PBM				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
3. Standards for Access *PBMC A.49.a* *TCA 56-7-2356(a)(1)* *TCA 56-7-2356(a)(1)(B)* *42 CFR § 438.207(b)(2)*	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 ii. travel time iii. the means of transportation ordinarily used by TennCare enrollees iv. whether the location provides physical access for TennCare enrollees with disabilities	a) ☒ Met ☐ Not Met ☐ NA b) ☒ Met ☐ Not Met ☐ NA c) ☒ Met ☐ Not Met ☐ NA d) ☒ Met ☐ Not Met ☐ NA	**4.0**	**4.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
4. Emergency Services *PBMC A.49.a* *TCA 56-7-2356(a)(1)* *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**	**1.0**
Comment: **Strengths:** **Suggestions:**				

2022 Annual Network Adequacy Review Standards Tool: PBM				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
AONs:				
5. Hours of Operation *PBMC A.49.a* *TCA 56-7-2605(c)* *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**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
6. Access Distance and Time *PBMC A.49.b* *TCA 56-7-2356(a)(1)(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 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**	**3.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				

2022 Annual Network Adequacy Review Standards Tool: PBM				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
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	**1.0**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
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**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
9. Out-of-Network Providers *PBMC A.13.* *TCA 56-7-2356(c)* *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**	**1.0**
Comment: **Strengths:** **Suggestions:** **AONs:**				
10. Out-of-Network Provider Payments *PBMC A.14.* *TCA 56-7-2356(c)*	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**	**1.0**

2022 Annual Network Adequacy Review Standards Tool: PBM				
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**	
			Value	**Score**
Network Adequacy: Availability and Accessibility				
42 CFR § 438.206(b)(5)				
Comment:				
Strengths:				
Suggestions:				
AONs:				
11. Limited English Proficiency (LEP)/Cultural Competence *PBMC A.6.i.* *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 disability and diverse cultural and ethnic backgrounds regardless of an enrollee's gender, sexual orientation, or gender identity.	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
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**	**1.0**
Comment:				
Strengths:				
Suggestions:				
AONs:				
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 and through its Pharmacy Help Desk.	☒ Met ☐ Not Met	**1.0**	**1.0**
Comment:				

2022 Annual Network Adequacy Review Standards Tool: PBM				
Evaluation Elements	Criteria	Criteria Met	Element	
			Value	Score
Network Adequacy: Availability and Accessibility				
Strengths:				
Suggestions:				
AONs:				
	Network Adequacy: Availability and Accessibility Score	**100%**	**18.0**	**18.0**

ANA Contract File Review Tools—MCOs

MCO: <MCO>	Reviewer:									Date of Review: mm/dd/2022															# 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*																														
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*																														
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 the TennCare rules and regulations. *CRA A.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*																														
E) If the provider performs laboratory services, require the provider to meet all applicable																														

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

MCO: <MCO>	Reviewer:									Date of Review: mm/dd/2022																				
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
requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988. *CRA A.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*																														
G) Require that the provider comply with corrective action plans initiated by the Contractor. *CRA A.2.12.9.23*																														
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*																														
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*																														
J) Provide for the participation and cooperation in any internal and external quality management/quality improvement, monitoring,																														

MCO: <MCO>	Reviewer:										Date of Review: mm/dd/2022										# 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**
utilization review, peer review and/or appeal procedures established by the Contractor and/or TennCare. *CRA A.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 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*																														
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 of the Contract/Agreement. *CRA A.2.12.9.55*																														

MCO: <MCO>	Reviewer:										Date of Review: mm/dd/2022										# 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**													
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. *CRA A.2.12.9.11*																																										
N) Provide for monitoring, whether announced or unannounced, of services rendered to members. *CRA A.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, 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*																																										
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*																																										
Q) Require compliance with applicable access requirements, including but not limited to																																										

MCO: <MCO>	Reviewer:										Date of Review: mm/dd/2022										# 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**
appointment and wait times as referenced in Section A.2.11 of the CRA. *CRA A.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*																														
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. *CRA A.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*																														
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*																														

MCO: <MCO>	Reviewer:									Date of Review: mm/dd/2022															# 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**
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*																														
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*																														
Total Number of Points																														
Maximum Number of Points																														
Score																														

Provider Contract Compliance Analysis		
Contract Item	**Number Compliant/ Total Possible**	**Percent Compliant**
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*		
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*		
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 the TennCare rules and regulations. *CRA A.2.12.9.8*		
Provide that emergency services be rendered without the requirement of prior authorization of any kind. *CRA A.2.12.9.9*		
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*		
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*		
Require that the provider comply with corrective action plans initiated by the Contractor. *CRA A.2.12.9.23*		

Provider Contract Compliance Analysis		
Contract Item	**Number Compliant/ Total Possible**	**Percent Compliant**
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*		
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*		
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*		
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 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*		
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 of the Contract/Agreement. *CRA A.2.12.9.55*		
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. *CRA A.2.12.9.11*		

Provider Contract Compliance Analysis		
Contract Item	**Number Compliant/ Total Possible**	**Percent Compliant**
Provide for monitoring, whether announced or unannounced, of services rendered to members. *CRA A.2.12.9.19*		
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, 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*		
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*		
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. *CRA A.2.12.9.10*		
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 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. *CRA A.2.12.9.39*		
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*		
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*		
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		

Provider Contract Compliance Analysis		
Contract Item	**Number Compliant/ Total Possible**	**Percent Compliant**
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*		
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*		
Total Results		**100.0%**

ANA Contract File Review Tools—DBM

DBM: <DBM>	Reviewer:										Date of Review: mm/dd/2022										# 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 and specify that the provider complies with the TennCare medical necessity rules. *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																																										

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

DBM: <DBM>	Reviewer:									Date of Review: mm/dd/2022									# 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
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 agreements must contain language that references the EPSDT benefit package and periodicity schedule. *TDC A.66.ll.*																														

DBM: <DBM>	Reviewer:										Date of Review: mm/dd/2022										# 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**
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), and Department of Justice , 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																														

DBM: <DBM>	Reviewer:										Date of Review: mm/dd/2022										# 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**
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																														

Provider Contract Compliance Analysis		
Contract Item	**Number Compliant/Total Possible**	**Total Percent Compliant**
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.*	CoverKids Contracts TennCare Medicaid Contracts **Total Contracts**	
]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.*	CoverKids Contracts TennCare Medicaid Contracts **Total**	
Specify the amount, duration, and scope of services to be provided by the provider and specify that the provider complies with the TennCare medical necessity rules. *TDC A.66.h.*	CoverKids Contracts TennCare Medicaid Contracts **Total Contracts**	

Provider Contract Compliance Analysis		
Contract Item	**Number Compliant/Total Possible**	**Total Percent Compliant**
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.*	CoverKids Contracts TennCare Medicaid Contracts **Total Contracts**	
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.*	CoverKids Contracts TennCare Medicaid Contracts **Total Contracts**	
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.*	CoverKids Contracts TennCare Medicaid Contracts **Total Contracts**	
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.*	CoverKids Contracts TennCare Medicaid Contracts **Total Contracts**	
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.*	CoverKids* Medicaid **Total**	
	CoverKids	

* *Note: EPSDT does not apply to CoverKids.*

Provider Contract Compliance Analysis		
Contract Item	**Number Compliant/Total Possible**	**Total Percent Compliant**
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.*	Medicaid	
	Total	
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.*	CoverKids Contracts	
	TennCare Medicaid Contracts	
	Total Contracts	
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), and Department of Justice, 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.*	CoverKids Contracts	
	TennCare Medicaid Contracts	
	Total Contracts	
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.*	CoverKids Contracts	
	TennCare Medicaid Contracts	
	Total Contracts	
Total Results		**100.0%**

AQS Tools

QP Standards Tool—MCOs

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
1. Adequate Access for All Members* 42 CFR § 438.206.b.1 CRA and TSA: 2.7.6.1.3; 2.11.1.1	The MCO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency (LEP) and/or physical and/or mental disabilities.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
2. Women's Health Specialists* 42 CFR § 438.206.b.2 CRA and TSA: 2.14.4.3	The MCO provides female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive healthcare services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON**					

* *Elements marked with an asterisk can be deemed if the MCO is fully compliant with the applicable NCQA standard.*

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
Suggestion					
3. Second Opinion* 42 CFR § 438.206.b.3 CRA and TSA: 2.6.4	The MCO provides for 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	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
4. Out-of-Network Services* 42 CFR § 438.206.b.4 CRA and TSA: 2.11.1.9	If the provider network is unable to provide necessary services, covered under the contract, to a particular member, the MCO adequately and timely covers these services out of network for the member, for as long as the MCO's provider network is unable to provide them.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
5. Out-of-Network Costs* 42 CFR § 438.206.b.5	The MCO requires out-of-network providers to coordinate with the MCO for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
CRA: 2.6.7.1.1 TSA: 2.6.7.1					
Comments **Strength** **AON** **Suggestion**					
6. Credentialing and Recredentialing Policy* 42 CFR § 438.214.b.2-.d.1; 438.206.b.6 CRA and TSA: 2.11.1.3; 2.11.1.3.1 and .3; 2.11.10.1-.4.1.12	The MCO demonstrates that its network providers are credentialed according to a uniform credentialing and recredentialing policy that addresses acute, primary, behavioral, and substance use disorders and long-term services and supports (LTSS) providers, as appropriate. The MCO follows a documented process for credentialing and recredentialing network providers. The MCO's 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 MCO does not employ or contract with providers excluded from participation in federal healthcare programs under the Social Security Act.	☐ Policy that addresses disorder treatment and LTSS providers ☐ Process for network providers ☐ P&Ps are non-discriminatory ☐ Excluded providers do not participate	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
7. Family Planning* 42 CFR § 438.206.b.7	The MCO demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
CRA and TSA: 2.7.5.1					
Comments					
Strength					
AON					
Suggestion					
8. Timely Access* 42 CFR § 438.206.c.1.i CRA and TSA: 2.12.9 and .10	The MCO requires its network providers to meet TennCare standards for timely access to care and services, taking into account the urgency of the need for services.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
9. Hours of Operation and Access* 42 CFR § 438.206.c.1.ii-.iii CRA and TSA: 2.12.9; 2.12.9.64; Attachment III	The MCO ensures that its network providers offer hours of operation that are no less than the hours of operation offered to commercial members. The MCO makes services included in the contract available 24 hours a day, seven days a week, when medically necessary.	☐ Comparable hours of operation ☐ 24/7 access	**0.50** **0.50**	**1.00**	**0.00**
Comments					
Strength					

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
AON					
Suggestion					
10. Compliance* 42 CFR § 438.206.c.1.iv-.vi CRA and TSA: 2.11.1.10	The MCO establishes mechanisms to ensure network provider compliance with the provision of timely access to care, monitors network providers regularly to determine compliance, and takes corrective action for noncompliance.	☐ Mechanisms ☐ Monitoring ☐ Corrective action if needed	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
11. Cultural Competency* 42 CFR § 438.206.c.2 CRA and TSA: 2.18.3	The MCO participates in TennCare's efforts to promote the delivery of services in a culturally competent manner to all members, including those with LEP, diverse cultural and ethnic backgrounds, and/or disabilities, and regardless of sex.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
ON					
Suggestion					

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
12. Accessibility for Members with Disabilities* 42 CFR § 438.206.c.3 CRA and TSA: 2.18.3	The MCO ensures that network providers offer physical access, reasonable accommodations, and accessible equipment for members with physical and/or mental disabilities.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
13. Provider Directory Inclusions 42 CFR § 438.10.h.1-.1.viii CRA and TSA: 2.17.8.5	The MCO maintains a Provider Directory that is available electronically and in hard copy by request. It includes the following for each provider: 1. Name and group affiliation 2. Street address(es) 3. Telephone number(s) 4. Website URL 5. Specialty 6. Whether the provider accepts new members 7. Cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
14. Provider Types 42 CFR § 438.10.h.2-.2.v CRA and TSA: 2.17.8.5	The Provider Directory includes information for each of the following provider types covered under the contract: 1. Physicians, including specialists 2. Hospitals 3. Pharmacies 4. Behavioral health providers 5. LTSS providers	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
15. Provider Directory Availability 42 CFR § 438.10.h.3-.4 CRA and TSA: 2.17.8.3 and .5	The hard copy version of the Provider Directory is updated at least monthly. The electronic version is updated at least three times weekly and is available on the MCO's website.	☐ Hard copy updated monthly ☐ Electronic version updated timely and available on website	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
		Availability of Services Score	**0.0%**	**15.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Assurances of Adequate Capacity and Services					
1. Appropriate Range of Services and Providers* 42 CFR § 438.207.b.1-.2 CRA and TSA: 2.11.1.1; 2.11.1.3; 2.11.1.3.2 CRA: 2.30.8.1.1-.2 TSA: 2.30.8.1	The MCO submits documentation to TennCare as evidence that it offers an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of members in the service area. It also submits documentation showing that it maintains a provider network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.	☐ Appropriate range of services ☐ Sufficient provider network ☐ Documentation submitted	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
2. Timely Documentation 42 CFR § 438.207.c-.c.3.ii CRA and TSA: 2.11.1.1; 2.11.1.3; 2.11.1.3.2 CRA: 2.30.8.1.1-.2 TSA: 2.30.8.1	The MCO submits documentation to TennCare evidencing its appropriate range of services and provider network no less frequently than 1. at the time it enters into a contract with TennCare; 2. on a monthly basis; and 3. at any time there has been a significant change (as defined by TennCare) in the MCO's operations that would affect the adequacy of capacity and services, including ♦ changes in services, benefits, geographic service area, composition of or payments to its network providers or ♦ enrollment of a new population.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Assurances of Adequate Capacity and Services					
Comments					
Strength					
AON					
Suggestion					
		Assurances of Adequate Capacity and Services Score	**0.0%**	**2.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
1. Primary Care* 42 CFR § 438.208.b.1 CRA and TSA: 2.11.2.1-.2 CRA: 2.17.4.6; 2.17.4.6.17 TSA: 2.17.4.7; 2.17.4.7.17	The MCO ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. The MCO provides information to the member on how to contact this source.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
2. Coordination of Services* 42 CFR § 438.208.b.2-.2.iv CRA and TSA: 2.9.2.4-.5; 2.9.7.1.3 CRA: 2.9.1.2-.2.1; 2.9.1.2.4-.6; 2.9.1.6; 2.9.7.3.27.11.4 TSA: 2.9.1.1-.2; 2.9.1.2; 2.9.1.2.2; 2.9.1.2.5-.7	The MCO coordinates the services that it furnishes to the member between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays, with services the member receives from any other MCO and services the member receives from community and social support providers.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
Comments **Strength** **AON** **Suggestion**					
3. Initial Screening* 42 CFR § 438.208.b.3 CRA and TSA: 2.8.3.1	The MCO makes a best effort to conduct an initial screening of each member's needs within 90 days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
4. Prevent Duplication of Services* 42 CFR § 438.208.b.4 CRA: 2.9.7.3.27.1 TSA: 2.8.3.2	The MCO shares with TennCare and other MCOs serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
Comments **Strength** **AON** **Suggestion**					
5. Medical Records* 42 CFR § 438.208.b.5 CRA: 2.24.8.1-.2.5 TSA: 2.24.6.1-.2.5	The MCO ensures that each provider furnishing services to members maintains and shares, as appropriate, medical records in accordance with professional standards.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
6. Protected Health Information* 42 CFR § 438.208.b.6 CRA and TSA: 2.27.5; 2.27.5.4	The MCO ensures that in the process of coordinating care, each member's protected health information (PHI) is used only for the purposes of treatment, payment, healthcare operations, and health oversight and its related functions.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON**					

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
Suggestion					
7. Comprehensive Assessment Mechanisms* 42 CFR § 438.208.c.2 CRA: 2.9.7.1.1-.1.5; 2.25.9; 2.25.9.5 TSA: 2.9.7.1.1-.1.5.1; 2.25.9	The MCO implements mechanisms to comprehensively assess each member identified by TennCare as needing LTSS or having special healthcare needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. The mechanisms include appropriate providers or individuals meeting LTSS service coordination requirements of TennCare or the MCO, as appropriate.	☐ Assessments for LTSS and special healthcare needs ☐ Mechanisms include appropriate providers or individuals who meet requirements	**0.50** **0.50**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
8. Treatment and Service Plans* 42 CFR § 438.208.c.3-.3.v CRA and TSA: 2.9.7.1.1-.2 CRA: 2.9.7.11.3.1-.1.1.1; 2.9.9.1-.1.1; 2.9.9.7 TSA: 2.9.6.9.3.1-.1.1.1; 2.9.8.1.1	The MCO produces a treatment or service plan that includes the following criteria for members who require LTSS: 1. Developed by an individual meeting LTSS service coordination requirements with member participation, and in consultation with any providers caring for the member 2. Developed by a person trained in person-centered planning using a person-centered process and plan for LTSS treatment or service plans 3. Approved by the MCO in a timely manner, if approval is required by the MCO 4. In accordance with any applicable TennCare quality assurance and utilization review standards 5. Reviewed and revised upon annual reassessment of functional needs, when the member's circumstances or needs change significantly, or at the request of the member	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
Comments **Strength** **AON** **Suggestion**					
9. Direct Access to Specialists* 42 CFR § 438.208.c.4 CRA and TSA: 2.14.3.3	For members with special healthcare needs determined through an assessment to need a course of treatment or regular care monitoring, the MCO has a mechanism in place to allow members direct access to a specialist (e.g., through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
10. Disenrollment by MCO Prohibited 42 CFR § 438.56.b-.b.3 CRA and TSA: 2.5.3 and .4	A member may be disenrolled from the MCO only when authorized by TennCare, and the MCO cannot request disenrollment of a member for any reason. The MCO promptly informs TennCare when it knows or has reason to believe that a member may satisfy any of the conditions for termination from the TennCare program as described in TennCare rules and regulations.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
11. Reasons for Disenrollment 42 CFR § 438.56.c-.d.2.iv CRA and TSA: 2.5.2-.12	A member may request disenrollment or be disenrolled if 1. the MCO does not, because of moral or religious objections, cover the service the member seeks; 2. the member needs related services (e.g., a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the member's primary care provider (PCP) or another provider determines that receiving the services separately would subject the member to unnecessary risk; 3. the member would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the MCO and, as a result, would experience a disruption in their residence or employment (applicable for LTSS members); 4. the member experiences poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in managing the member's care needs; 5. the member selects another MCO during the 90-day change period after enrollment (for all MCOs except TCS, which has a 45-day change period) or during the annual choice period and is enrolled in another MCO; 6. a request by the member to change MCOs based on hardship criteria is approved by TennCare, and the member is enrolled in another MCO; 7. an appeal by the member to change MCOs based on hardship criteria is decided by TennCare in favor of the member, and the member is enrolled in another MCO; 8. the member is assigned incorrectly to the MCO by TennCare and enrolled in another MCO; 9. the member moves outside the MCO's service area and is enrolled in another MCO; 10. a CHOICES/ECF CHOICES member requests reassignment and has reason to change MCO assignment if	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Coordination and Continuity of Care					
	all requirements are met in TennCare Rule (for all MCOs except TCS); 11. during the appeal process, if TennCare determines it is in the best interest of the member and TennCare; 12. the member loses eligibility or is terminated from the TennCare program; 13. the member exercises his/her TennCare-approved right to terminate enrollment and the member is enrolled in another MCO; or 14. the MCO no longer participates in TennCare.				
Comments					
Strength					
AON					
Suggestion					
		Coordination and Continuity of Care Score	**0.0%**	**11.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
1. Sufficient Services 42 CFR § 438.210.a.1-.3.i CRA and TSA: 2.6.3.3	The MCO ensures that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
2. Arbitrary Limitations Prohibited* 42 CFR § 438.210.a.3.ii CRA and TSA: 2.6.3.3	The MCO does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
3. Service Limitations* 42 CFR § 438.210.a.4-.4.i CRA and TSA: 2.6.3.1	The MCO has the ability to place appropriate limits on a service on the basis of criteria applied under TennCare rule, such as medical necessity.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Comments **Strength** **AON** **Suggestion**					
4. Utilization Control 42 CFR § 438.210.a.4; 438.210.a.4.ii-.ii.C CRA and TSA: 2.6.3.1; 2.14.1.6; 2.14.1.6.5	The MCO has the ability to place appropriate limits on a service for the purpose of utilization control, provided that 1. the services furnished can reasonably achieve their purpose; 2. the services supporting individuals with ongoing or chronic conditions or who require LTSS are authorized in a manner that reflects each member's ongoing need for LTSS; and 3. family planning services are provided in a manner that protects and enables each member's freedom to choose the method of family planning while being free from coercion or mental pressure.	☐ Services can achieve their purpose ☐ Services reflect need for LTSS ☐ Family planning services provided as described	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
5. Medically Necessary Definition* 42 CFR § 438.210.a.5-.5.i CRA and TSA: 2.6.1.3-.4; 2.6.3.1 CRA: 2.6.1.7.1-.5; 2.6.1.9 TSA: 2.6.1.7.1-.3	The MCO uses a definition of “medically necessary services” that is no more restrictive than what is used in the TennCare program, including quantitative and non-quantitative treatment limits, as indicated in TennCare statutes, regulations, and P&Ps.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Comments **Strength** **AON** **Suggestion**					
6. Medically Necessary Services 42 CFR § 438.210.a.5; 438.210.a.5.ii-.ii.D CRA and TSA: 2.6.3.1; 2.7.5.1; 2.7.6.3.1-.3.5; 2.7.6.4.1-.5 CRA: 2.6.1.9	The MCO provides "medically necessary services" in a manner that addresses the extent to which it is responsible for covering services that address: 1. the prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability; 2. the ability for a member to achieve age-appropriate growth and development; 3. the ability for a member to attain, maintain, or regain functional capacity; and 4. the opportunity for a member receiving LTSS to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.	☐ Prevention, diagnosis, and treatment ☐ Growth and development ☐ Functional capacity ☐ LTSS opportunities	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
7. Service Authorization P&Ps 42 CFR § 438.210.b-b.1 CRA and TSA: 2.14.2.1	The MCO and its subcontractors use written P&Ps to process requests for initial and continuing authorizations of services.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Comments					
Strength					
AON					
Suggestion					
8. Processing Authorizations* 42 CFR § 438.210.b.2-.2.iii CRA and TSA: 2.14.2.1; 2.14.5.1-.9	To process requests for initial and continuing authorizations of services, the MCO 1. uses mechanisms to ensure consistent application of review criteria for authorization decisions; 2. consults with the requesting provider for medical services when appropriate; and 3. authorizes LTSS based on a member's current needs assessment and consistent with the person-centered service plan.	☐ Criteria applied consistently ☐ Requesting provider consulted ☐ LTSS authorized	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
9. Appropriate Expertise* 42 CFR § 438.210.b.3 CRA: 2.14.1.8 TSA: 2.14.1.6	Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by an individual who has appropriate expertise in addressing the member's medical, behavioral health, or LTSS needs.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
10. Notice of Adverse Benefit Determination (NABD)* 42 CFR § 438.210.c CRA and TSA: 2.14.7.1	The MCO notifies the requesting provider and gives the member written NABD of any decision by the MCO to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. NABDs are sent within the TennCare-approved timeframes and include the determination, reasons for it, member's right to request an appeal, and an explanation of the appeal process.	☐ Sent to provider and member ☐ Includes required information	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
11. Notification Timeframes 42 CFR § 438.210.d-.d.3 CRA and TSA: 2.14.2.3 TSA: 2.14.7.2; 2.19.2	For standard authorization decisions, notices are sent as expeditiously as the member's condition requires and within TennCare-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days upon member or provider request or if the MCO justifies a need. For cases in which a provider indicates, or the MCO determines, that the standard timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, the MCO makes an expedited authorization decision and provides notice as expeditiously as the member's health condition requires, and no later than 72 hours after receipt of the request for service. The MCO may extend the 72-hour timeframe by up to 14 calendar days if the member requests an extension or if the MCO justifies a need for additional information and how the extension is in the member's interest. For all covered outpatient drug authorization decisions, the MCO provides notice as described in section 1927(d)(5)(A) of the Social Security Act.	☐ Standard authorizations ☐ Expedited authorizations ☐ Drug authorizations	**0.33** **0.33** **0.34**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Comments					
Strength					
AON					
Suggestion					
12. Compensation for Utilization Management (UM) 42 CFR § 438.210.e CRA: 2.14.1.11 TSA: 2.14.1.9	Compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
13. EPSDT Program Information 42 CFR § 441.56.a-.a.4 CRA and TSA: 2.7.6.2.1-.2; 2.7.6.2.2.2; 2.7.6.2.5	Using written and oral methods of communication, the MCO provides eligible members and their families with information about the EPSDT program. This information includes 1. benefits of preventive healthcare; 2. services available under the EPSDT program and where and how to obtain them; 3. a statement that the services provided under the EPSDT program are without cost to eligible individuals under 21 years of age; and 4. a statement that necessary transportation and scheduling assistance is available upon request. The MCO effectively provides this information for blind, deaf, and/or LEP members. The MCO also has processes in place to provide this	☐ Provided required information ☐ Information was accessible ☐ Provided information timely	**0.33** **0.33** **0.34**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
	information to members within 30 days of eligibility determination and annually thereafter if no EPSDT services have been used.				
Comments **Strength** **AON** **Suggestion**					
14. Screening Components 42 CFR § 441.56.b.1-.2; 441.61.a-.c CRA and TSA: 2.7.6.3.2-.4; 2.7.6.4.5	EPSDT screening services are provided in accordance with reasonable standards of medical and dental practice determined by the MCO after consultation with recognized medical and dental organizations involved in child healthcare. Screenings include, but are not limited to 1. comprehensive health and developmental history; 2. comprehensive unclothed physical examination; 3. vision testing; 4. hearing testing; 5. laboratory tests; and 6. dental screening services furnished by direct referral to a dentist for children beginning at three years of age. The MCO provides referral assistance for treatments that are not covered but are deemed necessary during a screening.	☐ Required components included ☐ Referral assistance provided	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON**					

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Suggestion					
15. Services Deemed Necessary 42 CFR § 441.56.c-.c.3; 441.59.a-.b CRA and TSA: 2.7.6.3 and .3.3; 2.7.6.4.1-.3	The MCO covers all of the following services that are determined necessary during a screening: 1. Diagnosis of and treatment for defects in vision and hearing, including eyeglasses and hearing aids 2. Dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth, and maintenance of dental health 3. Appropriate immunizations To avoid duplicate screening services, the MCO may accept written verification that the most recent age-appropriate screening services have been provided to an EPSDT-eligible member.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
16. Continuing Care Provider 42 CFR § 441.60.a-.e; 441.62.a-.b CRA and TSA: 2.11.2.1	The MCO assigns a continuing care provider to each EPSDT member, and the provider's responsibilities include 1. screening, diagnosis, treatment, and referral for follow-up services; 2. maintenance of the member's medical record, including information received from other providers; 3. physicians' services as needed for acute, episodic, or chronic illnesses or conditions; 4. dental services or a referral to a dentist; and 5. facilitating appointment scheduling and/or transportation assistance, or providing a referral for these services.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Suggestion					
17. Emergency Services Coverage 42 CFR § 438.114.c-.c.ii.A CRA and TSA: 2.7.1.4 and .6	The MCO covers and pays for emergency services regardless of whether the provider who furnishes the services has a contract with the MCO and does not deny payment for treatment obtained under either of the following circumstances: 1. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have placed the individual in serious jeopardy, seriously impaired bodily functions, or caused any body part to become seriously dysfunctional. 2. A representative of the MCO instructed the member to seek emergency services.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
18. Emergency Service Limitations* 42 CFR § 438.114.d-d.1.ii CRA and TSA: 2.7.1.5	The MCO does not limit what constitutes an emergency medical condition on the basis of diagnoses or symptoms and does not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's PCP, MCO, or TennCare within 10 calendar days of presentation for emergency services.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
19. Subsequent Treatment* 42 CFR § 438.114.d.2 CRA and TSA: 2.7.1.4	Members with emergency medical conditions are not held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
20. Transfer or Discharge* 42 CFR § 438.114.d.3 CRA and TSA: 2.7.1.4	Attending emergency physicians, or providers actually treating members, are responsible for determining when each member is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO as responsible for coverage and payment.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
21. Post-Stabilization Services 42 CFR § 438.114.e CRA and TSA: 2.7.1.3	The MCO is financially responsible for post-stabilization services in- and out-of-network under the following conditions: 1. Pre-approved by an MCO provider or other representative 2. Not pre-approved by an MCO provider or other representative, but administered to maintain the member's stabilized condition within one hour of a request to the MCO for pre-approval of further post-stabilization care services 3. Not pre-approved by an MCO provider or other representative, but administered to maintain, improve, or resolve the member's stabilized condition if the MCO 1) does not respond to a request for pre-approval within one hour, 2) the MCO cannot be contacted, or 3) the MCO representative and the treating physician cannot reach an agreement concerning the member's care and an in-network physician is not available for consultation. In this situation, the MCO gives the treating physician the opportunity to consult with an in-network physician and the treating physician may continue with care of the patient until a plan physician is reached.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
22. Financial Responsibility 42 CFR § 438.114.e CRA and TSA: 2.14.4.1	For purposes of cost-sharing, post-stabilization care services begin upon inpatient admission. The MCO's financial responsibility for post-stabilization care services it has not pre-approved ends when any of the following occurs: 1. An in-network physician with privileges at the treating hospital assumes responsibility for the member's care. 2. An in-network physician assumes responsibility for the member's care through transfer. 3. An MCO representative and the treating physician reach an agreement concerning the member's care. 4. The member is discharged.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Comments					
Strength					
AON					
Suggestion					
23. Member Rights 42 CFR § 438.100.b-.b.2.vi CRA: 2.12.15.8; 2.17.4.6; 2.17.4.6.35 and .38-.41 TSA: Standard X.A-.A.1; 2.17.4.7; 2.17.4.7.34 and.37-.40	Members and potential members have the right to 1. receive information in readily accessible formats and methods; 2. be treated with respect and with due consideration for his or her dignity and privacy; 3. receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand; 4. participate in decisions regarding his or her healthcare, including the right to refuse treatment; 5. be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; and 6. request and receive a copy of his or her medical records and request that they be amended or corrected.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
24. Language and Format* 42 CFR § 438.10.d-.d.6.iii CRA and TSA: 2.17.2.4 and .6-.8	The MCO makes oral interpretation available in all languages and written translation available in each prevalent non-English language. Written materials that are critical to obtaining services for potential members include taglines in the prevalent non-English languages to explain the availability of interpretation and translation services and information on how to request auxiliary aids and services. The MCO makes its Provider Directories, Member Handbooks, appeal and grievance notices, and denial and termination notices available in the prevalent non-English languages. The MCO provides translated written materials that are critical to obtaining services, auxiliary aids,	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
	and interpretation services to members and potential members at no cost.				
Comments					
Strength					
AON					
Suggestion					
25. Potential Members 42 CFR § 438.10.e-.e.2.x CRA: 2.4.10; 2.17.4.6; 2.17.4.6.4-.44 TSA: 2.4.10; 2.17.4.7; 2.17.4.7.4-.40	When a potential member becomes eligible for TennCare, the MCO makes the following information available to them: 1. Information about the right to disenroll and alternatives available based on their specific circumstance 2. Basic features of managed care 3. Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program, including the length of the enrollment period and all disenrollment opportunities available 4. Service area 5. Covered benefits 6. Provider Directory 7. Cost-sharing requirements 8. Access to covered services, including network adequacy standards 9. The MCO's responsibilities for care coordination 10. Quality and performance indicators, including member satisfaction	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Comments					
Strength					
AON					
Suggestion					
26. Provider Termination* 42 CFR § 438.10.f.1 CRA: 2.11.11.1.3 TSA: 2.11.9.1.2	If a provider 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.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
27. Member Handbook 42 CFR § 438.10.g-g.4 CRA: 2.17.4.1; 2.17.4.6; 2.17.4.6.5-.13; .16; .21; .23-.24; .26-.27; .34-.35; .38 TSA: 2.17.4.1; 2.17.4.7; 2.17.4.7.5-.13; .16; .22-.23; .25-.26; .33-.34; .37	Each Member Handbook includes the following: 1. Amount, duration, and scope of benefits available 2. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the member's PCP 3. Information about emergency services 4. Any restrictions on the member's freedom of choice among network providers 5. How to obtain family planning services and supplies from out-of-network providers 6. Information about cost-sharing 7. Member rights and responsibilities 8. Process of selecting and changing a PCP 9. Grievance, appeal, and fair hearing procedures and timeframes 10. How to exercise an advance directive 11. How to access auxiliary aids and translation and interpretation services 12. Toll-free numbers for member services 13. How to report suspected fraud or abuse 14. Upon notice to TennCare of material changes to the Member Handbooks, the MCO makes appropriate revisions and immediately distributes the revised Handbook to members and providers.	☐ Required information included ☐ Notice of changes provided timely	**0.50** **0.50**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
28. Advance Directives 42 CFR § 438.3.j.1-.4 CRA and TSA: 2.7.7.1-.2	The MCO provides adult members with written information on advance directives policies, including a description of applicable state laws, and the information reflects changes in state laws as soon as possible, but no later than 30 days after the effective date of the change.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
		Coverage and Authorization of Services Score	**0.0%**	**28.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Provider Selection					
1. Credentialing and Recredentialing Process* 42 CFR § 438.214.b.2 CRA and TSA: 2.11.10.1-.4.1.12	The MCO follows a documented process for credentialing and recredentialing its network providers.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
2. Provider Selection P&Ps* 42 CFR § 438.214.c CRA and TSA: 2.11.1.3; 2.11.1.3.3	The MCO's network provider selection P&Ps do not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Provider Selection					
3. Excluded Providers* 42 CFR § 438.214.d.1 CRA and TSA: 2.11.1.3; 2.11.1.3.1	The MCO does not employ or contract with providers excluded from participation in federal healthcare programs under either section 1128 or section 1128A of the Social Security Act.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
4. Provider Visits 5. CRA: 2.18.6.19 TSA: 2.18.6.14	The MCO's provider relations staff contacts all contract providers on a semiannual basis to update them on MCO initiatives and communicate pertinent information. For providers located in Tennessee and out-of-state providers located in contiguous counties, at least one of the contacts is face-to-face with the provider. Other contacts are conducted via a phone call with the provider. The MCO maintains records that show when and how contacts are made.	☐ Semiannual contacts made using appropriate methods ☐ Records maintained	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
		Provider Selection Score	**0.0%**	**4.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Confidentiality					
1. Written P&Ps* 42 CFR § 438.224 CRA and TSA: 2.27.5; 2.27.5.14	The MCO has written P&Ps to address the following: 1. Access to PHI across the MCO 2. Process for members to request restrictions on use and disclosure of their PHI 3. Process for members to request amendments to their PHI 4. Process for members to request an accounting of disclosures of their PHI	☐ Access ☐ Restrictions ☐ Amendments ☐ Accounting of disclosures	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
		Confidentiality Score	**0.0%**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Grievance and Appeal Systems						
1. System in Place* 42 CFR § 438.402.a CRA: 2.19.1.2-.4 TSA: 2.19.1-.2	The MCO has a grievance and appeal system in place for members.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. One Level* 42 CFR § 438.402.b CRA: 2.19.1.2 and .4 TSA: 2.19.1.2	The MCO has only one level of appeal for members.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
3. State Fair Hearing (SFH)* 42 CFR § 438.402.c-.c.1.i CRA: 2.19.1.1-.4 TSA: 12.19.1-.1.2	A member may file a grievance and request an appeal with the MCO. A member may request an SFH after receiving notice that the adverse benefit determination (ABD) is upheld (SFHs are not applicable for CoverKids).	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
4. Provider Assistance* 42 CFR § 438.402.c.1.ii CRA and TSA: 2.19.4.2	With written consent of the member, a provider or an authorized representative may request an appeal, file a grievance, or request an SFH on behalf of the member. Providers cannot request continuation of benefits. SFH requests are not applicable for CoverKids members.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
	A member may file a grievance with the MCO at any time. Following receipt of an NABD, a member has 60 calendar days	☐	May file a grievance at any time	**0.50**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
5. Timeframe to Request Appeal* 42 CFR § 438.402.c.2-.2.ii CRA and TSA: 2.19.5.1; 2.19.10.1	from the date on the NABD to file a request for an appeal to the MCO (not applicable for CoverKids).	☐	Has 60 calendar days to request an appeal after receiving NABD	**0.50**		
Comments **Strength** **AON** **Suggestion**						
6. Methods* 42 CFR § 438.402.c.3-.3.ii CRA and TSA: 2.19.6.1; 2.19.10.1	A member may file a grievance either orally or in writing and, as determined by TennCare, either with TennCare or the MCO. A member may request an appeal either orally or in writing (not applicable for CoverKids).	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
7. Availability of Notices* 42 CFR § 438.10; 438.404.a	The MCO gives members timely and adequate notice of an ABD in writing and makes the NABD available by the following means at no cost to the member: 1. Written translation 2. Oral interpretation 3. Alternative formats	☐ ☐	Timely and adequate notice Available via the listed means	**0.50** **0.50**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
CRA and TSA: 2.19.2.7	4. Auxiliary aids and services					
Comments **Strength** **AON** **Suggestion**						
8. NABD Inclusions* 42 CFR § 438.404.b.1-.6 CRA and TSA: 2.19.2.1-.7	Each NABD explains the following: 1. The determination the MCO made or intends to make 2. The reasons for the determination, including the right of the member to receive (upon request and free of charge) reasonable access to and copies of all documents, records, and other information relevant to the determination. Such information includes medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits. 3. The member's right to request an appeal of the determination, including information on exhausting the MCO's one level of appeal and the right to request an SFH (SFHs are not applicable for CoverKids.) 4. The circumstances under which an appeal process can be expedited and how to request it 5. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with TennCare policy, under which the member may be required to pay the costs of these services (not applicable for CoverKids). 6. The procedures for exercising his or her NABD-related rights	☐ ☐ ☐ ☐ ☐ ☐	Determination Reasons for determination Right to request appeal and How the process can be expedited Right to have continuous benefits and how to request them (not applicable for CoverKids) Procedures for exercising NABD-related rights	**0.16** **0.16** **0.17** **0.17** **0.17** **0.17**	**1.00**	**0.00**
Comments						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
Strength						
AON						
Suggestion						
9. NABD Mailing* 42 CFR § 438.404.c.1 CRA and TSA: 2.19.3.1-.3.3.9	The MCO mails NABD s at least 10 days before the date of action when the ABD is a termination, suspension, or reduction of previously authorized covered service unless 1. the member dies, denies services, or becomes ineligible for TennCare coverage or their current level of care; 2. the member's address is determined unknown based on returned mail with no forwarding address; 3. fraud is suspected or confirmed; or 4. the action will take place in less than 10 days.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
10. Denial of Payment* 42 CFR § 438.404.c.2 CRA and TSA: 2.19.3.4	For NABDs related to denial of payment, the MCO mails the notice at the time of any action affecting the claim.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
	If the MCO meets the criteria set forth for extending the timeframe for standard service authorization decisions, it 1. gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision; and 2. issues and carries out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.	☐ ☐	Provides written notice Makes the determination timely	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
11. Reasonable Assistance* 42 CFR § 438.406.a CRA: 2.19.1.5 TSA: 2.19.1.3	In handling grievances and appeals, the MCO gives members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free phone numbers that have adequate TTY/TTD and interpreter capability.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
12. Acknowledge Receipt* 42 CFR § 438.406.b-.b.1 CRA: 2.19.1.6.1-.2 TSA: 2.19.1.4.1-.2	The MCO's process for handling member grievances and appeals of ABDs acknowledges receipt of each grievance and appeal.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
13. Reviewer Require-ments* 42 CFR § 438.406.b and b.2-b.2.iii CRA: 2.19.1.7-.9 TSA: 2.19.1.5-.7	The MCO ensures that those who make decisions on grievances and appeals are individuals 1. who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual; 2. who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by TennCare, in treating the member's condition or disease: ♦ An appeal of a denial that is based on lack of medical necessity ♦ A grievance regarding denial of expedited resolution of an appeal ♦ A grievance or appeal that involves clinical issues; and 3. who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or	☐ ☐ ☐	Not involved in previous level of review nor a subordinate of reviewer Appropriate clinical expertise Consider all relevant information	**0.33** **0.33** **0.34**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
	considered in the initial ABD.					
Comments **Strength** **AON** **Suggestion**						
14. Oral Inquiries* 42 CFR § 438.406.b.3 CRA and TSA: 2.19.6.3	The MCO ensures that oral inquiries seeking to appeal an ABD are treated as appeals (to establish the earliest possible filing date for the appeal) and are confirmed in writing, unless the member or the provider requests expedited resolution.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
15. Opportunity to Make an Argument* 42 CFR § 438.406.b.4 CRA and TSA: 2.19.6.4	The MCO's process for handling member grievances and appeals of ABDs provides the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MCO informs the member of the limited time available for this sufficiently in advance of the standard and expedited resolution timeframes for appeals and the standard resolution timeframe for grievances.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Grievance and Appeal Systems						
Comments **Strength** **AON** **Suggestion**						
16. Member Information Provided* 42 CFR § 438.406.b.5 CRA and TSA: 2.19.6.5	The MCO provides the member (and his or her representative, if applicable) the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO (or at the direction of the MCO) in connection with the appeal of the ABD. This information is provided free of charge and sufficiently in advance of the applicable resolution timeframe.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
17. Parties to the Appeal* 42 CFR § 438.406.b.6-.6.ii CRA and TSA: 2.19.6.7	The MCO's process for handling member grievances and appeals of ABDs includes the member (and his or her representative, if applicable) or the legal representative of a deceased member's estate as parties to the appeal.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
18. Resolution Timeframes 42 CFR § 438.408.a CRA and TSA: 2.19.7.1; 2.19.10.2	The MCO resolves each grievance and appeal, and provides notice, as expeditiously as the member's health condition requires and within TennCare-established timeframes that may not exceed the standard and expedited resolution timeframes for appeals and the standard resolution timeframe for grievances.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
19. Standard Grievance Resolutions* 42 CFR § 438.408.b.1 CRA and TSA: 2.19.10.2	For standard resolutions, the MCO resolves each grievance and provides notice as expeditiously as the member's health condition requires, within 90 calendar days of receipt.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
20. Standard Appeal Resolutions*	For standard resolutions, the MCO resolves each appeal and provides notice within 14 calendar days of receipt.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Grievance and Appeal Systems						
42 CFR § 438.408.b.2 CRA and TSA: 2.19.6.2.1						
Comments **Strength** **AON** **Suggestion**						
21. Expedited Appeal Resolutions* 42 CFR § 438.408.b.3 CRA and TSA: 2.19.7.1	For expedited resolutions, the MCO resolves each appeal and provides notice within 72 hours of receipt.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
22. Timeframe Extensions* 42 CFR § 438.408.c.1-.1.ii CRA and TSA: 2.19.7.2-.2.2	The MCO may extend the grievance and appeal resolution timeframes by up to 14 calendar days if the member requests the extension or if the MCO shows (to the satisfaction of TennCare, upon its request) that there is need for additional information and how the delay is in the member's interest.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Grievance and Appeal Systems						
Strength **AON** **Suggestion**						
23. Requirements Following Extension* 42 CFR § 438.408.c.2-.2.ii CRA and TSA: 2.19.7.3	The MCO completes the following if it extends an appeal or grievance resolution timeframe not at the request of the member: 1. Make reasonable efforts to give the member prompt oral notice of the delay 2. Within two calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform them of their right to file a grievance if they disagree with that decision 3. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires	☐ ☐ ☐	Made reasonable efforts Written notice sent timely Resolved appeal timely	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
24. Format of Resolutions* 42 CFR § 438.408.d.2-.2.ii CRA and TSA: 2.19.8.1.-.2	For all appeals, the MCO provides written notice of resolution with the following options available: 1. Written translation 2. Oral interpretation 3. Alternative formats 4. Auxiliary aids and services For notice of an expedited resolution, the MCO makes reasonable efforts to provide oral notice.	☐ ☐	Written notice includes all options Reasonable efforts for oral notice	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength**						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
AON						
Suggestion						
25. Results and Date* 42 CFR § 438.408.e.1 CRA and TSA: 2.19.8.1; 2.19.10.4	Every written notice of a resolution includes the results of the resolution process and the date it was completed.	☐	Yes	**1.00**	**1.00**	**0.00**
		☐	No	**0.00**		
Comments						
Strength						
AON						
Suggestion						
26. Additional Resolution Contents* 42 CFR § 438.408.e.2-.2.iii	Every written notice of a resolution for appeals not resolved wholly in favor of the member states that the member 1. has the right to request an SFH and how to do so; 2. has the right to request and receive benefits while the hearing is pending, and how to make the request (not applicable for CoverKids); and 3. may be held liable for the cost of those benefits if the hearing decision upholds the MCO's ABD, in accordance with TennCare policy.	☐	Right to request SFH	**0.33**	**1.00**	**0.00**
		☐	Right to request and receive benefits (not applicable for CoverKids)	**0.33**		
		☐	May be liable for benefit costs	**0.34**		
Comments						
Strength						
AON						
Suggestion						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
27. Expedited Review Process* 42 CFR § 438.410.a CRA and TSA: 2.19.6.2.2	The MCO maintains an expedited review process for appeals that is used when the MCO determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
28. Punitive Action Prohibited* 42 CFR § 438.410.b CRA and TSA: 2.19.6.5	The MCO ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
29. Expedited Resolution Denials* 42 CFR § 438.410.c-.c.2 CRA and TSA: 2.19.6.2.1	If the MCO denies a request for expedited resolution of an appeal, it 1. transfers the appeal to the timeframe for standard resolution, 2. makes reasonable efforts to give the member prompt oral notice of the delay, 3. sends written notice to the member within two calendar days, 4. informs the member of his or her right to file a grievance, and 5. resolves the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.	☐	Transfer to the standard timeframe	**0.20**	**1.00**	**0.00**
		☐	Make reasonable efforts for oral notice	**0.20**		
		☐	Send written notice timely	**0.20**		
		☐	Inform member of right to file a grievance	**0.20**		
		☐	Resolve appeal timely	**0.20**		
Comments **Strength** **AON** **Suggestion**						
30. Information for Providers and Subcontractors* 42 CFR § 438.414 CRA and TSA: 2.19.12.1-.2; 2.19.12.2.2	The MCO provides information about the grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time they enter into a contract.	☐	Yes	**1.00**	**1.00**	**0.00**
		☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
31. Ongoing Monitoring* 42 CFR § 438.416.a CRA and TSA: 2.19.11.1	The MCO maintains records of grievances and appeals and reviews the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the TennCare Quality Strategy.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
32. Record Requirements* 42 CFR § 438.416.b-.b.6 CRA and TSA: 2.19.11.2-.2.5	The record of each grievance or appeal contains, at a minimum, all of the following information: 1. General description of the reason for the appeal or grievance 2. Date received and date of each review or, if applicable, review meeting 3. Resolution at each level of the appeal or grievance, if applicable 4. Date of resolution at each level, if applicable 5. Name of the covered person for whom the appeal or grievance was filed	☐ ☐ ☐ ☐ ☐	General description Dates of receipt and review Resolution at each level Resolution date(s) Name of covered person	**0.20** **0.20** **0.20** **0.20** **0.20**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
33. Record Maintenance 42 CFR § 438.416.c CRA and TSA: 2.19.11.1	The MCO accurately maintains the record of each grievance or appeal in a manner accessible to TennCare and available upon request to CMS.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
34. Continuous Benefits Requirements* 42 CFR § 438.420.b-.b.5 CRA: 2.19.9.1-.2.5 TSA: 2.19.9.1-.1.5	The MCO continues the member's benefits if all of the following occur: 1. The member files the request for an appeal within 60 calendar days of receiving an NABD. 2. The appeal involves the termination, suspension, or reduction of previously authorized services. 3. The services were ordered by an authorized provider. 4. The period covered by the original authorization has not expired. 5. The member files for continuation of benefits timely. Not applicable for CoverKids	☐ ☐ ☐ ☐ ☐	Member filed request for appeal timely Appeal involved the appropriate services Services ordered by authorized provider Original authorization had not expired Member filed for continuation of benefits timely	**0.20** **0.20** **0.20** **0.20** **0.20**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
35. Termination of Benefits* 42 CFR § 438.420.c-.c.3 CRA: 2.19.9.1; 2.19.9.2 and .2.5; 2.19.9.3-.3.2 TSA: 2.19.9.1 and .1.5; 2.19.9.2-.2.2	If, at the member's request, the MCO continues or reinstates the member's benefits while the appeal or SFH is pending, the benefits are continued until one of following occurs: 1. The member withdraws the appeal or request for an SFH. 2. The member fails to request an SFH and continuation of benefits within 10 calendar days after the MCO sends the NABD to the member's appeal. 3. An SFH office issues a hearing decision adverse to the member. Not applicable for CoverKids	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
36. Cost Recovery* 42 CFR § 438.420.d	If the final resolution of the appeal is adverse to the member, the MCO may recover the cost of services furnished to the member while the appeal was pending. Not applicable for CoverKids	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Grievance and Appeal Systems						
37. Services Not Furnished During Pending Appeal* 42 CFR §438 424.a CRA: 2.19.9.4 TSA: 2.19.9.3	If the MCO or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. Not applicable for CoverKids	☐ ☐	Yes No	**1.00** **0.00**	**0.00**	**1.00**
Comments **Strength** **AON** **Suggestion**						
38. Services Furnished During Pending Appeal* 42 CFR § 438.424.b CRA: 2.19.9.5 TSA: 2.19.9.4	If the MCO or the SFH officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO or TennCare pays for those services, in accordance with TennCare policy and regulations. Not applicable for CoverKids	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Grievance and Appeal Systems						
39. Services Furnished During Pending Appeal* 42 CFR § 438.424.b CRA: 2.19.9.5 TSA: 2.19.9.4	If the MCO or the SFH officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO or TennCare pays for those services, in accordance with TennCare policy and regulations. Not applicable for CoverKids	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
			Grievance and Appeal Systems Score	**0.0%**	**39.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Subcontractual Relationships and Delegation						
1. Delegated Activities* 42 CFR § 438.230.a-.c.1.i CRA and TSA: 2.26.1.2	The MCO specifies all of the activities and obligations that it has delegated to subcontractors in its subcontractor agreements.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. Remedies for Unsatisfactory Performance* 42 CFR § 438.230.c-.c.1 and .c.1.ii-.iii CRA and TSA: 2.26.1.2	The MCO has remedies in place that may be implemented if subcontractor performance is unsatisfactory.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Subcontractual Relationships and Delegation						
3. Compliance with Laws and Regulations 42 CFR § 438.230.c.2 CRA and TSA: 2.26.1	The MCO's subcontractor agreements specify that the subcontractors must comply with all applicable Medicaid laws and regulations, including applicable subregulatory guidance and contract provisions.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
4. Annual Review Requirements 42 CFR § 438.230.c.3-.3.i CRA and TSA: 2.25.3	The MCO's subcontractor agreements specify that TennCare, CMS, the HHS Inspector General, the Comptroller General, and their designees have the right to review, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor(s), or of the contractors of the subcontractor(s), that pertain to any aspect of services and activities performed or determination of amounts payable under the MCO's contract with TennCare.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Subcontractual Relationships and Delegation						
5. Annual Review Provisions 42 CFR § 438.230.c.3 and .3.ii CRA and TSA: 2.25.3	The MCO's subcontractor agreements specify that, for purposes of an annual review, evaluation, or inspection, the subcontractor(s) must make available all premises, physical facilities, equipment, books, records, contracts, and computer or other electronic systems relating to members.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
6. Annual Review Timeframes 42 CFR § 438.230.c.3 and .3.iii CRA and TSA: 2.25.6.1	The MCO's subcontractor agreements specify that TennCare, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to review, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor(s), or of the contractors of the subcontractor(s) through 10 years from the final date of the contract period or from the date of completion of any annual review, whichever is later.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Subcontractual Relationships and Delegation						
7. Suspicion of Fraud 42 CFR § 438.230.c.3 and .3.iv CRA and TSA: 2.20.2.12	The MCO's subcontractor agreements specify that if TennCare, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, then TennCare, CMS, or the HHS Inspector General may inspect, evaluate, and review the subcontractor(s) at any time.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
			Subcontractual Relationships and Delegation Score	**0.0%**	**7.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Practice Guidelines						
1. Requirements 42 CFR § 438.236.b-.b.4 CRA and TSA: 2.15.4	The MCO uses practice guidelines that meet the following requirements: 1. Based on valid and reliable clinical evidence or a consensus of providers in the particular field 2. Consider the needs of members 3. Adopted in consultation with contracting healthcare professionals 4. Reviewed and updated periodically as appropriate	☐ ☐ ☐ ☐	Based on evidence or a consensus Consider members' needs Adopted in consultation with healthcare professionals Reviewed and updated	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. Dissemination of Guidelines 42 CFR § 438.236.c CRA and TSA: 2.15.4	The MCO disseminates the practice guidelines to all affected providers and, upon request, to members and potential members.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Practice Guidelines						
3. Consistency with Guidelines 42 CFR § 438.236.d CRA and TSA: 2.15.4	Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
			Practice Guidelines Score	**0.0%**	**3.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Health Information Systems						
1. System Requirements* 42 CFR § 438.242.a CRA and TSA: 2.23.1.1	The MCO maintains a health information system that collects, analyzes, integrates, and reports data. The system provides information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for reasons other than loss of TennCare eligibility.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. Data Collection* 42 CFR § 438.242.b and .b.2 CRA: 2.23.4.3.1 TSA: 2.23.4.2.1	The MCO's health information system collects data on member and provider characteristics as specified by TennCare, and on all services furnished to members through an encounter data system or other methods as may be specified by TennCare.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Health Information Systems						
3. Data Accuracy and Completeness* 42 CFR § 438.242.b and .b.3-.3.iii CRA: 2.23.4.3.1 TSA: 2.23.4.2.1	The MCO ensures that data received from providers are accurate and complete by 1. verifying the accuracy and timeliness of reported data, including data from network providers the MCO is compensating on the basis of capitation payments; 2. screening the data for completeness, logic, and consistency; and 3. collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for TennCare quality improvement (QI) and care coordination efforts.	☐	Verify accuracy and timeliness	**0.33**	**1.00**	**0.00**
		☐	Screen for completeness, logic, and consistency	**0.33**		
		☐	Collect data in standardized formats	**0.34**		
Comments **Strength** **AON** **Suggestion**						
4. Data Availability* 42 CFR § 438.242.b and .b.4 CRA and TSA: 2.25.5.1	The MCO makes all collected data available to TennCare and, upon request, to CMS.	☐	Yes	**1.00**	**1.00**	**0.00**
		☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						
			Health Information Systems Score	**0.0%**	**4.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program						
1. Program in Place* 42 CFR § 438.330.a.1 CRA and TSA: 2.15.1.1	The MCO has an ongoing comprehensive QAPI program in place for the services it furnishes to its members.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. Program Components 42 CFR § 438.330.b-.b.2 CRA and TSA: 2.15.6.1.1; 2.15.6.3-.4	The QAPI program includes performance improvement projects (PIPs) and collection and submission of performance measurement data.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program						
3. Under-/Over-Utilization* 42 CFR § 438.330.b and .b.3-.4	The QAPI program includes mechanisms to detect under-/over-utilization of services and to assess the quality and appropriateness of care furnished to members with special healthcare needs, as defined by TennCare's Quality Strategy.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
4. LTSS Requirements* 42 CFR § 438.330.b and .b.5-.5.ii CRA and TSA: 2.15.1.1; 2.15.7.3.1-.4	The QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members using LTSS, including assessment of care between care settings and a comparison of LTSS received with those in the member's treatment/service plan, if applicable. The MCO participates in TennCare's efforts to prevent, detect, and remediate critical incidents that are based, at a minimum, on TennCare's requirements for home and community-based services (HCBS) waiver programs.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program						
5. Annual Evaluation 42 CFR § 438.330.c and .c.2-.2.iii CRA and TSA: 2.15.1.1; 2.15.7.3.1-.4	On an annual basis, the MCO evaluates its performance by completing one or both of the following activities: 1. Measure and report to TennCare on its performance, using the standard measures required by TennCare 2. Submit data to TennCare that allow TennCare to calculate the MCO's performance using the standard measures	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
6. PIPs 42 CFR § 438.330.d.1 CRA: 2.15.3.1 TSA: 2.15.3	The MCO conducts PIPs, including any PIP required by CMS, that focus on both clinical and nonclinical areas.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program						
7. Quality Indicators 42 CFR § 438.330.d.2-.2.i CRA and TSA: 2.15.3.2-.3	The MCO designs each PIP to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. PIPs include measurement of performance using objective quality indicators.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
8. Interventions 42 CFR § 438.330.d.2 and .2.ii CRA and TSA: 2.15.3.3	Each PIP design includes the implementation of interventions to achieve improvement in the access to and quality of care.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program						
9. Intervention Effectiveness 42 CFR § 438.330.d.2 and .2.iii CRA and TSA: 2.15.3.3	Each PIP includes an evaluation of the effectiveness of the interventions based on the performance measures.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
10. Activities for Increasing or Sustaining Improvement 42 CFR § 438.330.d.2 and .2.iv CRA and TSA: 2.15.3.2-.3	Each PIP includes planning and initiation of activities for increasing or sustaining improvement.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Quality Assessment and Performance Improvement (QAPI) Program						
11. Reporting PIP Results 42 CFR § 438.330.d.3 CRA: 2.30.12.1.1 TSA: 2.30.11.2	The MCO reports the status and results of each PIP to TennCare as requested, but no less than once per year.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
			Quality Assessment and Performance Improvement Program (QAPI) Score	**0.0%**	**11.00**	**0.00**

2021 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
BESMART Program						
1. BESMART Provider Network CRA and TSA: 2.11.4.1.1	The MCO has a high-quality Buprenorphine Enhanced Supportive Medication-Assisted Recovery and Treatment (BESMART) provider network for members with OUD.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2021 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
BESMART Program						
Comments						
Strength						
AON						
Suggestion						
2. Annual Engagements CRA and TSA: 2.11.4.1.1.1	The MCO has documentation to show that it provides at least three annual engagements per BESMART network provider, including an in-person check-in, an in-person annual review meeting, and a virtual education session. If deemed appropriate by the MCO, the check-in and annual review meeting may be conducted virtually.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
3. Quarterly MAT Network Quality Metrics Reports CRA and TSA: 2.11.4.1.1.2	The MCO distributes quarterly MAT Network Quality Metrics Reports in a format described by TennCare to all contracted BESMART providers on an NPI-level within 120 calendar days after the end of each calendar year quarter, unless otherwise approved by TennCare.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						

2021 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
BESMART Program						
4. BESMART Network Program Description CRA and TSA: 2.11.4.1.1	The MCO maintains the most current BESMART network program description and, if applicable, relevant network provider attestations.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
5. BESMART Network Provider Quality Reviews CRA and TSA: 2.11.4.1.1.2	The MCO conducts a BESMART network provider quality review each calendar year using the Quality Review tool as prescribed by TennCare to ensure that the providers accurately and consistently implement the program description and provide high-quality care.	☐ ☐	Review completed each calendar year Review includes the Quality Review tool	**0.50** **0.50**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
			BESMART Program Score	**0.0%**	**5.00**	**0.00**

2022 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	**1.00** **0.00**	**1.00**	**0.00**
Comments **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: 1. Member Handbook sent within 30 calendar days of enrollment and annually thereafter, upon the member's anniversary date of enrollment 2. Four quarterly newsletters 3. One reminder before screenings are due (with transportation and scheduling assistance offered) 4. 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	☐ ☐ ☐ ☐	Member Handbook sent within 30 calendar days of enrollment and annually thereafter Quarterly newsletters Screening due reminder One outreach attempt advises specified members of alternative formats and information availability	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
3. Additional Outreach	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.	☐ ☐	Outreach efforts made Staff demonstrated knowledge	**0.50** **0.50**	**1.00**	**0.00**

2022 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)						
CRA and TSA: 2.7.6.2.4						
Comments						
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	**0.50** **0.50**	**1.00**	**0.00**
Comments						
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	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						

2022 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 develops and maintains smoking cessation programs with targeted outreach for pregnant women and adolescents.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
7. Prenatal Appointment Assistance CRA and TSA: 2.7.5.2.1; 2.7.6.2.7	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. As soon as the MCO becomes aware of the enrollment, it offers individual assistance in making a timely first prenatal appointment. For a woman past her first trimester, this appointment occurs within 15 calendar days of the day she was determined to be eligible. Pregnant women are also offered EPSDT services for the child when it is born.	☐ ☐ ☐ ☐	Services provided for identified women On the day eligibility was determined, offered appointment assistance For each woman past her first trimester, appointment occurred within 15 calendar days Postpartum EPSDT services offered	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						

2022 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 for 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 in each member's medical record. MCO staff is able to describe and demonstrate coordination efforts by the MCO.	☐ ☐	P&Ps in place Staff described efforts	**0.50** **0.50**	**1.00**	**0.00**
Comments **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	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
10. Rehabilitative Services CRA and TSA: 2.7.6.1.1	TennCare Kids services include EPSDT to ascertain children's individual physical and mental defects, and providing 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. To be covered by the MCO, all services other than screenings must be medically necessary.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 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)						
Comments						
Strength						
AON						
Suggestion						
11. Medical Necessity Decisions CRA and TSA: 2.6.3.1-.2	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.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
12. 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	**0.50** **0.50**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						

2022 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. 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	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
14. Follow-Up After Inpatient or Residential Treatment CRA: 2.9.10.3.2 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.	☐ ☐ ☐ ☐	Discharge plan completed Member participated Outpatient appointment scheduled Appropriate placement or housing secured	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 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)						
15. 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	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
16. 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.	☐ ☐ ☐	Access provided No blanket restrictions Assistance included identified components	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
17. Individual Education Plans (IEPs) CRA: 2.9.15.7.1 and .4-.4.3 TSA: 2.9.16.7-.7.2.3	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	☐ ☐ ☐	Accepted problem or had child re-evaluated Shared with PCP Notified school contact of disposition of request	**0.33** **0.33** **0.34**	**1.00**	**0.00**

2022 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)						
	parental consent prior to providing and paying for medically necessary covered services or upon request during a post-payment annual review. 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: 1. 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. 2. Sends a copy of the IEP and related information to the PCP 3. Notifies the designated school contact of the ultimate disposition of the request within 14 days of receipt of the IEP					
Comments **Strength** **AON** **Suggestion**						
18. IEP Services Provided Without Submission of the IEP CRA: 2.9.15.7.2-.3.1 TSA: 2.9.17.7.1-.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 annual reviews 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	**1.00** **0.00**	**1.00**	**0.00**

2022 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)						
Comments						
Strength						
AON						
Suggestion						
19. 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	**0.50** **0.50**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
			Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Score	**0.0%**	**19.00**	**0.00**

2022 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	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. Display of Non-Discrimination Information CRA: D.7 TSA: 5.32.1-.3	The MCO assures that no person 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	**1.00** **0.00**	**1.00**	**0.00**
Comments **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	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Non-Discrimination Compliance						
Comments						
Strength						
AON						
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 an update of all discrimination complaints related to the provision of TennCare-covered services if the MCO is assisting TennCare with the investigation.	☐ ☐ ☐	Processes in place Provided complaint investigations to TennCare Quarterly reports submitted and included required information	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
5. 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	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Non-Discrimination Compliance						
Comments						
Strength						
AON						
Suggestion						
6. Health Disparities Projects CRA and TSA: 2.30.22.4; 2.30.22.4.1	On an annual basis, the MCO documents that it assisted TennCare with its health disparities projects and survey efforts. The surveys are conducted online over a period of 10 weeks.	☐ ☐	Documentation for project and survey assistance Survey assistance provided over a 10-week period	**0. 50** **0.50**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
7. Provider and Subcontractor Compliance Education CRA and TSA: 2.18.2.1; 2.28.2.1.1	The MCO provides non-discrimination compliance and cultural competence training to all contracted providers and subcontractors, ensuring they have been made aware of their obligations under the applicable civil rights laws.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
			Non-Discrimination Compliance Score	**0.0%**	**7.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
1. Written P&Ps for Credentialing: Contracted/ Employed Providers* *CRA A.2.11.10.1.1* *TSA 2.11.10.1.1* *42 CFR §438.214(b)(1–2)* *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**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
2. Written P&Ps for Recredentialing: Contracted/ Employed Providers* *CRA A.2.11.10.1.1* *TSA 2.11.10.1.1NCQA 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**	
Comment: **Strengths**: **Suggestions**: **AONs**:					

* *Element can be deemed based on the MCO's NCQA score.*

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
3. Credentialing Committee* *CRA A.2.11.10.1.1TSA 2.11.10.1.1* *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 designated physician to review and approve files that meet established criteria.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
4. Credentialing Prior to Providing Services* *CRA A.2.11.10.1.1* *TSA 2.11.10.1.1* *NCQA CR1*	Credentialing documents include the statement that practitioners are credentialed prior to providing care to TennCare MCO members.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
5. Recredentialing Timeline* *CRA A.2.11.10.1.1* *TSA 2.11.10.1.1* *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**	
Comment: **Strengths**: **Suggestions**: **AONs**:					

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
6. Provisional Credentialing* *CRA A.2.11.10.1.1* *TSA 2.11.10.1.1* *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**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
7. Length of Provisional* Credentialing *CRA A.2.11.10.1.1* *TSA 2.11.10.1.1* *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**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
8. Documents Required for Provisional Credentialing* *CRA A.2.11.10.1.1* *TSA 2.11.10.1.1* *NCQA CR1*	If the MCO uses provisional credentialing, the following documents are obtained prior to the MCO granting provisional credentialing privileges: Primary-source verification of a current, valid license to practice Primary-source verification of the past five years of malpractice claims or settlements from the malpractice	a) ☐ Met ☐ Not Met ☐ NA b) ☐ Met ☐ Not Met ☐ NA c) ☐ 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.*

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
	carrier, or the results of the National Practitioner Data Bank (NPDB) query Current, signed application with the attestation 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.	☐ Not Met ☐ NA d) ☐ Met ☐ Not Met ☐ NA Each Variable = .25			
Comment: **Strengths**: **Suggestions**: **AONs**:					
9. Evaluation of Complaints and Adverse Events* *CRA A.2.11.10.1.1* *TSA 2.11.10.1.1* *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**	
Comment: **Strengths**: **Suggestions**: **AONs**:					

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
10. Delegated Credentialing P&Ps* *CRA A.2.11.10.1.1* *TSA 2.11.10.1.1* *NCQA CR8*	If credentialing and recredentialing activities are delegated, the MCO has a delegation agreement describing the delegated credentialing activities. The delegation agreement also describes the responsibilities of the organization and the delegated entity.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
11. Delegated Credentialing Accountability* *CRA A.2.11.10.1.1* *TSA 2.11.10.1.1* *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**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
12. Delegated Credentialing Reporting *CRA A.2.26.1.4TSA 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**	
Comment: **Strengths**:					

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
Suggestions:					
AONs:					
13. Nondiscrimination in Credentialing and Recredentialing* *CRA A.2.11.10.1.1* *TSA 2.11.10.1.1* *42 CFR §438.214(c)* *NCQA CR1*	Credentialing P&Ps concerning nondiscrimination explicitly specify that the organization does not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or patient type (e.g., Medicaid) in which the practitioner specializes. The MCO does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
14. Monitoring to Prevent Discrimination in Credentialing and Recredentialing* *CRA A.2.11.10.1.1* *TSA 2.11.10.1.1* *NCQA CR1*	Credentialing P&Ps concerning nondiscrimination explicitly specify how the organization monitors the credentialing and recredentialing processes for discriminatory practices, at least annually.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
15. Interventions for Providers Concerning Poor Quality Care*	The organization implements interventions based on its P&Ps if there is evidence of poor	☐ Met ☐ Not Met	**1.0**	**0.0**	

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
CRA A.2.11.10.1.1 *TSA 2.11.10.1.1* *NCQA CR5*	quality that could affect the health and safety of its members.				
Comment:					
Strengths:					
Suggestions:					
AONs:					
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**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
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 Office of Program Integrity.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
18. Confidentiality* *CRA A.2.11.10.1.1*	The MCO's credentialing P&Ps describe the organization's process for securing the	☐ Met	**1.0**	**0.0**	

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
TSA 2.11.10.1.1 *NCQA CR1*	confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.	☐ Not Met			
Comment:					
Strengths:					
Suggestions:					
AONs:					
19. Provider Appeals Processes* *CRA A.2.11.10.1.1* *TSA 2.11.10.1.1* *NCQA CR6*	The MCO has written P&Ps for the range of actions available to the MCO and makes the appeal process known to practitioners.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
20. Provider Notification* *CRA A.2.11.10.1.1* *TSA 2.11.10.1.1* *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**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
21. Provider Appeal Rights* *CRA A.2.11.10.1.1* *TSA 2.11.10.1.1* *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**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
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 licensure rules and/or program standards, that the individuals are appropriately: Educated Trained Qualified 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**	

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
		d) ☐ Met ☐ Not Met ☐ NA Each Variable = .25			
Comment: **Strengths**: **Suggestions**: **AONs**:					
23. Credentialing Timeline *CRA A.2.11.10.1.2* *TSA 2.11.10.1.2*	The MCO completely processes credentialing applications from all types of providers (physical health, behavioral health, and long-term care providers) 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**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
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 any delegated credentialing agency 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**	

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
Comment:					
Strengths:					
Suggestions:					
AONs:					
25. Credentialing and Recredentialing CHOICES and ECF CHOICES Providers *CRA A.2.11.10.4.1.1* *TSA 2.11.10.4.1.1*[*]	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**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
26. Frequency of Recredentialing for Ongoing CHOICES and ECF CHOICES Providers *CRA A.2.11.10.4.1.1.1* *TSA 2.11.10.4.1.1.1*	The MCO had P&Ps to ensure that the MCO recredentials the ongoing CHOICES [CRA only: and managed care long-term services and supports (MLTSS) Programs] HCBS providers at least annually.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
27. Frequency of Recredentialing for Non-ongoing/One Time CHOICES Providers	All other CHOICES and ECF CHOICES, and 1915(c) waiver HCBS providers must be recredentialed, at a minimum, every three	☐ Met ☐ Not Met	**1.0**	**0.0**	

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

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
CRA A.2.11.10.4.1.1.2 *TSA 2.11.10.4.1.1.2*	years. (One-time CHOICES providers include in-home respite care, in-patient respite care, assistive technology, minor home modifications, and pest control.)	☐ NA			
Comment:					
Strengths:					
Suggestions:					
AONs:					
28. Background Checks Conducted by CHOICES and ECF CHOICES Providers *CRA A.2.11.10.4.1.2.4* *TSA 2.11.10.4.1.2.4*	The MCO had P&Ps to ensure that during credentialing of CHOICES and ECF CHOICES 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 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**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
29. Initial and Ongoing Education Conducted by CHOICES and ECF CHOICES Providers	The MCO had P&Ps to ensure that during credentialing, the MCO verified that CHOICES and ECF CHOICES providers had a process in	a) ☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
CRA A.2.11.10.4.1.2.5 *TSA 2.11.10.4.1.2.5*	place to conduct and document initial and ongoing education for employees who provided services to CHOICES and ECF CHOICES members to include: a) Delivering person-centered services and supports b) Abuse and neglect prevention, identification, and reporting c) Reportable event management and reporting d) Documentation of service delivery e) Use of the Electronic Visit Verification (EVV) System f) Other training requirements specified by TennCare	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			
Comment: **Strengths**: **Suggestions**: **AONs**:					
30. Initial and Ongoing Education Conducted by CHOICES and ECF CHOICES 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 providers had a process in place to conduct and document initial and ongoing education for employees who provided services to CHOICES and ECF CHOICES members to include:	a) ☐ Met ☐ Not Met ☐ NA b) ☐ Met ☐ Not Met ☐ NA c) ☐ Met	**1.0**	**0.0**	

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
	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 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	☐ Not Met ☐ NA d) ☐ Met ☐ Not Met ☐ NA e) ☐ Met ☐ Not Met ☐ NA Each Variable= .20			
Comment: **Strengths**: **Suggestions**: **AONs**:					
31. Initial and Ongoing Education Conducted by CHOICES and ECF CHOICES Providers	The MCO had a process to ensure that during credentialing, the MCO verified that CHOICES and ECF CHOICES providers had a process in place to conduct and document initial and	a) ☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
CRA A.2.11.10.4.1.2.5	ongoing education for employees who provided services to CHOICES and ECF CHOICES 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	b) ☐ Met ☐ Not Met ☐ NA c) ☐ Met ☐ Not Met ☐ NA d) ☐ Met ☐ Not Met ☐ NA Each Variable= .25			
Comment: **Strengths**: **Suggestions**: **AONs**:					
32. Recredentialing Verifications for CHOICES and ECF CHOICES Providers	The MCO had plan documents in place to ensure that the recredentialing of CHOICES and ECF CHOICES providers included: a) Verification of licensure/certification	a) ☐ Met ☐ Not Met ☐ NA b) ☐ Met	**1.0**	**0.0**	

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
CRA A.2.11.9.10.4.1.4TSA 2.11.10.4.1.3	b) Verification of background checks c) Verification of training requirements d) Verification of reportable event reporting and management e) Verification of the use of the EVV	☐ Not Met ☐ NA c) ☐ Met ☐ Not Met ☐ NA d) ☐ Met ☐ Not Met ☐ NA e) ☐ Met ☐ Not Met ☐ NA Variables a – d = .167 Variables e & f = .166			
Comment:					
Strengths:					
Suggestions:					
AONs:					
33. Volunteers and employees hired after last credentialing visit *CRA A.2.11.10.4.1.4.1*	The MCO verifies that any persons required to have background checks, including registry checks, as applicable, who have been employed or have begun volunteering since the last credentialing visit have had criminal background checks, including registry checks, as applicable.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					

2022 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
34. Site Visits for CHOICES and ECF CHOICES Providers *CRA A.2.11.10.4.1.5* *TSA 2.11.10.4.1.4* *42 CFR § 438.206(c)(3)*	The MCO has plan documents to ensure that the MCO conducts 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**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
35. Monthly Verification of CHOICES and ECF CHOICES Providers *CRA A.2.11.10.4.1.6* *TSA 2.11.10.4.1.5* *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 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**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
	Credentialing/Recredentialing P&Ps Score	**100%**	**35.0**	**0.0**	

QP Standards Tool—DBM

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Availability of Services						
1. Adequate Access for All Members 42 CFR § 438.206.b.1 DBMC: A.4; A.165.a.3	The DBM maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency (LEP) and/or physical and/or mental disabilities.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. Second Opinion 42 CFR § 438.206.b.3 DBMC: A.46-.46.a	The DBM provides for 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	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
	If the provider network is unable to provide necessary services, covered under the contract, to a particular member, the DBM	☐	Yes	**1.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Availability of Services						
3. Out-of-Network Services 42 CFR § 438.206.b.4 DBMC: A.26	adequately and timely covers these services out of network for the member, for as long as the DBM's provider network is unable to provide them.	☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						
4. Out-of-Network Costs 42 CFR § 438.206.b.5 DBMC:A.26	The DBM requires out-of-network providers to coordinate with the DBM for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
5. Credentialing and		☐ ☐	Process for network providers P&Ps are non-discriminatory	**0.33** **0.33**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Availability of Services						
Recredentialing Policy 42 CFR § 438.214.b.2-.d.1; 438.206.b.6 DBMC: A.64; A.138-.139; A.166	The DBM demonstrates that its network providers are credentialed according to a uniform credentialing and recredentialing policy. The DBM follows a documented process for credentialing and recredentialing network providers. The DBM's 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 DBM does not employ or contract with providers excluded from participation in federal healthcare programs under the Social Security Act.	☐	Excluded providers do not participate	**0.34**		
Comments **Strength** **AON** **Suggestion**						
6. Timely Access 42 CFR § 438.206.c.1.i DBMC: A.20	The DBM requires its network providers to meet TennCare standards for timely access to care and services, taking into account the urgency of the need for services.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
		☐	Comparable hours of operation	**0.50**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Availability of Services						
7. Hours of Operation and Access 42 CFR § 438.206.c.1.ii-.iii DBMC: A.20	The DBM ensures that its network providers offer hours of operation that are no less than the hours of operation offered to commercial members. The DBM makes services included in the contract available 24 hours a day, seven days a week, when medically necessary.	☐	24/7 access	**0.50**		
Comments **Strength** **AON** **Suggestion**						
8. Compliance 42 CFR § 438.206.c.1.iv-.vi DBMC: A.52.b; A.66; A.66.q	The DBM establishes mechanisms to ensure network provider compliance with the provision of timely access to care, monitors network providers regularly to determine compliance, and takes corrective action for noncompliance.	☐ ☐ ☐	Mechanisms Monitoring Corrective action if needed	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
	The DBM participates in TennCare's efforts to promote the delivery of services in a culturally competent manner to all members, including	☐	Yes	**1.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Availability of Services						
9. Cultural Competency 42 CFR § 438.206.c.2 DBMC: A.27; D.9	those with LEP, diverse cultural and ethnic backgrounds, and/or disabilities, and regardless of sex.	☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						
10. Accessibility for Members with Disabilities 42 CFR § 438.206.c.3 DBMC: A.165.a; A.165.a.3	The DBM ensures that network providers offer physical access, reasonable accommodations, and accessible equipment for members with physical and/or mental disabilities.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
11. Provider Directory Inclusions 42 CFR § 438.10.h.1-.1.viii	The DBM maintains a Provider Directory that is available electronically and in hard copy by request. It includes the following for each provider: 1. Name and group affiliation 2. Street address(es) 3. Telephone number(s)	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Availability of Services						
DBMC: A.10.c-.c.1	4. Website URL 5. Specialty 6. Whether the provider accepts new members 7. Cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training					
Comments **Strength** **AON**						
12. Provider Types 42 CFR § 438.10.h.2-.2.v DBMC: A.10.c.4	The Provider Directory includes a breakdown by specialist.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
	The hard copy version of the Provider Directory is updated at least monthly. The electronic version is available on the DBM's website and	☐	Hard copy updated monthly	**0.50**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Availability of Services						
13. Provider Directory Availability 42 CFR § 438.10.h.3-.4 DBMC: A.10.c	is updated no later than 30 calendar days after the DBM receives updated provider information.	☐	Electronic version available on website and updated timely	**0.50**		
Comments						
Strength						
AON						
Suggestion						
			Availability of Services Score	**0.0%**	**13.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Assurances of Adequate Capacity and Services						
1. Appropriate Provider Network 42 CFR § 438.207.b.1-.2 DBMC: A.20-.20.f; A.148.a; A.148.a.3	The DBM submits documentation to TennCare as evidence that it maintains a provider network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.	☐ ☐	Documentation submitted Sufficient provider network	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. Timely Documentation 42 CFR § 438.207.c-.c.3.ii DBMC: A.148.a; A.148.a.3	The DBM submits documentation to TennCare evidencing its appropriate range of services and provider network no less frequently than 1. at the time it enters into a contract with TennCare; 2. on a monthly basis; and 3. at any time there has been a significant change (as defined by the TennCare) in the DBM 's operations that would affect the adequacy of capacity and services, including ♦ changes in services, benefits, geographic service area, composition of or payments to its network providers or ♦ enrollment of a new population.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
			Assurances of Adequate Capacity and Services Score	**0.0%**	**2.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Coordination and Continuity of Care						
1. Primary Care 42 CFR § 438.208.b.1 DBMC: A.18.e; A.63	The DBM ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. The DBM provides information to the member on how to contact this source.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. Coordination of Services 42 CFR § 438.208.b.2-.2.iv DBMC: A.49; A.49.d-.e	The DBM aids the MCO in coordinating services by providing a means for referral, transferring information, maintaining confidentiality, assessing members and providing results, contributing to treatment plans if applicable, and designating a staff member to serve as a liaison. The DBM also coordinates the services that it furnishes to the member with services the member receives from community and social support providers.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Coordination and Continuity of Care						
3. Prevent Duplication of Services 42 CFR § 438.208.b.4 DBMC: A.49.d and .d.5	The DBM shares with TennCare and MCOs serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
4. Medical Records 42 CFR § 438.208.b.5 DBMC: A.145.a-.b.2.i	The DBM ensures that each provider furnishing services to members maintains and shares, as appropriate, medical records in accordance with professional standards.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Coordination and Continuity of Care						
5. Protected Health Information 42 CFR § 438.208.b.6 DBMC: A.144.h-.h.5	The DBM ensures that in the process of coordinating care, each member's protected health information (PHI) is used only for the purposes of treatment, payment, healthcare operations, and health oversight and its related functions.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
6. Comprehensive Assessment Mechanisms 42 CFR § 438.208.c.2 DBMC: A.49.d and .d.6-.7	The DBM implements mechanisms to comprehensively assess each member identified by TennCare as having special healthcare needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Coordination and Continuity of Care						
7. Treatment and Service Plans 42 CFR § 438.208.c.3-.3.v DBMC A.49.d; A.49.d.6-.7	If applicable, the DBM contributes to a treatment or service plan for members with special healthcare needs that require a course of treatment or regular care monitoring. Each plan meets the following requirements: 1. Approved by the DBM in a timely manner, if approval is required by the DBM 2. In accordance with any applicable TennCare quality assurance and utilization review standards 3. Reviewed and revised upon annual reassessment of functional needs, when the member's circumstances or needs change significantly, or at the request of the member	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
8. Direct Access to Specialists 42 CFR § 438.208.c.4 DBMC: A.46 and .46.b	For members with special healthcare needs determined through an assessment to need a course of treatment or regular care monitoring, the DBM has a mechanism in place to allow members direct access to a specialist (e.g., through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Coordination and Continuity of Care						
9. Disenrollment by DBM Prohibited 42 CFR § 438.56.b-.b.3 DBMC: A.153; A.153.b	A member may be disenrolled from the DBM only when authorized by TennCare, and the DBM cannot request disenrollment of a member for any reason. The DBM promptly informs TennCare when it knows or has reason to believe that a member may satisfy any of the conditions for termination from the TennCare program as described in TennCare rules and regulations.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
10. Reasons for Disenrollment 42 CFR § 438.56.c-.d.2.iv	A member may request disenrollment or be disenrolled if 1. the DBM does not, because of moral or religious objections, cover the service the member seeks or 2. the member experiences poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in managing the member's care needs.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
			Coordination and Continuity of Care Score	**0.0%**	**10.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Coverage and Authorization of Services						
1. Sufficient Services 42 CFR § 438.210.a.1-.3.i DBMC: A.38.b.9	The DBM ensures that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. Arbitrary Limitations Prohibited 42 CFR § 438.210.a.3.ii DBMC: A.38.b.9	The DBM does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Coverage and Authorization of Services						
3. Service Limitations 42 CFR § 438.210.a.4-.4.i DBMC: A.38	The DBM has the ability to place appropriate limits on a service on the basis of criteria applied under TennCare rule, such as medical necessity.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
4. Utilization Control 42 CFR § 438.210.a.4; 438.210.a.4.ii-.ii.C DBMC: A.38; A.38.b; A.38.b.9-.c	The DBM has the ability to place appropriate limits on a service for the purpose of utilization control, provided that the services can reasonably achieve their purpose and support individuals with ongoing or chronic conditions.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Coverage and Authorization of Services						
5. Medically Necessary Definition 42 CFR § 438.210.a.5-.5.i DBMC: A.106	The DBM uses a definition of "medically necessary services" that is no more restrictive than what is used in the TennCare program, including quantitative and non-quantitative treatment limits, as indicated in TennCare statutes, regulations, and P&Ps.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
6. Medically Necessary Services 42 CFR § 438.210.a.5; 438.210.a.5.ii-.ii.D DBMC: A.106	The DBM provides "medically necessary services" in a manner that addresses the extent to which it is responsible for covering services that address the prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Coverage and Authorization of Services						
7. Service Authorization P&Ps 42 CFR § 438.210.b-b.1 DBMC: A.38; A.41	The DBM and its subcontractors use written P&Ps to process requests for initial and continuing authorizations of services.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
8. Processing Authorizations 42 CFR § 438.210.b.2-.2.iii DBMC: A.109	To process requests for initial and continuing authorizations of services, the DBM uses mechanisms to ensure consistent application of review criteria for authorization decisions and consults with the requesting provider when appropriate.	☐ ☐	Mechanisms in place Requesting provider consulted	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
9. Appropriate Expertise 42 CFR § 438.210.b.3 DBMC: A.109	Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by an individual who has appropriate expertise in addressing the member's needs.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Coverage and Authorization of Services						
Comments **Strength** **AON** **Suggestion**						
10. Notice of Adverse Benefit Determination (NABD) 42 CFR § 438.210.c DBMC: A.41.a	The DBM notifies the requesting provider and gives the member written NABD of any decision by the DBM to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. NABDs are sent within the TennCare-approved timeframes and include the determination, reasons for it, member's right to request an appeal, and an explanation of the appeal process.	☐ ☐	Sent to provider and member Included required information	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
11. Notification Timeframes 42 CFR § 438.210.d-.d.3 DBMC: A.41.a	For standard authorization decisions, notices are sent as expeditiously as the member's condition requires and within TennCare-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days upon member or provider request or if the DBM justifies a need. For cases in which a provider indicates, or the DBM determines, that the standard timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, the DBM makes an expedited authorization decision and provides notice as expeditiously as the member's health condition requires, and no later than 72 hours after receipt of the request for service. The DBM may extend the 72-hour timeframe by up to 14 calendar days if the member requests an extension or if the DBM justifies a need for additional information and how the extension is in the member's interest.	☐ ☐	Standard authorizations Expedited authorizations	**0.50** **0.50**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Coverage and Authorization of Services						
Comments **Strength** **AON** **Suggestion**						
12. Compensation for Utilization Management (UM) 42 CFR § 438.210.e DBMC: A.41.c	Compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
13. EPSDT Program Information 42 CFR § 441.56.a-.a.4 DBMC: A.10; A.10.a.1; A.10.a.3; A.10.a.3.f; .r, and .s; A.10.d; A.13.f; A.115	Using written and oral methods of communication, the DBM provides eligible members and their families with information about the EPSDT program. This information includes 1. benefits of preventive healthcare; 2. services available under the EPSDT program and where and how to obtain them; 3. a statement that the services provided under the EPSDT program are without cost to eligible individuals under 21 years of age; and 4. a statement that necessary transportation and scheduling assistance is available upon request. The DBM effectively provides this information for blind, deaf, and/or LEP members. The DBM also has processes in place to provide this information to members within 30 days of eligibility determination and annually thereafter if no EPSDT services have been used.	☐ ☐ ☐	Provided required information Information was accessible Provided information timely	**0.33** **0.33** **0.34**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Coverage and Authorization of Services						
Comments						
Strength						
AON						
Suggestion						
14. Screening Components 42 CFR § 441.56.b.1-.2; 441.61.a-.c DBMC A.114	EPSDT screening services are provided in accordance with reasonable standards of medical and dental practice determined by the DBM after consultation with recognized medical and dental organizations involved in child healthcare. EPSDT services include timely provision of exams, cleaning, fluoride treatment, silver diamine fluoride treatments, sealants and referral for treatment. The DBM provides referral assistance for treatments that are not covered but are deemed necessary during a screening.	☐ ☐	Required components included Referral assistance provided	**0.50** **0.50**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
15. Services Deemed Necessary 42 CFR § 441.56.c-.c.3; 441.59.a-.b DBMC: A.110	The DBM covers all services that are determined necessary during a screening, including care at as early an age as needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. To avoid duplicate screening services, the DBM may accept written verification that the most recent age-appropriate screening services have been provided to an EPSDT-eligible member.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Coverage and Authorization of Services						
Comments **Strength** **AON** **Suggestion**						
16. Emergency Services Coverage 42 CFR § 438.114.c-.c.ii.A DBMC: A.44.a-.b	The DBM covers and pays for emergency services regardless of whether the provider who furnishes the services has a contract with the DBM and does not deny payment for treatment obtained under either of the following circumstances: 1. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have placed the individual in serious jeopardy, seriously impaired bodily functions, or caused any body part to become seriously dysfunctional. 2. A representative of the DBM instructed the member to seek emergency services.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
17. Emergency Service Limitations 42 CFR § 438.114.d-d.1.ii DBMC: A.44.b	The DBM does not limit what constitutes an emergency medical condition on the basis of diagnoses or symptoms and does not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's PCP, DBM, or TennCare within 10 calendar days of presentation for emergency services.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Coverage and Authorization of Services						
Comments						
Strength						
AON						
Suggestion						
18. Member Rights 42 CFR § 438.100.b-.b.2.vi DBMC: A.144.a; A.144.a.1; .4; .6-.7; and .9	Members and potential members have the right to 1. receive information in readily accessible formats and methods; 2. be treated with respect and with due consideration for his or her dignity and privacy; 3. receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand; 4. participate in decisions regarding his or her healthcare, including the right to refuse treatment; 5. be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; and 6. request and receive a copy of his or her medical records and request that they be amended or corrected.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
19. Language and Format 42 CFR § 438.10.d-.d.6.iii DBMC: A.13.c; .e-.g; A.165.a.8	The DBM makes oral interpretation available in all languages and written translation available in each prevalent non-English language. Written materials that are critical to obtaining services for potential members include taglines in the prevalent non-English languages to explain the availability of interpretation and translation services and information on how to request auxiliary aids and services. The DBM makes its Provider Directories, Member Handbooks, appeal and grievance notices, and denial notices available in the prevalent non-English languages. The DBM provides translated written materials that	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Coverage and Authorization of Services						
	are critical to obtaining services, auxiliary aids, and interpretation services to members and potential members at no cost.					
Comments **Strength** **AON** **Suggestion**						
20. Potential Members 42 CFR § 438.10.e-.e.2.x DBMC: A.10.c; A.144.a and .a.2-.3; A.144.d and d.5-.5.b	When a potential member becomes eligible for TennCare, the DBM makes the following information available to them: 1. Basic features of managed care 2. Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program, including the length of the enrollment period and all disenrollment opportunities available 3. Service area 4. Covered benefits 5. Provider Directory 6. Cost-sharing requirements 7. Access to covered services, including network adequacy standards 8. The DBM's responsibilities for care coordination 9. Quality and performance indicators, including member satisfaction	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Coverage and Authorization of Services						
Comments						
Strength						
AON						
Suggestion						
21. Provider Termination 42 CFR § 438.10.f.1	If a provider ceases participation in the DBM, the DBM 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 had received his or her primary care from the terminated provider.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Coverage and Authorization of Services						
22. Member Handbook 42 CFR § 438.10.g-g.4 DBMC: A.10.a.3; A.10.a.3.d-.f; .h-.k; .m; .p	Each Member Handbook includes the following: 1. Amount, duration, and scope of benefits available 2. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care 3. Information about emergency services 4. Any restrictions on the member's freedom of choice among network providers 5. Information about cost-sharing 6. Member rights and responsibilities 7. Grievance, appeal, and fair hearing procedures and timeframes 8. How to exercise an advance directive 9. How to access auxiliary aids and translation and interpretation services 10. Toll-free numbers for member services 11. How to report suspected fraud or abuse 12. Upon approval from TennCare, the DBM provides notice to each member of significant changes in the Member Handbook at least 30 days before the intended effective date of each change.	☐ ☐	Required information included Notice of changes provided timely	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
23. Advance Directives 42 CFR § 438.3.j.1-.4	The DBM provides adult members with written information on advance directives policies, including a description of applicable state laws, and the information reflects changes in state laws as soon as possible, but no later than 30 days after the effective date of the change.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Coverage and Authorization of Services						
DBMC: A.10.a.3 and .3.k						
Comments						
Strength						
AON						
Suggestion						
		Coverage and Authorization of Services Score		**0.0%**	**23.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Provider Selection						
1. Credentialing and Recredentialing Process 42 CFR § 438.214.b.2 DBMC: A.138-.139	The DBM follows a documented process for credentialing and recredentialing its network providers.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. Provider Selection P&Ps 42 CFR § 438.214.c DBMC: A.67; A.138	The DBM's network provider selection P&Ps do not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Provider Selection						
3. Excluded Providers 42 CFR § 438.214.d.1 DBMC: A.166	The DBM does not employ or contract with providers excluded from participation in federal healthcare programs under either section 1128 or section 1128A of the Social Security Act.	☐	Yes	**1.00**	**1.00**	**0.00**
		☐	No	**0.00**		
Comments						
Strength						
AON						
Suggestion						
			Provider Selection Score	**0.0%**	**3.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Confidentiality						
1. Written P&Ps 42 CFR § 438.224 DBMC: A.49.k	The DBM has written P&Ps to address the following: 1. Access to PHI across the DBM 2. Process for members to request restrictions on use and disclosure of their PHI 3. Process for members to request amendments to their PHI 4. Process for members to request an accounting of disclosures of their PHI	☐	Access	**0.25**	**1.00**	**0.00**
		☐	Restrictions	**0.25**		
		☐	Amendments	**0.25**		
		☐	Accounting of disclosures	**0.25**		
Comments						
Strength						
AON						
Suggestion						
			Confidentiality Score	**0.0%**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
1. System in Place 42 CFR § 438.402.a DBMC: A.118.a-.b; A.132	The DBM has a grievance and appeal system in place for members.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. One Level 42 CFR § 438.402.b DBMC: A.118.b	The DBM has only one level of appeal for members.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
3. State Fair Hearing (SFH) 42 CFR § 438.402.c-.c.1.i DBMC: A.119.c-.d; A.132	A member may file a grievance and request an appeal with the DBM. A member may request an SFH after receiving notice that the adverse benefit determination (ABD) is upheld (SFHs are not applicable for CoverKids).	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
Comments **Strength** **AON** **Suggestion**						
4. Provider Assistance 42 CFR § 438.402.c.1.ii DBMC: A.121.c; A.132	With written consent of the member, a provider or an authorized representative may request an appeal, file a grievance, or request an SFH on behalf of the member. Providers cannot request continuation of benefits. SFH requests are not applicable for CoverKids members.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
5. Timeframe to Request Appeal 42 CFR § 438.402.c.2-.2.ii DBMC: A.122; A.128.a; A.132	A member may file a grievance with the DBM at any time. Following receipt of an NABD, a member has 60 calendar days from the date on the NABD to file a request for an SFH to the DBM (not applicable for CoverKids).	☐ ☐	May file a grievance at any time Has 60 calendar days to request an SFH after receiving NABD	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
6. Methods 42 CFR § 438.402.c.3-.3.ii DBMC: A.123.a; A.128.a; A.132	A member may file a grievance either orally or in writing and, as determined by TennCare, either with TennCare or the DBM. A member may request an SFH either orally or in writing (not applicable for CoverKids).	☐	Yes	**1.00**	**1.00**	**0.00**
		☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						
7. Availability of Notices 42 CFR § 438.10; 438.404.a DBMC: A.119.f	The DBM gives members timely and adequate notice of an ABD in writing and makes the NABD available by the following means at no cost to the member: 1. Written translation 2. Oral interpretation 3. Alternative formats 4. Auxiliary aids and services	☐	Timely and adequate notice	**0.50**	**1.00**	**0.00**
		☐	Available via the listed means	**0.50**		
Comments **Strength** **AON** **Suggestion**						
8. NABD Inclusions 42 CFR § 438.404.b.1-.6	Each NABD explains the following: 1. The determination the DBM made or intends to make 2. The reasons for the determination, including the right of the member to receive (upon request and free of charge) reasonable access to and copies of all	☐	Determination	**0.16**	**1.00**	**0.00**
		☐	Reasons for determination	**0.16**		
		☐	Right to request appeal	**0.17**		

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
DBMC: A.119.a-.f	documents, records, and other information relevant to the determination. Such information includes medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits. 3. The member's right to request an appeal of the determination, including information on exhausting the DBM's one level of appeal and the right to request an SFH (SFHs are not applicable for CoverKids.) 4. The circumstances under which an appeal process can be expedited and how to request it 5. The member's right to have benefits continue pending resolution of the SFH, how to request that benefits be continued, and the circumstances, consistent with TennCare policy, under which the member may be required to pay the costs of these services (not applicable for CoverKids) 6. The procedures for exercising his or her NABD-related rights	☐	How the process can be expedited	**0.17**		
		☐	Right to have continuous benefits and how to request them (not applicable for CoverKids)	**0.17**		
		☐	Procedures for exercising NABD-related rights	**0.17**		
Comments **Strength** **AON** **Suggestion**						
9. NABD Mailing 42 CFR § 438.404.c.1 DBMC: A.120.a-.b	The DBM mails NABDs at least 10 days before the date of action when the ABD is a termination, suspension, or reduction of previously authorized covered service unless 1. the member dies, denies services, or becomes ineligible for TennCare coverage or their current level of care; 2. the member's address is determined unknown based on returned mail with no forwarding address;	☐	Yes	**1.00**	**1.00**	**0.00**
		☐	No	**0.00**		

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
	3. fraud is suspected or confirmed; or 4. the action will take place in less than 10 days.					
Comments **Strength** **AON** **Suggestion**						
10. Denial of Payment 42 CFR § 438.404.c.2 DBMC: A.120.e	For NABDs related to denial of payment, the DBM mails the notice at the time of any action affecting the claim.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
11. Standard Authorization Extensions 42 CFR § 438.404.c.4-.4.ii DBMC: A.120.c and .f-.g	If the DBM meets the criteria set forth for extending the timeframe for standard service authorization decisions, it 1. gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision; and 2. issues and carries out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.	☐ ☐	Provides written notice Makes the determination timely	**0.50** **0.50**	**1.00**	**0.00**
Comments						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Grievance and Appeal Systems						
Strength						
AON						
Suggestion						
12. Reasonable Assistance 42 CFR § 438.406.a DBMC: A.118.e.1	In handling grievances and appeals, the DBM gives members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free phone numbers that have adequate TTY/TTD and interpreter capability.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
13. Acknowledge Receipt 42 CFR § 438.406.b-.b.1 DBMC: A.118.e.2	The DBM's process for handling member grievances and appeals of ABDs acknowledges receipt of each grievance and appeal.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
	The DBM ensures that those who make decisions on grievances and appeals are individuals	☐	Not involved in previous level of review nor a subordinate of reviewer	**0.33**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
14. Reviewer Require-ments 42 CFR § 438.406.b and b.2-b.2.iii DBMC: A.118.f-.f.3	1. who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual; 2. who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by TennCare, in treating the member's condition or disease: ♦ An appeal of a denial that is based on lack of medical necessity ♦ A grievance regarding denial of expedited resolution of an appeal ♦ A grievance or appeal that involves clinical issues; and 3. who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial ABD.	☐ ☐	Appropriate clinical expertise Consider all relevant information	**0.33** **0.34**		
Comments **Strength** **AON** **Suggestion**						
15. Oral Inquiries 42 CFR § 438.406.b.3 DBMC: A.123.a and .c	The DBM ensures that oral inquiries seeking to appeal an ABD are treated as appeals (to establish the earliest possible filing date for the appeal) and are confirmed in writing, unless the member or the provider requests expedited resolution.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Grievance and Appeal Systems						
Strength						
AON						
Suggestion						
16. Opportunity to Make an Argument 42 CFR § 438.406.b.4	The DBM's process for handling member grievances and appeals of ABDs provides the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The DBM informs the member of the limited time available for this sufficiently in advance of the standard and expedited resolution timeframes for appeals and the standard resolution timeframe for grievances.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
17. Member Information Provided 42 CFR § 438.406.b.5 DMBC: A.119.b	The DBM provides the member (and his or her representative, if applicable) the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the DBM (or at the direction of the DBM) in connection with the appeal of the ABD. This information is provided free of charge and sufficiently in advance of the applicable resolution timeframe.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
	The DBM's process for handling member grievances and appeals of ABDs includes the member (and his or her representative, if	☐	Yes	**1.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
18. Parties to the Appeal 42 CFR § 438.406.b.6-.6.ii	applicable) or the legal representative of a deceased member's estate as parties to the appeal.	☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						
19. Resolution Timeframes 42 CFR § 438.408.a DBMC: A.124; A.128.b	The DBM resolves each grievance and appeal, and provides notice, as expeditiously as the member's health condition requires and within TennCare-established timeframes that may not exceed the standard and expedited resolution timeframes for appeals and the standard resolution timeframe for grievances.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
20. Standard Grievance Resolutions 42 CFR § 438.408.b.1 DBMC: A.128.b	For standard resolutions, the DBM resolves each grievance and provides notice as expeditiously as the member's health condition requires, within 90 calendar days of receipt.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Grievance and Appeal Systems						
Strength						
AON						
Suggestion						
21. Standard Appeal Resolutions 42 CFR § 438.408.b.2 DBMC: A.123.e.2	For standard resolutions, the DBM resolves each appeal and provides notice within 14 calendar days of receipt.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
22. Expedited Appeal Resolutions 42 CFR § 438.408.b.3 DBMC: A.124	For expedited resolutions, the DBM resolves each appeal and provides notice within 72 hours of receipt.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
	The DBM may extend the grievance and appeal resolution timeframes by up to 14 calendar days if the member requests the	☐	Yes	**1.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
23. Timeframe Extensions 42 CFR § 438.408.c.1-.1.ii	extension or if the DBM shows (to the satisfaction of TennCare, upon its request) that there is need for additional information and how the delay is in the member's interest.	☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						
24. Requirements Following Extension 42 CFR § 438.408.c.2-.2.ii	The DBM completes the following if it extends an appeal or grievance resolution timeframe not at the request of the member: 1. Make reasonable efforts to give the member prompt oral notice of the delay 2. Within two calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform them of their right to file a grievance if they disagree with that decision 3. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires	☐ ☐ ☐	Made reasonable efforts Written notice sent timely Resolved appeal timely	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
25. Format of Resolutions 42 CFR § 438.408.d.2-.2.ii	For all appeals, the DBM provides written notice of resolution with the following options available:	☐ ☐	Written notice includes all options Reasonable efforts for oral notice	**0.50** **0.50**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
DBMC: A.125.a-.b	1. Written translation 2. Oral interpretation 3. Alternative formats 4. Auxiliary aids and services For notice of an expedited resolution, the DBM makes reasonable efforts to provide oral notice.					
Comments **Strength** **AON** **Suggestion**						
26. Results and Date 42 CFR § 438.408.e.1 DBMC: A.125.a; A.128.d	Every written notice of a resolution includes the results of the resolution process and the date it was completed.	☐	Yes	**1.00**	**1.00**	**0.00**
		☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						
27. Additional Resolution Contents 42 CFR § 438.408.e.2-.2.iii	Every written notice of a resolution for appeals not resolved wholly in favor of the member states that the member	☐	Right to request SFH (not applicable for CoverKids)	**0.33**	**1.00**	**0.00**
		☐	Right to request and receive benefits (not applicable for CoverKids)	**0.33**		
		☐	May be liable for benefit costs	**0.34**		

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
	1. has the right to request an SFH and how to do so; 2. has the right to request and receive benefits while the hearing is pending, and how to make the request; and 3. may be held liable for the cost of those benefits if the hearing decision upholds the DBM's ABD, in accordance with TennCare policy. SFHs and continuous benefits are not applicable for CoverKids.					
Comments **Strength** **AON** **Suggestion**						
28. Expedited Review Process 42 CFR § 438.410.a DBMC: A.123.e and .e.3	The DBM maintains an expedited review process for appeals that is used when the DBM determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.	☐	Yes	**1.00**	**1.00**	**0.00**
		☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						
		☐	Yes	**1.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
29. Punitive Action Prohibited 42 CFR § 438.410.b	The DBM ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.	☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						
30. Expedited Resolution Denials 42 CFR § 438.410.c-.c.2	If the DBM denies a request for expedited resolution of an appeal, it 1. transfers the appeal to the timeframe for standard resolution, 2. makes reasonable efforts to give the member prompt oral notice of the delay, 3. sends written notice to the member within two calendar days, 4. informs the member of his or her right to file a grievance, and 5. resolves the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.	☐ ☐ ☐ ☐ ☐	Transfer to the standard timeframe Make reasonable efforts for oral notice Send written notice timely Inform member of right to file a grievance Resolve appeal timely	**0.20** **0.20** **0.20** **0.20** **0.20**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
31. Information for Providers		☐	Yes	**1.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
and Subcontract-ors 42 CFR § 438.414 DBMC: A.130.a-.b and .b.2	The DBM provides information about the grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time they enter into a contract.	☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						
32. Ongoing Monitoring 42 CFR § 438.416.a DBMC: A.131.a	The DBM maintains records of grievances and appeals and reviews the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the TennCare Quality Strategy.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
33. Record Requirements 42 CFR § 438.416.b-.b.6	The record of each grievance or appeal contains, at a minimum, all of the following information:	☐ ☐ ☐	General description Dates of receipt and review Resolution at each level	**0.20** **0.20** **0.20**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
DBMC: A.129.b	1. General description of the reason for the appeal or grievance 2. Date received and date of each review or, if applicable, review meeting 3. Resolution at each level of the appeal or grievance, if applicable 4. Date of resolution at each level, if applicable 5. Name of the covered person for whom the appeal or grievance was filed	☐ Resolution date(s) ☐ Name of covered person	**0.20** **0.20**		
Comments **Strength** **AON** **Suggestion**					
34. Record Maintenance 42 CFR § 438.416.c DBMC: A.129.a	The DBM accurately maintains the record of each grievance or appeal in a manner accessible to TennCare and available upon request to CMS.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
35. Continuous Benefits Requirements 42 CFR § 438.420.b-.b.5	The DBM continues the member's benefits if all of the following occur:	☐ Member filed request for appeal timely ☐ Appeal involved the appropriate services ☐ Services ordered by authorized provider	**0.20** **0.20** **0.20**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
DBMC: A.126.a-.a.5	1. The member files the request for an appeal within 60 calendar days of receiving an NABD. 2. The appeal involves the termination, suspension, or reduction of previously authorized services. 3. The services were ordered by an authorized provider. 4. The period covered by the original authorization has not expired. 5. The member files for continuation of benefits timely. Not applicable for CoverKids	☐	Original authorization had not expired	**0.20**		
		☐	Member filed for continuation of benefits timely	**0.20**		
Comments **Strength** **AON** **Suggestion**						
36. Termination of Benefits 42 CFR § 438.420.c-.c.3 DBMC: A.126.b-.b.2; A.126.a.5; A.132	If, at the member's request, the DBM continues or reinstates the member's benefits while the appeal or SFH is pending, the benefits are continued until one of following occurs: 1. The member withdraws the appeal or request for an SFH. 2. The member fails to request an SFH and continuation of benefits within 10 calendar days after the DBM sends the NABD to the member's appeal. 3. An SFH office issues a hearing decision adverse to the member. Not applicable for CoverKids	☐	Yes	**1.00**	**1.00**	**0.00**
		☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
37. Cost Recovery 42 CFR § 438.420.d	If the final resolution of the appeal is adverse to the member, the DBM may recover the cost of services furnished to the member while the appeal was pending. Not applicable for CoverKids	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
38. Services Not Furnished During Pending Appeal 42 CFR §438 424.a DBMC: A.126.c	If the DBM or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the DBM authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. Not applicable for CoverKids	☐ ☐	Yes No	**1.00** **0.00**	**0.00**	**1.00**
Comments **Strength** **AON** **Suggestion**						
39. Services Furnished During Pending Appeal	If the DBM or the SFH officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the DBM or TennCare pays for those services, in accordance with TennCare policy and regulations. Not applicable for CoverKids	☐	Yes	**1.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Grievance and Appeal Systems						
42 CFR § 438.424.b DBMC: A.127.d 40.		☐	No	**0.00**		
Comments						
Strength						
AON						
Suggestion						
			Grievance and Appeal Systems Score	**0.0%**	**39.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Subcontractual Relationships and Delegation						
1. Delegated Activities 42 CFR § 438.230.a-.c.1.i DBMC: A.83.b	The DBM specifies all of the activities and obligations that it has delegated to subcontractors in its subcontractor agreements.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Subcontractual Relationships and Delegation						
AON						
Suggestion						
2. Remedies for Unsatisfactory Performance 42 CFR § 438.230.c-.c.1 and .c.1.ii-.iii DBMC: A.83.b and .d	The DBM has remedies in place that may be implemented if subcontractor performance is unsatisfactory.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
3. Compliance with Laws and Regulations 42 CFR § 438.230.c.2 DBMC: A.83	The DBM's subcontractor agreements specify that the subcontractors must comply with all applicable Medicaid laws and regulations, including applicable subregulatory guidance and contract provisions.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
	The DMB's subcontractor agreements specify that TennCare, CMS, the HHS Inspector General, the Comptroller General, and their	☐	Yes	**1.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Subcontractual Relationships and Delegation						
4. Annual Review Requirements 42 CFR § 438.230.c.3-.3.i DBMC: A.66.n	designees have the right to review, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor(s), or of the contractors of the subcontractor(s), that pertain to any aspect of services and activities performed or determination of amounts payable under DBM's contract with TennCare.	☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						
5. Annual Review Provisions 42 CFR § 438.230.c.3 and .3.ii DBMC: A.66.n	The DBM's subcontractor agreements specify that, for purposes of an annual review, evaluation, or inspection, the subcontractor(s) must make available all premises, physical facilities, equipment, books, records, contracts, and computer or other electronic systems relating to members.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
6. Annual Review Timeframes 42 CFR § 438.230.c.3 and .3.iii DBMC: A.66.n	The DBM's subcontractor agreements specify that TennCare, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to review, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor(s), or of the contractors of the subcontractor(s) through 10 years from the final date of the contract period or from the date of completion of any annual review, whichever is later.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Subcontractual Relationships and Delegation						
Comments						
Strength						
AON						
Suggestion						
7. Suspicion of Fraud 42 CFR § 438.230.c.3 and .3.iv DBMC: A.66.n	The DBM's subcontractor agreements specify that if TennCare, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, then TennCare, CMS, or the HHS Inspector General may inspect, evaluate, and review the subcontractor(s) at any time.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
			Subcontractual Relationships and Delegation Score	**0.0%**	**7.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Practice Guidelines						
1. Requirements 42 CFR § 438.236.b-.b.4 DBMC: A.56 and .56.b-.e	The DBM uses practice guidelines that meet the following requirements: 1. Based on valid and reliable clinical evidence or a consensus of providers in the particular field 2. Consider the needs of members 3. Adopted in consultation with contracting healthcare professionals 4. Reviewed and updated periodically as appropriate	☐ ☐ ☐ ☐	Based on evidence or a consensus Consider members' needs Adopted in consultation with healthcare professionals Reviewed and updated	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. Dissemination of Guidelines 42 CFR § 438.236.c DBMC: A.56 and .56.f	The DBM disseminates the practice guidelines to all affected providers and, upon request, to members and potential members.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
3. Consistency with Guidelines 42 CFR § 438.236.d	Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	Criteria		Criteria Met	Criteria Value	Element	
					Value	Score
Practice Guidelines						
DBMC: A.56 and .56.a; A.114						
Comments						
Strength						
AON						
Suggestion						
			Practice Guidelines Score	**0.0%**	**3.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Health Information Systems						
1. System Requirements 42 CFR § 438.242.a DBMC: A.93.b.3	The DBM maintains a health information system that collects, analyzes, integrates, and reports data. The system provides information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for reasons other than loss of TennCare eligibility.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. Data Collection 42 CFR § 438.242.b and .b.2	The DBM's health information system collects data on member and provider characteristics as specified by TennCare, and on all services furnished to members through an encounter data system or other methods as may be specified by TennCare.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
3. Data Accuracy and Completeness 42 CFR § 438.242.b and .b.3-.3.iii	The DBM ensures that data received from providers are accurate and complete by 1. verifying the accuracy and timeliness of reported data, including data from network providers the DBM is compensating on the basis of capitation payments; 2. screening the data for completeness, logic, and consistency; and 3. collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for TennCare quality improvement (QI) and care coordination efforts.	☐ ☐ ☐	Verify accuracy and timeliness Screen for completeness, logic, and consistency Collect data in standardized formats	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Health Information Systems						
Strength						
AON						
Suggestion						
4. Data Availability 42 CFR § 438.242.b and .b.4 DBMC: A.177	The DBM makes all collected data available to TennCare and, upon request, to CMS.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
			Health Information Systems Score	**0.0%**	**4.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program						
1. Program in Place 42 CFR § 438.330.a.1 DBMC: A.142	The DBM has an ongoing comprehensive QAPI program in place for the services it furnishes to its members.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. Program Components 42 CFR § 438.330.b-.b.2 DBMC: A.143.A	The QAPI program includes performance improvement projects (PIPs) and collection and submission of performance measurement data.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
3. Under-/Over-Utilization 42 CFR § 438.330.b and .b.3-.4	The QAPI program includes mechanisms to detect under-/over-utilization of services and to assess the quality and appropriateness of care furnished to members with special healthcare needs, as defined by TennCare's Quality Strategy.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength**						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Quality Assessment and Performance Improvement (QAPI) Program						
AON						
Suggestion						
4. Annual Evaluation 42 CFR § 438.330.c and .c.2-.2.iii	On an annual basis, the DBM evaluates its performance by completing one or both of the following activities: 1. Measure and report to TennCare on its performance, using the standard measures required by TennCare 2. Submit data to TennCare that allow TennCare to calculate the DBM's performance using the standard measures	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
5. PIPs 42 CFR § 438.330.d.1 DBMC: A.143.a	The DBM conducts PIPs, including any PIP required by CMS, that focus on both clinical and nonclinical areas.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
6. Quality Indicators 42 CFR § 438.330.d.2-.2.i	The DBM designs each PIP to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. PIPs include measurement of performance using objective quality indicators.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program						
DBMC: A.143.b-.b.6 and .d						
Comments **Strength** **AON** **Suggestion**						
7. Interventions 42 CFR § 438.330.d.2 and .2.ii DBMC: A.143.d	Each PIP design includes the implementation of interventions to achieve improvement in the access to and quality of care.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
8. Intervention Effectiveness 42 CFR § 438.330.d.2 and .2.iii DBMC: A.143.b-.b.6	Each PIP includes an evaluation of the effectiveness of the interventions based on the performance measures.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON**						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program						
Suggestion						
9. Activities for Increasing or Sustaining Improvement 42 CFR § 438.330.d.2 and .2.iv DBMC: A.143.d	Each PIP includes planning and initiation of activities for increasing or sustaining improvement.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
10. Reporting PIP Results 42 CFR § 438.330.d.3 DBMC: Attachment C	The DBM reports the status and results of each PIP to TennCare as requested, but no less than once per year.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
		Quality Assessment and Performance Improvement(QAPI) Program Score		**0.0%**	**10.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
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 mails a Member Handbook to each member within 30 days of enrollment and distributes five outreach contacts each year that include four quarterly newsletters and a notice informing members of their dental benefits and encouraging them to schedule an appointment.	☐ ☐ ☐	Member Handbook Four quarterly newsletters Annual reminder to schedule appointment	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments **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	**1.00** **0.00**	**1.00**	**0.00**
Comments **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	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON**						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)						
Suggestion						
4. Appointment Assistance CFR 441.62 and .62.b DBMC A.32	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	**0.50** **0.50**	**1.00**	**0.00**
Comments						
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: 1. The DBM notifies the requesting provider of its prior authorization decision within 14 days of receiving a standard request. 2. Prior authorizations are not required for referrals from the public health screening program, primary care physicians (PCPs), and for preventive services. 3. 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.	☐ ☐ ☐	Provider notified of decision within 14 days of receipt Prior authorizations not required for referrals from the public health screening program, PCPs, or preventive services UM activities structured so no incentives were provided	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)						
6. Referrals DBMC A.46; A.145.b.1; A.145.b.1.n; A.145.b.2; A.145.b.2.h	A patient must be referred by a general dentist or pediatric dentist to a dental specialist (e.g., endodontist, oral surgeon, orthodontist, periodontist, prosthodontist) for the initial visit for services requiring specialized expertise. Subsequent visits to the same specialist in a course of treatment do not require separate referrals. The DBM sets standards for dental records that include requirements for referrals and results thereof. All patient encounters must be recorded in writing and dated. Documentation of individual encounters must provide adequate evidence of consultations, referrals, and specialist reports. Consultation, lab, and x-ray reports filed in the chart have the ordering dentist's/physician's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.	☐ ☐	Referral requirements in place Evidence ensuring provider compliance	**0.50** **0.50**	**1.00**	**0.00**
Comments **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	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
8. Provider Education	The DBM holds at least two training sessions per year for each Grand	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)						
DBMC A.52.a	Region in the state. At a minimum, the training addresses 1. the extent and limits of TennCare dental and orthodontic treatment coverage rules and medical necessity rule and 2. federal EPSDT law, Children and Youth with Special Needs, and TennCare rules.					
Comments **Strength** **AON** **Suggestion**						
9. Medical Necessity DBMC A.106 and 109.c	The DBM determines medical necessity on a case-by-case basis, and uses procedures to determine medical necessity that are consistent with the contractual definition of medical necessity and applicable TennCare rules. During the processing of appeals, the DBM provides information from medical records that supports these determinations.	☐ ☐	Procedures are consistent with contractual definition and TennCare rules All documentation provided upon request	**0.50** **0.50**	**1.00**	**0.00**
Comments **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.	☐ ☐ ☐	No limits or capitations imposed unless excluded under TennCare rule Services based on individual needs No utilization control guidelines/limits unless supported by individual member's medical history	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments **Strength** **AON**						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)						
Suggestion						
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	**0.50** **0.50**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
12. Dentists Supervise TCA 63-5-108	All dental services are performed by or under the supervision of dentists.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
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 may 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	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)						
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	**1.00** **0.00**	**1.00**	**0.00**
Comments						
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	**0.50** **0.50**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
16. Coordination of Dental Services DBMC A.20; A.113	The DBM maintains a dental provider network with a sufficient number of providers who accept new members in accordance with the geo access standards that state appointment waiting times do not exceed three weeks for regular appointments and 48 hours for urgent care. For children with urgent dental treatment needs and unmet dental treatment needs identified in the Tennessee Department of Health's School-Based Dental Prevention Program (SBDPP), the DBM schedules appointments in accordance with access standards so that appointment waiting times do not exceed three weeks for regular appointments and 48 hours for urgent care.	☐ ☐	Sufficient provider network Access standards met	**0.50** **0.50**	**1.00**	**0.00**
Comments						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
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	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
18. EPSDT Provisions DBMC A.66.II	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	**1.00** **0.00**	**1.00**	**0.00**
Comments						
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	**1.00** **0.00**	**1.00**	**0.00**
Comments						

2022 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
Strength					
AON					
Suggestion					
		Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Score	**0.0%**	**19.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Non-Discrimination Compliance						
1. Non-Discrimination Compliance Questionnaire DBMC A. 165.b.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	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. Display of Non-Discrimination Information DBMC D.9	The DBM assures that no person 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	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
3. Non-Discrimination Written Materials DBMC A.13.e.–.g; A.165.a.7-.8.c	All vital DBM documents and member materials are made available to members as noted below: 1. 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.	☐ ☐ ☐ ☐	Documents translated as described Written notice provided to specified members Written materials notify members of communication and language assistance services at no expense—TennCare taglines Written materials made available in alternative formats at no cost	**0.20** **0.20** **0.20** **0.20**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Non-Discrimination Compliance						
	2. 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. 3. 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. 4. 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. 5. 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.	☐	Staff demonstrated availability of vital documents in alternative formats	**0.20**		
Comments **Strength** **AON** **Suggestion**						
4. Written P&P DBMC A.29; A.30.a-.c; A. 31; A.165.a.3	The DBM has a written P&P on file for the provision of language interpretation and translation services, including providing auxiliary aids and services to any member who needs such services, including but not limited to LEP and visually/hearing-impaired members. The DBM shows that it provides member translation services and communication assistance in alternative formats through member services and provider services help-lines.	☐ ☐ ☐ ☐	Language interpretation and translation services addressed Communication assistance in alternative formats addressed Telephone numbers made known to members and providers Proof of communication assistance demonstrated through available help-lines	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Non-Discrimination Compliance						
5. 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.	☐ ☐ ☐ ☐	Quarterly Non-Discrimination Compliance Reports submitted to TennCare Reports included all required information All complaints reported within two business days Provided assistance to TennCare as needed	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
6. Provider and Subcontractor Compliance Education DBMC A.165.a-.a.1	The DBM provides non-discrimination compliance and cultural competency training to all contracted providers and subcontractors, ensuring they have been made aware of their obligations under the applicable civil rights laws.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
7. Provision of Services DBMC A.165.a.3	The DBM has written non-discrimination P&Ps on file that demonstrate services are provided in a non-discriminatory manner.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength**						

2022 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Non-Discrimination Compliance					
AON					
Suggestion					
		Non-Discrimination Compliance Score	**0.0%**	**7.00**	**0.000**

2022 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
1. Initial Credentialing P&Ps *TennCare Dental Benefits Manager Contract (TDC) A.138.b.* *42 CFR § 438.214(a)* *42 CFR § 438.214(b)* *42 CFR § 438.206(b)(1)*	The DBM has written initial credentialing P&Ps.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
2. Recredentialing P&Ps *TDC A.138.b.* *42 CFR § 438.214(a)* *42 CFR § 438.214(b)* *42 CFR § 438.206(b)(1)*	The DBM has written recredentialing P&Ps.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
3. Oversight by Governing Body *TDC A.138.c.*	Credentialing P&Ps are reviewed and approved by the governing body or the group/individual formally delegated the credentialing process by the governing body.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:**					

2022 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
AONs:					
4. Credentialing Entity *TDC A.17.b.* *TDC A.138.d.*	A credentialing committee or other peer review body (to include the dental director) has been designated by the DBM to make recommendations regarding credentialing decisions.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
5. Credentialing/Timeline *TDC A.138.f.1.*	The DBM ensures that there is a process and procedure for the periodic reverification of clinical credentials (recredentialing, reappointment or recertification) and that the procedure is implemented at least every three years.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
6. Pre-Delegation Credentialing Activities *TDC A.83.a.*	If credentialing and recredentialing activities are delegated, the DBM evaluates the prospective subcontractor's ability to perform the activities to be delegated.	☐ Met ☐ Not Met ☐ NA*	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:**					

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

2022 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
AONs:					
7. Monitoring Delegated Credentialing Activities *TDC A.83.b.c.*	If credentialing and recredentialing activities are delegated, the DBM: Executes a written agreement that specifies the activities and report responsibilities delegated to the subcontractor Monitors and evaluates delegated credentialing activities on an ongoing basis	a) ☐ Met ☐ Not Met ☐ NA b) ☐ Met ☐ Not Met ☐ NA Each Variable = 0.50	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
8. Corrective Action Plans for Delegated Credentialing Activities *TDC A.83.d.*	If credentialing and recredentialing activities are delegated, the DBM identifies deficiencies or areas for improvement, and the DBM and subcontractors take corrective action as necessary.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
9. Periodic Review of Performance *TDC A.138.f.3.*	The DBM conducts periodic review of information from the National Practitioner Data Bank (NPDB), along with performance data, on all dentists to decide whether to renew the participating dentist agreement.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	

2022 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
Comment: **Strengths:** **Suggestions:** **AONs:**					
10. Review of Data for Recredentialing *TDC A.138.f.4.*	During recredentialing, the DBM reviews data from: Member grievances Results of quality reviews Utilization management Member satisfaction surveys Reverification of hospital privileges and current licensure	☐ Met ☐ Not Met ☐ NA ☐ Met ☐ Not Met ☐ NA ☐ Met ☐ Not Met ☐ NA ☐ Met ☐ Not Met ☐ NA ☐ Met ☐ Not Met ☐ NA Each Variable = 0.20	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:**					

2022 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
AONs:					
11. Reporting Quality Deficiencies *TDC A.138.g.*	Through the review of plan documents there is evidence that the DBM established a mechanism for reporting serious quality deficiencies resulting in suspension or termination of a practitioner, to the appropriate authorities.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
12. Denial of Provider Credentialing *TDC A.138.i.*	If credentialing is denied, the provider must be notified in writing and the reasons for the denial must be specified (view denial letter).	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
13. Appeals Process *TDC A.138.h.*	The DBM has a process for providers to appeal determinations that reduce, suspend or terminate a provider's privileges.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					

2022 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
14. Current Dental Licenses *TDC A.138.*	The DBM ensures that a copy of the current, valid license is maintained on file at the Contractor's location for every dental professional in the network since dental licenses are renewed every two years.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
15. Credentialing Site Visits *TDC A.138.e.5.*	A site review will be required for a dentist's office for which the DBM receives a grievance from a member.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
16. Site Visits for ECF CHOICES Providers *TDC A.139.*	The DBM conducts a site visit for all ECF CHOICES dental providers to: Ensure accessibility to the physical location Review the provider's practices with respect to serving individuals with intellectual or developmental disabilities (I/DD) The provider's use of sedation services for individuals with I/DD and the provider's use of alternative	a) ☐ Met ☐ Not Met ☐ NA b) ☐ Met ☐ Not Met ☐ NA c) ☐ Met ☐ Not Met	**1.0**	**0.0**	

2022 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
	adjunctive techniques and modalities to reduce the use of sedation To ensure provider participation in education and training opportunities to further develop capacity and expertise to provide dental services to individuals with I/DD	☐ NA d) ☐ Met ☐ Not Met ☐ NA Each Variable = 0.25			
Comment: **Strengths:** **Suggestions:** **AONs:**					
17. Credentialing Timeline *TDC A.138.a.*	The DBM has a process to ensure that the DBM completely processes credentialing applications within 30 calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, a Medicaid ID number, and a signed provider agreement/contract.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
18. Non-discrimination *TDC A.67.* *TDC A.138.* *42 CFR 438.210(c)*	The DBM's written policies and procedures for the selection and/or retention of providers includes information concerning: Non-discrimination against providers that serve high-risk populations or specialize in conditions that require costly treatment.	☐ Met ☐ Not Met ☐ NA ☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	

2022 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
	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.	Each Variable = 0.50			
Comment: **Strengths:** **Suggestions:** **AONs:**					
19. Providers Excluded from Participation in Federal Health Care Programs *TDC A.166* *42 CFR 438.210(d)*	The DBM does not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1156 of the Social Security Act or who are otherwise not in good standing with TennCare or CoverKids programs.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
	Credentialing/Recredentialing P&Ps Score	**<##>%**	**19.0**	**0.0**	

QP Standards Tool—PBM

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Availability of Services						
1. Adequate Access for All Members 42 CFR § 438.206.b.1 PBMC: A.10	The PBM maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency (LEP) and/or physical and/or mental disabilities.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. Out-of-Network Services 42 CFR § 438.206.b.4 PBMC: A.14	If the provider network is unable to provide necessary services, covered under the contract, to a particular member, the PBM adequately and timely covers these services out of network for the member, for as long as the PBM's provider network is unable to provide them.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
3. Out-of-Network Costs 42 CFR § 438.206.b.5	The PBM requires out-of-network providers to coordinate with the PBM for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Availability of Services						
PBMC: A.14						
Comments						
Strength						
AON						
Suggestion						
4. Timely Access 42 CFR § 438.206.c.1.i PBMC: A.49.a-.a.4; A.49.b-.b.4	The PBM requires its network providers to meet TennCare standards for timely access to care and services, taking into account the urgency of the need for services.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
5. Hours of Operation and Access 42 CFR § 438.206.c.1.ii-.iii PBMC: A.49.a; A.49.a.4	The PBM ensures that its network providers offer hours of operation that are no less than the hours of operation offered to commercial members. The PBM makes services included in the contract available 24 hours a day, seven days a week, when medically necessary.	☐ ☐	Comparable hours of operation 24/7 access	**0.50** **0.50**	**1.00**	**0.00**
Comments						
Strength						
AON						

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Availability of Services						
Suggestion						
6. Compliance 42 CFR § 438.206.c.1.iv-.vi PBMC: A.10; A.49.a; A.49.a.4	The PBM establishes mechanisms to ensure network provider compliance with the provision of timely access to care, monitors network providers regularly to determine compliance, and takes corrective action for noncompliance.	☐ ☐ ☐	Mechanisms Monitoring Corrective action if needed	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
7. Cultural Competency 42 CFR § 438.206.c.2 PBMC: A.6.i	The PBM participates in TennCare's efforts to promote the delivery of services in a culturally competent manner to all members, including those with LEP, diverse cultural and ethnic backgrounds, and/or disabilities, and regardless of sex.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
8. Accessibility for Members with Disabilities 42 CFR § 438.206.c.3	The PBM emphasizes the importance of network providers to have the capabilities to ensure physical access, accommodations, and accessible equipment for the furnishing of services to members with physical or mental disabilities.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Availability of Services						
PBMC: A.6.i						
Comments						
Strength						
AON						
Suggestion						
9. Provider Directory Inclusions 42 CFR § 438.10.h.1-.1.viii PBMC:A.49.d-.d.1	The PBM maintains a Provider Directory that is available electronically and in hard copy by request. It includes the following for each provider: 1. Name and group affiliation 2. Street address(es) 3. Telephone number(s) 4. Website URL 5. Specialty 6. Whether the provider accepts new members 7. Cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training	☐	Yes	**1.00**	**1.00**	**0.00**
		☐	No	**0.00**		
Comments						
Strength						
AON						
Suggestion						
10. Provider Directory Availability	The hard copy version of the Provider Directory is updated at least monthly. The electronic version is updated at least weekly and is available on the PBM's website.	☐	Hard copy updated monthly	**0.50**	**1.00**	**0.00**
		☐	Electronic version updated weekly and available on website	**0.50**		

2022 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	Criteria		Criteria Met	Criteria Value	Element
					Value / Score
Availability of Services					
42 CFR § 438.10.h.3-.4 PBMC: A.49.d-.d.1					
Comments					
Strength					
AON					
Suggestion					
			Availability of Services Score	**0.0%**	**10.00** / **0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Assurances of Adequate Capacity and Services						
1. Appropriate Provider Network 42 CFR § 438.207.b.1-.2 PBMC: A.60.c-.e	The PBM submits documentation to TennCare as evidence that it maintains a provider network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.	☐ ☐	Documentation submitted Sufficient provider network	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. Timely Documentation 42 CFR § 438.207.c-.c.3.ii PBMC: A.17	The PBM submits documentation to TennCare evidencing its appropriate range of services and provider network no less frequently than 1. at the time it enters into a contract with TennCare; 2. on an annual basis; and 3. at any time there has been a significant change (as defined by the TennCare) in the PBM's operations that would affect the adequacy of capacity and services, including ♦ changes in services, benefits, geographic service area, composition of or payments to its network providers or ♦ enrollment of a new population.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
			Assurances of Adequate Capacity and Services Score	**0.0%**	**2.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Coordination and Continuity of Care						
1. Protected Health Information 42 CFR § 438.208.b.6 PBMC: A.44.h.2-.3	The PBM ensures that in the process of coordinating care, each member's protected health information (PHI) is used only for the purposes of treatment, payment, healthcare operations, and health oversight and its related functions.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. Disenrollment by PBM Prohibited 42 CFR § 438.56.b-.b.3 PBMC: A.42.d.10; A.44.o	A member may be disenrolled from the PBM only when authorized by TennCare, and the PBM cannot request disenrollment of a member for any reason. On a daily basis, TennCare ensures that its 834 eligibility file is accurate and complete; the PBM uses this information to identify individuals added and whose enrollment status has changed and updates the eligibility information in its data system.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
			Coordination and Continuity of Care Score	**0.0%**	**2.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Coverage and Authorization of Services						
1. Service Limitations 42 CFR § 438.210.a.4-.4.i PBMC: A.46.b and .b.2	The PBM has the ability to place appropriate limits on a service on the basis of criteria applied under TennCare rule, such as medical necessity.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. Medically Necessary Definition 42 CFR § 438.210.a.5-.5.i PBMC: A.8.b.11	The PBM uses a definition of “medically necessary services” that is no more restrictive than what is used in the TennCare program, including quantitative and non-quantitative treatment limits, as indicated in TennCare statutes, regulations, and P&Ps.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
3. Service Authorization P&Ps 42 CFR § 438.210.b-b.1	The PBM and its subcontractors use written P&Ps to process requests for initial and continuing authorizations of services.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Coverage and Authorization of Services						
PBMC: A.46.a						
Comments						
Strength						
AON						
Suggestion						
4. Processing Authorizations 42 CFR § 438.210.b.2-.2.iii PBMC: A.46.a.1; A.77.b.1	To process requests for initial and continuing authorizations of services, the PBM uses mechanisms to ensure consistent application of review criteria for authorization decisions.	☐ ☐	Yes No	**0.50** **0.50**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
5. Appropriate Expertise 42 CFR § 438.210.b.3 PBMC: A.46.a.3; A.77.b.1	Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by an individual who has appropriate expertise in addressing the member's needs.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Coverage and Authorization of Services						
AON						
Suggestion						
6. Notice of Adverse Benefit Determination (NABD) 42 CFR § 438.210.c PBMC: A.46.b-.b.6; A.77.b.2	The PBM notifies the requesting provider and gives the member written NABD of any decision by the PBM to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. NABDs are sent within the TennCare-approved timeframes and include the determination, reasons for it, member's right to request an appeal, and an explanation of the appeal process.	☐ ☐	Sent to provider and member Included required information	**0.50** **0.50**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
7. Notification Timeframes 42 CFR § 438.210.d-.d.3 PBMC: A.46.a and .d.3	Notices are sent within 24 hours following receipt of the request for service. If a provider indicates, or the PBM determines, that following the 24-hour authorization timeframe could seriously jeopardize the member's life or health or his/her ability to attain, maintain, or regain maximum function, the PBM makes an decision and provides notice as expeditiously as the member's health condition requires, and no later than 72 hours after receipt of the request for service. For all covered outpatient drug authorization decisions, the PBM provides notice as described in section 1927(d)(5)(A) of the Social Security Act.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Coverage and Authorization of Services						
8. Compensation for Utilization Management (UM) 42 CFR § 438.210.e PBMC: A.40.d	Compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
9. Member Rights 42 CFR § 438.100.b-.b.2.vi	Members and potential members have the right to 1. receive information in readily accessible formats and methods; 2. be treated with respect and with due consideration for his or her dignity and privacy; 3. receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand; 4. participate in decisions regarding his or her healthcare, including the right to refuse treatment; and 5. request and receive a copy of his or her medical records and request that they be amended or corrected.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
	The PBM makes oral interpretation available in all languages and written translation available in each prevalent non-English language.	☐	Yes	**1.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Coverage and Authorization of Services						
10. Language and Format 42 CFR § 438.10.d-.d.6.iii PBMC: A.8.b.1 and .3-.5	Written materials that are critical to obtaining services for potential members include taglines in the prevalent non-English languages to explain the availability of interpretation and translation services and information on how to request auxiliary aids and services. The PBM makes its appeal and grievance notices and denial notices available in the prevalent non-English languages. The PBM provides translated written materials that are critical to obtaining services, auxiliary aids, and interpretation services to members and potential members at no cost.	☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						
11. Formulary 42 CFR § 438.10.i-.i.3 PBMC: A.43.a.1-.2; A.73.d	The PBM's formulary includes which medications are covered (both generic and name brand) and which tier each medication is on and is available on the PBM's website.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
			Coverage and Authorization of Services Score	**0.0%**	**11.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Provider Selection						
1. Credentialing and Recredentialing Process 42 CFR § 438.214.b.2 PBMC: A.6.g.1; A.7.a.2; A.10.b	The PBM follows a documented process for credentialing and recredentialing its network providers.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. Provider Selection P&Ps 42 CFR § 438.214.c PBMC: A.15	The PBM's network provider selection P&Ps do not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
3. Excluded Providers 42 CFR § 438.214.d.1	The PBM does not employ or contract with providers excluded from participation in federal healthcare programs under either section 1128 or section 1128A of the Social Security Act.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Provider Selection						
PBMC: A.30.f-.g.6						
Comments						
Strength						
AON						
Suggestion						
			Provider Selection Score	**0.0%**	**3.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Confidentiality						
1. Written P&Ps 42 CFR § 438.224 PBMC: A.44.h.3; A.58.g.3	The PBM has written P&Ps to address confidentiality in accordance with TennCare and federal regulations.	☐	Yes	**1.00**	**1.00**	**0.00**
		☐	No	**0.00**		
Comments						
Strength						
AON						
Suggestion						
			Confidentiality Score	**0.0%**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
1. System in Place 42 CFR § 438.402.a PBMC: A.46.d.1-.2; A.77.d	The PBM has a grievance and appeal system in place for members.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. One Level 42 CFR § 438.402.b PB**M**C: A.46.d.2; A.77.d	The PBM has only one level of appeal for members.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
3. State Fair Hearing (SFH) 42 CFR § 438.402.c-.c.1.i	A member may file a grievance and request an appeal with the PBM. A member may request an SFH after receiving notice that the adverse benefit determination (ABD) is upheld (SFH is not applicable for CoverKids).	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
PBMC: A.46.d.7.b; A.46.d.14.a; A.77.d						
Comments **Strength** **AON** **Suggestion**						
4. Provider Assistance 42 CFR § 438.402.c.1.ii PBMC: A.46.d.9; A.77.d	With written consent of the member, a provider or an authorized representative may request an appeal, file a grievance, or request an SFH on behalf of the member. Providers cannot request continuation of benefits. SFH requests are not applicable for CoverKids members.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
5. Timeframe to Request Appeal 42 CFR § 438.402.c.2-.2.ii PBMC:A.46.d.10; A.46.d.14.a; A.77.d	A member may file a grievance with the PBM at any time. TennCare members have 60 calendar days from the date on an NABD to file a request for an appeal. CoverKids members have 30 days from receipt of a Denial Letter for an adverse prior authorization decision to file an appeal.	☐ ☐ ☐	May file a grievance at any time Has 60 calendar days to request an appeal after receiving NABD (TennCare members) Has 30 calendar days to request an appeal after receiving Denial Letter (CoverKids members)	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments						

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Grievance and Appeal Systems						
Strength						
AON						
Suggestion						
6. Methods 42 CFR § 438.402.c.3-.3.ii PBMC: A.46.d.11.a and .c; A.46.d.14.b; A.77.d	A member may file a grievance either orally or in writing and, as determined by TennCare, either with TennCare or the PBM. A member may request an appeal either orally or in writing.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
7. Availability of Notices 42 CFR § 438.10; 438.404.a PBMC: A.46.d.7.e	The PBM gives members timely and adequate notice of an ABD in writing and makes the NABD available by the following means at no cost to the member: 1. Written translation 2. Oral interpretation 3. Alternative formats 4. Auxiliary aids and services	☐ ☐	Timely and adequate notice Available via the listed means	**0.50** **0.50**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
	Each NABD explains the following:	☐	Determination	**0.20**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
8. NABD Inclusions 42 CFR § 438.404.b.1-.6 PBMC: A.46.d.7-.7.d; A.77.d	1. The determination the PBM made or intends to make 2. The reasons for the determination, including the right of the member to receive (upon request and free of charge) reasonable access to and copies of all documents, records, and other information relevant to the determination. Such information includes medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits. 3. The member's right to request an appeal of the determination, including information on exhausting the PBM 's one level of appeal and the right to request an SFH (SFHs are not applicable for CoverKids.) 4. The circumstances under which an appeal process can be expedited and how to request it 5. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with TennCare policy, under which the member may be required to pay the costs of these services (not applicable for CoverKids). 6. The procedures for exercising his or her NABD-related rights	☐	Reasons for determination	**0.20**		
		☐	Right to request appeal and how the process can be expedited	**0.20**		
		☐	Right to have continuous benefits and how to request them (not applicable for CoverKids)	**0.20**		
		☐	Procedures for exercising NABD-related rights	**0.20**		
Comments **Strength** **AON** **Suggestion**						
		☐	Yes	**1.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
9. NABD Mailing 42 CFR § 438.404.c.1	The PBM mails NABDs at least 10 days before the date of action when the ABD is a termination, suspension, or reduction of previously authorized covered service unless 1. the member dies, denies services, or becomes ineligible for TennCare coverage or their current level of care; 2. the member's address is determined unknown based on returned mail with no forwarding address; 3. fraud is suspected or confirmed; or 4. the action will take place in less than 10 days.	☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						
10. Denial of Payment 42 CFR § 438.404.c.2 PBMC: A.46.d.8.c	For NABDs related to denial of payment, the PBM mails the notice at the time of any action affecting the claim.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
11. Standard Authorization Extensions	If the PBM meets the criteria set forth for extending the timeframe for standard service authorization decisions, it 1. gives the member written notice of the reason for the decision to extend the timeframe and informs	☐ ☐	Provides written notice Makes the determination timely	**0.50** **0.50**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
42 CFR § 438.404.c.4-.4.ii	the member of the right to file a grievance if he or she disagrees with that decision; and 2. issues and carries out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.					
Comments						
Strength						
AON						
Suggestion						
12. Reasonable Assistance 42 CFR § 438.406.a PBMC: A.46.d.5.a	In handling grievances and appeals, the PBM gives members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free phone numbers that have adequate TTY/TTD and interpreter capability.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
13. Acknowledge Receipt 42 CFR § 438.406.b-.b.1 PBMC: A.46.d.5.b	The PBM's process for handling member grievances and appeals of ABDs acknowledges receipt of each grievance and appeal.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
Strength						
AON						
Suggestion						
14. Reviewer Requirements 42 CFR § 438.406.b and b.2-b.2.iii PBMC: A.46.d.6-.6.c	The PBM ensures that those who make decisions on grievances and appeals are individuals 1. who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual; 2. who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by TennCare, in treating the member's condition or disease: ♦ An appeal of a denial that is based on lack of medical necessity ♦ A grievance regarding denial of expedited resolution of an appeal ♦ A grievance or appeal that involves clinical issues; and 3. who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial ABD.	☐ ☐ ☐	Not involved in previous level of review nor a subordinate of reviewer Appropriate clinical expertise Consider all relevant information	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
	The PBM ensures that oral inquiries seeking to appeal an ABD are treated as appeals (to establish the earliest possible filing date for	☐	Yes	**1.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
15. Oral Inquiries 42 CFR § 438.406.b.3 PBMC: A.46.d.11.a and .c	the appeal) and are confirmed in writing, unless the member or the provider requests expedited resolution.	☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						
16. Opportunity to Make an Argument 42 CFR § 438.406.b.4	The PBM's process for handling member grievances and appeals of ABDs provides the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The PBM informs the member of the limited time available for this sufficiently in advance of the standard and expedited resolution timeframes for appeals and the standard resolution timeframe for grievances.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
17. Parties to the Appeal 42 CFR § 438.406.b.6-.6.ii	The PBM's process for handling member grievances and appeals of ABDs includes the member (and his or her representative, if applicable) or the legal representative of a deceased member's estate as parties to the appeal.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Grievance and Appeal Systems						
Strength						
AON						
Suggestion						
18. Resolution Timeframes 42 CFR § 438.408.a PBMC: A.46.d.11.e.3; A.46.d.14.c	The PBM resolves each grievance and appeal, and provides notice as expeditiously as the member's health condition requires and within TennCare-established timeframes that may not exceed the standard and expedited resolution timeframes for appeals and the standard resolution timeframe for grievances.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
19. Standard Grievance Resolutions 42 CFR § 438.408.b.1 PBMC: A.46.d.14.c	For standard resolutions, the PBM resolves each grievance and provides notice as expeditiously as the member's health condition requires, within 90 calendar days of receipt.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
	For standard resolutions, the PBM resolves each appeal and provides notice within 14 calendar days of receipt.	☐	Yes	**1.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
20. Standard Appeal Resolutions 42 CFR § 438.408.b.2 PBMC: A.46.d.11.e.2		☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						
21. Expedited Appeal Resolutions 42 CFR § 438.408.b.3 PBMC: A.46.d.11.e.1	For expedited resolutions, the PBM resolves each appeal and provides notice within 72 hours of receipt.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
22. Timeframe Extensions 42 CFR § 438.408.c.1-.1.ii	The PBM may extend the grievance and appeal resolution timeframes by up to 14 calendar days if the member requests the extension or if the PBM shows (to the satisfaction of TennCare, upon its request) that there is need for additional information and how the delay is in the member's interest.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
PBMC: A.46.d.14.d-.d.2						
Comments						
Strength						
AON						
Suggestion						
23. Requirements Following Extension 42 CFR § 438.408.c.2-.2.ii PBMC: A.46.d.14.c and .e-.e.2	The PBM completes the following if it extends an appeal or grievance resolution timeframe not at the request of the member: 1. Make reasonable efforts to give the member prompt oral notice of the delay 2. Within two calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform them of their right to file a grievance if they disagree with that decision 3. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires	☐	Made reasonable efforts	**0.33**	**1.00**	**0.00**
		☐	Written notice sent timely	**0.33**		
		☐	Resolved appeal timely	**0.34**		
Comments						
Strength						
AON						
Suggestion						
24. Format of Resolutions 42 CFR § 438.408.d.2-.2.ii PBMC: A.46.d.14.f	For all appeals, the PBM provides written notice of resolution with the following options available: 1. Written translation 2. Oral interpretation 3. Alternative formats 4. Auxiliary aids and services For notice of an expedited resolution, the PBM makes reasonable efforts to provide oral notice.	☐	Written notice includes all options	**0.50**	**1.00**	**0.00**
		☐	Reasonable efforts for oral notice	**0.50**		

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Grievance and Appeal Systems						
Comments						
Strength						
AON						
Suggestion						
25. Results and Date 42 CFR § 438.408.e.1	Every written notice of a resolution includes the results of the resolution process and the date it was completed.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
26. Additional Resolution Contents 42 CFR § 438.408.e.2-.2.iii	Every written notice of a resolution for appeals not resolved wholly in favor of the member states that the member 5. has the right to request an SFH and how to do so (not applicable for CoverKids); 6. has the right to request and receive benefits while the hearing is pending, and how to make the request (not applicable for CoverKids); and 7. may be held liable for the cost of those benefits if the hearing decision upholds the PBMC's ABD, in accordance with TennCare policy.	☐ ☐ ☐	Right to request SFH Right to request and receive benefits (not applicable for CoverKids) May be liable for benefit costs	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
	The PBM maintains an expedited review process for appeals that is used when the PBM determines (for a request from the	☐	Yes	**1.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
27. Expedited Review Process 42 CFR § 438.410.a PBMC: A.46.d.11.b; A.46.d.11.e-.e.1 and.e.3	member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.	☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						
28. Punitive Action Prohibited 42 CFR § 438.410.b PBMC: A.15.d	The PBM ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
29. Expedited Resolution Denials	If the PBM denies a request for expedited resolution of an appeal, it 1. transfers the appeal to the timeframe for standard	☐ ☐	Transfer to the standard timeframe Make reasonable efforts for oral notice	**0.20** **0.20**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
42 CFR § 438.410.c-.c.2	resolution, 2. makes reasonable efforts to give the member prompt oral notice of the delay, 3. sends written notice to the member within two calendar days, 4. informs the member of his or her right to file a grievance, and 5. resolves the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.	☐	Send written notice timely	**0.20**		
		☐	Inform member of right to file a grievance	**0.20**		
		☐	Resolve appeal timely	**0.20**		
Comments **Strength** **AON** **Suggestion**						
30. Information for Providers and Subcontractors 42 CFR § 438.414 PBMC: A.46.d.17.b and .b.2	The PBM provides information about the grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time they enter into a contract.	☐	Yes	**1.00**	**1.00**	**0.00**
		☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						
	The PBM maintains records of grievances and appeals and reviews the information as part of its ongoing monitoring	☐	Yes	**1.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
31. Ongoing Monitoring 42 CFR § 438.416.a PBMC: A.46.d.15.a	procedures, as well as for updates and revisions to the TennCare Quality Strategy.	☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						
32. Record Requirements 42 CFR § 438.416.b-.b.6 PBMC: A.46.d.15.b	The record of each grievance or appeal contains, at a minimum, all of the following information: 1. General description of the reason for the appeal or grievance 2. Date received and date of each review or, if applicable, review meeting 3. Resolution at each level of the appeal or grievance, if applicable 4. Date of resolution at each level, if applicable 5. Name of the covered person for whom the appeal or grievance was filed	☐ ☐ ☐ ☐ ☐	General description Dates of receipt and review Resolution at each level Resolution date(s) Name of covered person	**0.20** **0.20** **0.20** **0.20** **0.20**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
		☐	Yes	**1.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
33. Record Maintenance 42 CFR § 438.416.c PBMC: A.46.d.15.c	The PBM accurately maintains the record of each grievance or appeal in a manner accessible to TennCare and available upon request to CMS.	☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						
34. Continuous Benefits Requirements 42 CFR § 438.420.b-.b.5 PBMC: A.46.d.12.a-.a.3	The PBM continues the member's benefits if all of the following occur: 1. The member files the request for an appeal within 60 calendar days of receiving an NABD. 2. The appeal involves the termination, suspension, or reduction of previously authorized services. 3. The services were ordered by an authorized provider. 4. The period covered by the original authorization has not expired. 5. The member files for continuation of benefits timely. Not applicable for CoverKids	☐ ☐ ☐ ☐ ☐	Member filed request for appeal timely Appeal involved the appropriate services Services ordered by authorized provider Original authorization had not expired Member filed for continuation of benefits timely	**0.20** **0.20** **0.20** **0.20** **0.20**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
35. Termination of Benefits 42 CFR § 438.420.c-.c.3 PBMC: A.46.d.12.a and .a.3; A.46.d.12.b-.b.2	If, at the member's request, the PBM continues or reinstates the member's benefits while the appeal or SFH is pending, the benefits are continued until one of following occurs: 1. The member withdraws the appeal or request for an SFH. 2. The member fails to request an SFH and continuation of benefits within 10 calendar days after the PBM sends the NABD to the member's appeal. 3. An SFH office issues a hearing decision adverse to the member. Not applicable for CoverKids	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
36. Cost Recovery 42 CFR § 438.420.d	If the final resolution of the appeal is adverse to the member, the PBM may recover the cost of services furnished to the member while the appeal was pending. Not applicable for CoverKids	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
37. Services Not Furnished	If the PBM or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was	☐	Yes	**1.00**	**0.00**	**1.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
During Pending Appeal 42 CFR §438 424.a PBMC: A.46.d.13.b	pending, the PBM authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. Not applicable for CoverKids	☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						
38. Services Furnished During Pending Appeal 42 CFR § 438.424.b PBMC: A.46.d.13.d	If the PBM or the SFH officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the PBM or TennCare pays for those services, in accordance with TennCare policy and regulations. Not applicable for CoverKids	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
			Grievance and Appeal Systems Score	**0.0%**	**38.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Subcontractual Relationships and Delegation						
1. Delegated Activities 42 CFR § 438.230.a-.c.1.i PBMC: A.7.a.5	The PBM specifies all of the activities and obligations that it has delegated to subcontractors in its subcontractor agreements.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. Remedies for Unsatisfactory Performance 42 CFR § 438.230.c-.c.1 and .c.1.ii-.iii PBMC: A.7.a.5	The PBM has remedies in place that may be implemented if subcontractor performance is unsatisfactory.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
3. Compliance with Laws and Regulations 42 CFR § 438.230.c.2	The PBM's subcontractor agreements specify that the subcontractors must comply with all applicable Medicaid laws and regulations, including applicable subregulatory guidance and contract provisions.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Subcontractual Relationships and Delegation						
PBMC: A.7.a.5						
Comments						
Strength						
AON						
Suggestion						
4. Annual Review Requirements 42 CFR § 438.230.c.3-.3.i PBMC: A.18	The PBM's subcontractor agreements specify that TennCare, CMS, the HHS Inspector General, the Comptroller General, and their designees have the right to review, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor(s), or of the contractors of the subcontractor(s), that pertain to any aspect of services and activities performed or determination of amounts payable under the PBM's contract with TennCare.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
5. Annual Review Provisions 42 CFR § 438.230.c.3 and .3.ii PBMC: A.20	The PBM's subcontractor agreements specify that, for purposes of annual review, evaluation, or inspection, the subcontractor(s) must make available all premises, physical facilities, equipment, books, records, contracts, and computer or other electronic systems relating to members.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Subcontractual Relationships and Delegation						
Suggestion						
6. Annual Review Timeframes 42 CFR § 438.230.c.3 and .3.iii PBMC: A.20	The PBM's subcontractor agreements specify that TennCare, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to review, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor(s), or of the contractors of the subcontractor(s) through 10 years from the final date of the contract period or from the date of completion of any annual review, whichever is later.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
7. Suspicion of Fraud 42 CFR § 438.230.c.3 and .3.iv PBMC: A.20	The PBM's subcontractor agreements specify that if TennCare, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, then TennCare, CMS, or the HHS Inspector General may inspect, evaluate, and review the subcontractor(s) at any time.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
			Subcontractual Relationships and Delegation Score	**0.0%**	**7.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Practice Guidelines						
1. Consistency with Guidelines 42 CFR § 438.236.d	Decisions for utilization management, member education, and coverage of services are based on TennCare Pharmacy Advisory Committee recommendations.	☐	Yes	**1.00**	**1.00**	**0.00**
		☐	No	**0.00**		
Comments						
Strength						
AON						
Suggestion						
			Practice Guidelines Score	**0.0%**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Health Information Systems						
1. System Requirements 42 CFR § 438.242.a PBMC: A.40.f	The PBM maintains a health information system that collects, analyzes, integrates, and reports data. The system provides information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for reasons other than loss of TennCare eligibility.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. Data Collection 42 CFR § 438.242.b and .b.2 PBMC: A.40.f	The PBM's health information system collects data on member and provider characteristics as specified by TennCare, and on all services furnished to members through an encounter data system or other methods as may be specified by TennCare.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
3. Data Accuracy and Completeness 42 CFR § 438.242.b and .b.3-.3.iii PBMC: A.40.f	The PBM ensures that data received from providers are accurate and complete by 1. verifying the accuracy and timeliness of reported data, 2. screening the data for completeness, logic, and consistency; and 3. collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for TennCare quality improvement (QI) and care coordination efforts.	☐ ☐ ☐	Verify accuracy and timeliness Screen for completeness, logic, and consistency Collect data in standardized formats	**0.33** **0.33** **0.34**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Health Information Systems						
Comments						
Strength						
AON						
Suggestion						
4. Data Availability 42 CFR § 438.242.b and .b.4 PBMC: A.40.g	The PBM makes all collected data available to TennCare and, upon request, to CMS.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
			Health Information Systems Score	**0.0%**	**4.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program						
1. Program in Place 42 CFR § 438.330.a.1 PBMC: A.46.a.12	The PBM has an ongoing comprehensive QAPI program in place for the services it furnishes to its members.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
2. Program Components 42 CFR § 438.330.b-.b.2 PBMC: A.52; A.54	The QAPI program includes performance improvement projects (PIPs) and collection and submission of performance measurement data.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
3. Under-/Over-Utilization 42 CFR § 438.330.b and .b.3-.4	The QAPI program includes mechanisms to detect under-/over-utilization of services and to assess the quality and appropriateness of care furnished to members with special healthcare needs, as defined by TennCare's Quality Strategy.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Quality Assessment and Performance Improvement (QAPI) Program						
Strength **AON** **Suggestion**						
4. Annual Evaluation 42 CFR § 438.330.c and .c.2-.2.iii	On an annual basis, the PBM evaluates its performance by completing one or both of the following activities: 1. Measure and report to TennCare on its performance, using the standard measures required by TennCare 2. Submit data to TennCare that allow TennCare to calculate the PBM's performance using the standard measures	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
5. PIPs 42 CFR § 438.330.d.1 PBMC: A.54	The PBM conducts PIPs, including any PIP required by CMS that focus on both clinical and nonclinical areas.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
	The PBM designs each PIP to achieve significant improvement, sustained over time, in health outcomes and member satisfaction.	☐	Yes	**1.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program						
6. Quality Indicators 42 CFR § 438.330.d.2-.2.i PBMC: A.54	PIPs include measurement of performance using objective quality indicators.	☐	No	**0.00**		
Comments **Strength** **AON** **Suggestion**						
7. Interventions 42 CFR § 438.330.d.2 and .2.ii PBMC: A.54	Each PIP design includes the implementation of interventions to achieve improvement in the access to and quality of care.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
8. Intervention Effectiveness 42 CFR § 438.330.d.2 and .2.iii PBMC: A.54	Each PIP includes an evaluation of the effectiveness of the interventions based on the performance measures.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program						
Comments **Strength** **AON** **Suggestion**						
9. Activities for Increasing or Sustaining Improvement 42 CFR § 438.330.d.2 and .2.iv PBMC: A.54	Each PIP includes planning and initiation of activities for increasing or sustaining improvement.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
10. Reporting PIP Results 42 CFR § 438.330.d.3 PBMC: A.54	The PBM reports the status and results of each PIP to TennCare as requested, but no less than once per year.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						

2022 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Quality Assessment and Performance Improvement (QAPI) Program					
	Quality Assessment and Performance Improvement (QAPI) Program Score		**0.0%**	**10.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
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	**1.00** **0.00**	**1.00**	**0.00**
Comments						
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	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Non-Discrimination Compliance						
3. Written Materials PBMC A.6.a.8-.8.c; A.8.b.4-.5	All vital PBM documents and member materials are made available to members and potential members as noted below: 1. 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. 2. 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 oral interpretation of those written materials free of cost. 3. PBM 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.	☐ ☐ ☐	Documents translated as described Written notice provided to specified members Staff demonstrated availability of vital documents in alternative formats	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**						
4. Complaint Resolution and Reporting PBMC A.6.b.2; A.6.b.2.c; A.6.c-.c.3	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 members, providers, and subcontractors.	☐ ☐ ☐	Processes in place Provided complaint investigations to TennCare Quarterly reports submitted and included required information	**0.33** **0.33** **0.34**	**1.00**	**0.00**

2022 Annual Quality Survey—Quality Process Standards: <PBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Non-Discrimination Compliance						
Comments						
Strength						
AON						
Suggestion						
5. Non-Discrimination Compliance Questionnaire PBMC A.6.b.1	There is documentation of the PBM'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	**0.50** **0.50**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
6. Staff Compliance Training PBMC A.6.a; A.6.b.2.-.2.b	The PBM provides non-discrimination compliance and cultural competency training to all staff, ensuring they have been made aware of their obligations under the applicable civil rights laws.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
			Non-Discrimination Compliance Score	**0.0%**	**6.00**	**0.000**

2022 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/ Evidence as Provided by PBM***
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
1) Initial Credentialing Policies and Procedures (P&Ps) *TennCare Pharmacy Benefits Manager Contract (PBMC) PBMC A.15.* *TennCare Requirements* *42 CFR § 438.214(a)* *42 CFR § 438.214(b)(2)*	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**	

Comment:

Strengths:

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

2022 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/ Evidence as Provided by PBM***
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
Suggestions:					
AONs:					
2) Recredentialing P&Ps *PBMC A.15.* *42 CFR § 438.214(a)* *42 CFR § 438.214(b)(2)*	The PBM has written P&Ps for the monitoring and retention of providers.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
3) Electronic Provider Registration and Valid TennCare Provider Number *PBMC A.10.b.*	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**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
4) Maintaining Licenses, Certifications, and Permits *PBMC A.10.b.*	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**	
Comment:					
Strengths:					
Suggestions:					

2022 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/ Evidence as Provided by PBM***
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
AONs:					
5) Any Willing Provider *PBMC A.6.g.* *PBMC A.14.*	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**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
6) Staff Licensing and Certification Requirements *PBMC A.7.a.2.*	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	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
7) Denial of Provider Participation in the Network *PBMC A.16.*	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**	
Comment:					

2022 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/ Evidence as Provided by PBM***
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
Strengths: **Suggestions:** **AONs:**					
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**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
9) Providers Acting Within the Scope of Licensure *PBMC A.6.g.* *PBMC A.15.*	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**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
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**	

2022 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/ Evidence as Provided by PBM***
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
Comment: **Strengths:** **Suggestions:** **AONs:**					
11) Dismissal for not Complying with State and Federal Prescribing Laws *PBMC A.10.c.*	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**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
Credentialing/Recredentialing P&Ps Score		**100%**	**17.0**	**17.0**	

PA File Review Tools

UM Denials File Review Tool

MCC:																mm/dd/2022
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	

Complaints File Review Tool											
MCC:											mm/dd/2022
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	

Appeals File Review Tool

MCC: **mm/dd/2022**

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 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.
** Accelerated/Expedited/Standard

Total Compliant	
Total Applicable	
Percent Compliant	

Appeals File Review Tool															
MCC:															mm/dd/2022
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:											mm/dd/2022
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											

Total Compliant	
Total Applicable	
Percent Compliant	

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

CHOICES Annual Level of Care Assessment File Review Tool									
MCC:									mm/dd/2022
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>														mm/dd/2022
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>															mm/dd/2022
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: mm/dd/2022												# 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							
A site visit is conducted for all in-state providers. Requirement	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			

MCO:	Reviewer:				Date of Review: mm/dd/2022																# of Files:			
Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA
may be waived for out-of-state providers and the reason documented in the provider file. *CRA A.2.11.10.4.1.5*	#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**											
																	100%							

CHOICES Recredentialing

MCO:	Reviewer:				Date of Review: mm/dd/2022																# 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							
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.	#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			

MCO:	Reviewer:								Date of Review: mm/dd/2022								# of Files:							
Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA
CRA A.2.11.10.4.1.5	#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
				100%

PMV Tool—MCOs

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

NCQA's Information System Standards		
Standards	**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.		
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.		

NCQA's Information System Standards		
Standards	**Audit Findings**	**Impact on Reporting**
IS 3.5 The organization regularly monitors vendor performance against expected performance standards.		
IS 4.0 Medical Record Review Processes—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. **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 5.7** NCQA-validated data resulting from the Data Aggregator Validation (DAV) program 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.		

NCQA's Information System Standards		
Standards	**Audit Findings**	**Impact on Reporting**
IS 7.0 Data Integration and Reporting—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 Tool

2022 PIP Validation Tool—<MCC Name> <PIP Topic>				
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	Was selected through a comprehensive statewide or regional analysis of TennCare 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	5			
Comment:	<Type comment here>.			
Strength:	None were identified.			
AON:	None were identified.			
Suggestion:	None were identified.			

* *Not Applicable*

2022 PIP Validation Tool—<MCO Name> <PIP Topic>				
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 (i.e., includes a realistic and unambiguous goal)	☐	☐	☐
6	Is measurable	☐	☐	☐
Step 2 Results:	**Total**	**Met**	**Not Met**	**NA**
Elements	6			
Comment:	<Type comment here>.			
Strength:	None were identified.			
AON:	None were identified.			
Suggestion:	None were identified.			

2022 PIP Validation Tool—<MCO Name> <PIP Topic>				
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	Is captured in its entirety by the data collection approach, if the entire eligible population is included	☐	☐	☐
Step 3 Results:	**Total**	**Met**	**Not Met**	**NA**
Elements	3			
Comment:	<Type comment here>.			
Strength:	None were identified.			
AON:	None were identified.			
Suggestion:	None were identified.			

2022 PIP Validation Tool—<MCO Name> <PIP Topic>				
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	5			
Comment:	<Type comment here>.			
Strength:	None were identified.			
AON:	None were identified.			
Suggestion:	None were identified.			

2022 PIP Validation Tool—<MCO Name> <PIP Topic>				
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 other MCC results over time, if available; and inform the selection and evaluation of quality improvement strategies	☐	☐	☐
6	Consider existing measures. If an existing measure is not selected, the rationale is provided.	☐	☐	☐
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 (e.g., time periods, characteristics of eligible members, services to be assessed, exclusion 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	If process measures, have strong evidence that the process being measured is meaningfully associated with outcomes	☐	☐	☑
Step 5 Results:	**Total**	**Met**	**Not Met**	**NA**
Elements	11			

2022 PIP Validation Tool—<MCO Name> <PIP Topic>	
Step 5: Review the Selected PIP Variables and Performance Measures	
Comment:	<Type comment here>
Strength:	None were identified.
AON:	None were identified.
Suggestion:	None were identified.

2022 PIP Validation Tool—<MCO Name> <PIP Topic>				
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	Connects to the data analysis plan to ensure appropriate data are available	☐	☐	☐
6	Uses data collection instruments that allow for consistent and accurate data collection over PIP time periods	☐	☐	☐
7	Specifies well-defined methods to collect meaningful and useful information (for qualitative data collection methods—e.g., surveys, focus groups)	☐	☐	☐
8	Includes an estimated degree of data completeness (not applicable for surveys)	☐	☐	☐
9	Describes qualifications of staff responsible for abstracting data (for medical record review)	☐	☐	☐
10	Describes both intra- and inter-rater reliability processes in place (for medical record review)	☐	☐	☐
11	Addresses guidelines developed for abstraction staff (for medical record review)	☐	☐	☐
Step 6 Results:	**Total**	**Met**	**Not Met**	**NA**
Elements	11			
Comment:	<Type comment here>.			
Strength:	None were identified.			
AON:	None were identified.			
Suggestion:	None were identified.			

2022 PIP Validation Tool—<MCO Name> <PIP Topic>				
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 assessing 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; if none are identified, analysis includes an explicit statement that no factors influenced comparability	☐	☐	☐
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 discussion of lessons learned about less-than-optimal performance	☐	☐	☐
Step 7 Results:	**Total**	**Met**	**Not Met**	**NA**
Elements	8			
Comment:	<Type comment here>.			
Strength:	None were identified.			
AON:	None were identified.			
Suggestion:	None were identified.			

2022 PIP Validation Tool—<MCO Name> <PIP Topic>				
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	Designed to address causes/barriers identified through data analysis and quality improvement processes	☐	☐	☐
3	Implemented on a rapid-cycle, PDSA basis	☐	☐	☐
4	Culturally and linguistically appropriate (for member-facing strategies)	☐	☐	☐
5	Designed to account for major confounding variables that could have an obvious impact on PIP outcomes	☐	☐	☐
6	Evaluated to determine the extent to which they were successful, with potential follow-up activities identified	☐	☐	☐
Step 8 Results:	**Total**	**Met**	**Not Met**	**NA**
Elements	6			
Comment:	<Type comment here>.			
Strength:	None were identified.			
AON:	None were identified.			
Suggestion:	None were identified.			

2022 PIP Validation Tool—<MCO Name> <PIP Topic>				
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, if any, is likely to be the result of the selected improvement strategy	☐	☐	☐
4	The statistical evidence that observed improvement, if any, 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	5			
Comment:	<Type comment here>.			
Strength:	None were identified.			
AON:	None were identified.			
Suggestion:	None were identified.			

APPENDIX C | 2022 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' aims and strategies in their own words. Also included in the table are each PIP's measurement year (Baseline [B]; Remeasurement 1 [R1]; Remeasurement 2 [R2]; Remeasurement 3 [R3]; Remeasurement 4 [R4]; Remeasurement 5[R5]) and classification as clinical (C) or non-clinical (NC).

Table C-1. 2022 Performance Improvement Projects

Year	C/NC	Topic	PIP Aim Statement	Improvement Strategies	Results
			Amerigroup		
R1	C	*Improve Childhood Immunization Status (CIS) Combination 10 Rates—East, Middle, and West Regions*	*Will targeted interventions, such as member incentives, digital outreach, and innovative community collaborations, increase the percentage of members receiving childhood combination 10 immunizations over each measurement year?*	♦ Healthy Rewards Member Incentive for Rotavirus and Flu Vaccines	B AGE: 33.58% AGM: 45.26% AGW: 24.09% R1 AGE: 36.98% AGM: 42.34% AGW: 23.11%
R2	C	*Improve Diabetic Screening Compliance for Members with Schizophrenia or Bipolar Disorder Using Antipsychotic Medication in West Region*	*Will targeted interventions consisting of education, member gap closures and incentives for gap closures improve over each measurement year 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) ♦ Provider Incentives ♦ Glucose and Hemoglobin A1c Testing Capture During Inpatient Behavioral Health (BH) Hospitalization Encounter	B: 81.61% R1: 73.48% R2: 77.53%
R2	NC	*Improve East Grand Region Member Satisfaction with the Health Plan*	*Will health plan and provider education along with telehealth and additional transportation options increase over each measurement year 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—Educate Amerigroup staff (including provider collaboration staff), Develop a Providers one-page summary 11-16-20 ♦ Telemedicine—Telehealth with member's provider ♦ Enhance Non-emergency medical transportation (NEMT)	B: 83.96% R1: 86.68% R2: 87.94%

Table C-1. 2022 Performance Improvement Projects

Year	C/NC	Topic	PIP Aim Statement	Improvement Strategies	Results
R1	NC	*Increase Eye Exam Screening Rates for Members with Diabetes Type 1 or Type 2*	*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?*	♦ Provider monetary incentive to purchase of a retinal eye camera for diabetic eye exams within the practice to close gaps-in-care on members struggling in an environmental health disparity	B-AGE: 33.09% AGM: 40.15% AGW: 35.28% R1-AGE: 36.01% AGM: 41.12% AGW: 44.53%
B	NC	*Increase Statewide the % of Members with Documented LTSS Reassessment and Care Plan Update, Including Nine Core Elements, within 30 Days of Inpatient Discharge*	*Will targeted interventions, electronic data capture system enhancements, new monitoring reports, and PCSP re-assessment auditing with inter-rater reliability testing, for established LTSS members 18 years of age and over in Groups 2 through 8, improve the time frame for the completion of re-assessments and care plan updates with the nine core elements to within 30 days of discharge from an inpatient facility over each measurement year?*		B: 51.04%
B	C	*Increase Well Child Visit (WCV) HEDIS Rate in West TN Region*	*Will targeted member outreach along with member and provider incentives and innovative interventions improve the WCV HEDIS rate in the 3–20-year-old age group over each measurement year in the West Region?*		B, AGW: 44.27%
			BlueCare		
R2	NC	*Decrease the Use of Opioids at High Dosage (HDO)*	*Will implementing provider and member 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. ♦ Behavioral Health Quality Coaches ♦ BlueCare Statewide 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.	B, E: 6.01% M: 2.68% W: 1.67% R1, E: 5.87% M: 4.21% W: 2.62% R2, E: 7.11% M: 4.22% W: 2.44%
R2	C	*Improving Antidepressant Medication Management (AMM)*	*Will focused provider interventions increase member compliance with the continuation phase of antidepressant therapy for treatment of major depression for members 18 years of*	♦ Initiated text message and telephone calls for new fills and refills of antidepressant medication to MCO plan members	B, E: 31.57% M: 27.35% W: 26.12%

Table C-1. 2022 Performance Improvement Projects

Year	C/NC	Topic	PIP Aim Statement	Improvement Strategies	Results
			age and older with a diagnosis of major depression over each remeasurement year?	statewide and implemented provider education strategy. ♦ Periodic provider education statewide on the AMM-C measure in partnership with the Provider Incentive and Engagement (PIE) team ♦ Implemented telehealth for a variety of measures, and additional medication allowances, and developed targeted provider notification and education strategy to make providers aware of allowances that could specifically impact this measure. ♦ Targeted provider practice collaboration and education strategy to better understand barriers and provide education to providers seeing a large part of the population for this study.	R1, E: 34.25% M: 29.73% W: 26.83% R2, E: 38.65% M: 34.34% W: 32.51%
R1 R2	C	*Improving Childhood and Adolescents Immunization Rates (CIS/IMA)*	*Will targeted provider interventions result in increased influenza vaccination in children 2 years of age and HPV vaccination rates in adolescents 13 years of age over each remeasurement period in the Statewide BlueCare population (broken out by regions)?*	♦ Development of a Vaccination Hesitancy Educational Flyer for providers to use during clinical encounters (Statewide) ♦ Provider Incentive and Engagement Team began Quarterly reviews statewide with providers addressing child and adolescent immunizations targeting influenza and HPV ♦ Targeted provider practice collaboration and education strategy focused on Child and Adolescent Immunizations and Catch-Up Schedules for providers that serve a large part of the population < 21 years of age	**PM 1** B, E: 32.38% M: 33.14% W: 20.55% R1, E: 36.61% M: 38.83% W: 21.89% R2, E: 34.16% M: 36.93% W: 21.96% **PM 2** B, E: 31.95% M: 33.51% W: 29.68% R1, E: 33.28% M: 32.41% W: 29.33% R2, E: 31.24% M: 32.48%

Table C-1. 2022 Performance Improvement Projects

Year	C/NC	Topic	PIP Aim Statement	Improvement Strategies	Results
					W: 27.55% **PM 3** B, E: 43.12% M: 47.71% W: 29.89% R1, E: 43.12% M: 47.71% W: 29.89% **PM 4** B, E: 32.16% M: 33.25% W: 28.40% R1, E: 32.16% M: 33.25% W: 28.40%
R5	NC	*Improving Early Periodic Screening Diagnosis & Treatment (EPSDT)*	*Do targeted provider engagement activities improve the EPSDT rates over each remeasurement period for BlueCare members under the age of 21 (all regions)?*	♦ Provider Education and Partnerships ♦ Implementation of an Integrated Appointment Scheduling Platform ♦ Supersizing Provider Program-Incentivize providers to capitalize on sick visits and covert to an EPSDT visit to address preventive care. ♦ Partnerships with THL providers in the past have been successful at engaging members.	B, E: 72% M: 69%. W: 70% R1, E: 76% M: 76%. W: 73% R2, E: 81% M: 79%. W: 79% R3, E: 85% M: 82%. W: 80% R4, E: 78% M: 75%. W: 67% R5, E: 78% M: 72%. W: 66%
B	NC	*Long-Term Services and Supports Reassessment/Care Plan Update After Inpatient Discharge (RAC)*	*Will targeted data interventions improve the rate of completion of a reassessment/care plan update for CHOICES/ECF CHOICES members 18 years of age and older within 30 days of inpatient discharge, over each remeasurement year?*		**PM 1** B, E: 62.96% M: 42.11% W: 51.61% **PM 2**

Table C-1. 2022 Performance Improvement Projects

Year	C/NC	Topic	PIP Aim Statement	Improvement Strategies	Results
					B, E: 55.56% M: 42.11% W: 45.16%
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 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 ♦ 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. (Statewide) ♦ 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. (Statewide) ♦ BlueCare Tennessee Statewide Shift to new PH Model/Program-This new model included a focus on identifying social determinants, addressing through referral sources so that our Statewide BlueCare members have improved health outcomes.	**PM 1** B, E: 90.84% M: 94.42% W: 92.78% R1, E: 81.40% M: 82.20% W: 77.50% R2, E: 94.22% M: 94.26% W: 92.81% **PM 2** B, E: 50.72% M: 36.61% W: 69.04% R1, E: 43.90% M: 40.70% W: 35.00% R2, E: 37.89% M: 31.95% W: 41.13% **PM 3** B, E: 44.74% M: 48.34% W: 47.73% R1, E: 53.70% M: 53.20% W: 56.10% R2, E: 50.16% M: 53.58% W: 54.34%

Table C-1. 2022 Performance Improvement Projects					
Year	**C/NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**	**Results**
			TennCare*Select*		
R2	NC	*Decreasing Plan All-Cause Readmissions*	*Do targeted member interventions decrease the number of Statewide TennCareSelect acute inpatient and observation stays for members 1864 years of age that are followed by an unplanned acute readmission for any diagnosis within 30 days over each measurement year?*	♦ Member Outreach phone calls to members statewide for appointment scheduling assistance, with financial incentive for members who keep appointment. ♦ Transition of Care (TOC) / Discharge Planning Transition ♦ 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 that has the potential to impact readmissions. ♦ Provider Coaching – BH Provider Quality Coaching to address follow-up care, coordination, and readmissions.	B: 9.72% R1: 10.96% R2: 11.94%
R3	C	*Follow-Up After Hospitalization for Mental Illness – 7 Day – TennCareSelect*	*Do targeted member and/or provider interventions improve the rate of timely follow-up care for TennCareSelect members ages 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. FUH – within 7 Days is an incentivized THL quality measure. ♦ Member Outreach phone calls to members statewide for appointment scheduling assistance, with financial incentive for members who keep appointment. ♦ 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	B: 39.27% R1: 42.38% R2: 41.75% R3: 36.05%

Table C-1. 2022 Performance Improvement Projects

Year	C/NC	Topic	PIP Aim Statement	Improvement Strategies	Results
				hospitalization for mental illness. ♦ Provider and Community Partner Education. Educational WebEx presented for providers and Department of Children's Services (DCS) workers (Nurses, Case Managers, etc.) statewide to increase knowledge about Behavioral Health HEDIS® measures, including FUH (compliance and importance of timely follow-up). ♦ Provider Coaching. • BH Provider Quality Coaching to address follow-up care, coordination, and readmissions.	
B R2	C	*Improving Childhood and Adolescents Immunization Rates (CIS/IMA)*	*Will targeted provider interventions result in increased influenza vaccination in children 2 years of age and HPV vaccination rates in adolescents 13 years of age over each remeasurement period in the Statewide TennCareSelect population?*	♦ Development of a Vaccination Hesitancy Educational Flyer for providers to use during clinical encounters (Statewide) ♦ Provider Incentive and Engagement (PIE) Team began Quarterly reviews statewide with providers addressing child and adolescent immunizations targeting influenza and HPV. ♦ Targeted provider practice collaboration and education strategy focused on Child and Adolescent Immunizations and Catch-Up Schedules for providers that serve a large part of the population < 21 years of age.	**PM 1,** B: 20.33% R1: 25.73% R2: 33.10% **PM 2,** B: 30.44% R1: 32.33% R2: 30.33% **PM 3**, B: 54.56% **PM 4,** B: 31.44%
R2	NC	*Improving Comprehensive Diabetes Care (Blood Pressure Control for SelectCommunity)*	*Does providing member and/or provider focused interventions and approaches improve the Comprehensive Diabetes Care: Blood Pressure Control (CDC BP) HEDIS® rate for the TennCareSelect SelectCommunity population (18-75 years old) over each measurement year?*	♦ Interventions during baseline measurement (1/1/19-12/31/19) were limited. The focus for 2019 for 2019 for SelectCommunity Case Management was on Agent Workspace technology being implemented for the SelectCommunity program during 2019. ♦ COVID-19 presented challenges for interventions with this population during 2020. BlueCare suspended all face-to-face visits in conjunction with Department of Intellectual & Developmental Disabilities	B: 54.86% R1: 75.78% R2: 60.00%

Table C-1. 2022 Performance Improvement Projects

Year	C/NC	Topic	PIP Aim Statement	Improvement Strategies	Results
				(DIDD) effective 3/17/2020. In 4th quarter 2020, limited medical appointments began being allowed, while limiting contact with external customers coming into homes, etc. ♦ Targeted Provider and Case Manager education/communication strategy regarding COVID related allowances for blood pressure medication. ♦ Provider HEDIS letter reporting patient's HEDIS gaps.	
R5	NC	*Improving Early Periodic Screening Diagnosis & Treatment (EPSDT) – BlueCareTennCareSelect*	*Do targeted provider engagement activities improve the EPSDT rates over each remeasurement period for TennCareSelect members under the age of 21 (all regions)?*	♦ Provider Education and Partnerships ♦ Implementation of an Integrated Appointment Scheduling Platform ♦ Supersizing Provider Program-Incentivize providers to capitalize on sick visits and covert to an EPSDT visit address preventive care ♦ Partnerships with THL providers in the past have been successful at engaging members	B: 60.00% R1: 66.00% R2: 69.00% R3: 71.00% R4: 65.00% R5: 66.00%
R3	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 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 – Internal education for all case managers on the use/documentation of the new modified SDoH tool in the documentation system of record so that the data is in the same location for use by case managers for the collection of data. This education will continue for new hires moving forward. (Statewide) ♦ 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. (Statewide) ♦ Identification of the process for collecting the SDoH Performance Measures data	**PM 1,** B: 11.43% R1: 86.71% R2: 63.30% R3: 85.66% **PM 2:** B: 42.29% R1: 42.56% R2: 35.30% R3: 37.02% **PM 3,** B: 28.97% R1: 51.02% R2: 68.60% R3: 56.72%

Table C-1. 2022 Performance Improvement Projects

Year	C/NC	Topic	PIP Aim Statement	Improvement Strategies	Results
				directly from the internal documentation system of record based on the assessment tool completed by the case managers. (Statewide) ♦ BlueCare Tennessee Statewide Shift to new PH Model/Program-This new model included a focus on identifying social determinants, addressing through referral sources so that our Statewide TCS members have improved health outcomes.	
UnitedHealthcare					
R2	C	*Adherence to Antipsychotic Medications for Individuals w/ Schizophrenia (SAA)*	*Will targeted provider and member interventions increase adherence to antipsychotic medications for individuals diagnosed with schizophrenia over each measurement period?*	♦ Provider Targeted. To improve SAA HEDIS® measure rates, the Quality Analyst developed a provider-specific educational flyer. ♦ Provider Targeted. To increase SAA medication adherence, the UHCCP Behavioral Health Quality Analyst provided quarterly outreach and member-specific pharmacy fill data to THL providers. ♦ Member Targeted. To increase SAA medication adherence, the UHCCP Behavioral Health Quality Analyst developed a member-specific educational newsletter article on the importance of medication adherence.	B, W: 58.26% R1, W: 64.27% R2, W: 64.62%
R3	NC	*Care Coordination*	*Can targeted provider outreach improve provider and member perception of coordination of care between health care practitioners as indicated by UnitedHealthcare Community Plan Provider Satisfaction Survey and CAHPS® Survey responses over each measurement period?*	♦ Creation of a new Social Determinants of Health (SDOH) role within the health plan to assist network providers with resource access for their patients/our members with these non-medical risk factors as a support for care coordination activities. ♦ Care Management staff restructure to organize into geographically aligned community care teams situated under	**PM 1**, B, E: 23.53% M: 13.04% W: 24.32% R1, E: 34.78% M: 47.37% W: 13.33% R2, E: 42.10% M: 31.25%

Table C-1. 2022 Performance Improvement Projects

Year	C/NC	Topic	PIP Aim Statement	Improvement Strategies	Results
				our existing Population Health structure.	W: 37.50% R3, E: 28.57% M: 27.59% W: 45.45% **PM 2**, B, E: 88.24% M: 82.32% W: 76.98% R1, E: 91.33% M: 83.20% W: 80.33% R2, E: 85.19% M: 85.33% W: 80.00% R3, E: 87.50% M: 78.26% W: 79.55% **PM 3,** B, E: 86.29% M: 84.24% W: 83.77% R1, E: 87.80% M: 84.17% W: 86.89% R2, E: 89.04% M: 81.25% W: 93.94% R3, E: 90.90% M: 77.20% W: 100%

Table C-1. 2022 Performance Improvement Projects

Year	C/NC	Topic	PIP Aim Statement	Improvement Strategies	Results
R3	C	*Impact of Member and Provider Outreach on Immunization Rates for CIS Combo 10*	*Will targeted provider and member interventions increase the immunization rates for members ages birth to two years old over each remeasurement period?*	♦ Maximize the alignment of our education and outreach strategies with the metrics and incentives of value based contracting programs, specifically Patient Centered Medical Home (PCMH) and TennStar. ♦ Increase outreach and education efforts for those identified as past due for immunizations.	B, E: 35.28% M: 43.07% W: 27.01% R1, E: 37.23% M: 43.07% W: 27.74% R2, E: 37.96% M: 44.28% W: 22.14% R3, E: 36.74% M: 43.80% W: 21.65%
R2	NC	*Increasing the Physical Health Provider Satisfaction Survey Engagement Rate*	*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?*	♦ In an effort to increase our Physical Health Provider Satisfaction Survey response rate, details of improvements made based on responses from the previous year were added to the Survey Cover Letter from our Chief Medical Officer (CMO) emphasizing the impact of the survey.	B, E: 9.40% M: 12.60% W: 11.50% R1, E: 8.80% M: 11.80% W: 11.20% R2, E: 3.70% M: 10.70% W: 7.50%
R1	C	*Increasing the Screening Rates of Child & Adolescent Well-Care Visits (WCV)*	*Will the use of targeted member outreach and incentives increase screening rates for children 18-21 years of age over each remeasurement year?*	♦ Maximize the alignment of our education and outreach strategies with the metrics and incentives of value based contracting programs.	B, E: 25.92% M: 26.72% W: 20.30% R1, E: 24.24% M: 24.22% W: 20.84%
B	NC	*UnitedHealthcare Long Term Services and Supports (LTSS) HEDIS Process Improvement for Reassessment and Care Plan Updates Within 30 days After*	*Will targeted reporting interventions improve the HEDIS rates for Reassessment within 30 days from Inpatient Discharge and Reassessment and Care Plan within 30 days of Inpatient Discharge for LTSS populations by 3% points from the baseline?*		**PM 1**, B: 12.50% **PM 2**, B: 11.46%

Table C-1. 2022 Performance Improvement Projects

Year	C/NC	Topic	PIP Aim Statement	Improvement Strategies	Results
		Inpatient Discharge for LTSS Eligible Populations			
			DentaQuest		
R4	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 ♦ 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	B 0.20% of utilizers received SDF R1 0.50% R2 0.89% R3 1.55% R4 2.22%
R4	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. ♦ (disco) DQ Dental Director presented dangers of and alternatives to opioids to dental students at Meharry and University of TN Dental Schools. ♦ DentaQuest identified Dental Providers that are outliers amongst their peers, in	B 4.77% R1 2.99% R2 2.96% R3

Table C-1. 2022 Performance Improvement Projects

Year	C/NC	Topic	PIP Aim Statement	Improvement Strategies	Results
				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.	2.88% R4 2.66%
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 $13,542.90 per patient
R1	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?*	♦ Distribute TennCare's Diagnosis Code for PA Bypass List to all TennCare prescribers and pharmacies via fax, email, and newsletter throughout the year as education for 2021	B 6.06% R1 6.64%