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2023 Annual

EQRO Technical Report

Final

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Acknowledgements, Acronyms, and Initialisms[1]

A .... Access, an aspect of care
AD .... adult
AG .... Amerigroup Tennessee, Amerigroup, a wholly owned subsidiary of Anthem, Inc.
AGE/AGM/AGW .... Amerigroup referenced by operational region: East/Middle/West
AIDS .... Acquired Immunodeficiency Syndrome
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
CAHPS® .... Consumer Assessment of Healthcare Providers and Systems, a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)
CAP .... Corrective Action Plan
CBP .... Controlling High Blood Pressure
CCS .... Cervical Cancer Screening
CDC .... Comprehensive Diabetes Care (HEDIS measure)
CDT .... Current Dental Terminology
CFR .... *Code of Federal Regulations*
CH .... child
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
CLIA .... Clinical Laboratory Improvement Amendments
CLS/CLS—FM .... Community Living Supports, CLS—Family Model
CIS .... Childhood Immunization Status (HEDIS measure)
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
CY .... Calendar Year
D-SNPs .... Dual-Eligible Special Needs Plans
DBM/DBMC .... Dental Benefits Manager/DBM Contract
DHHS .... U.S. Department of Health and Human Services
DIDD .... Department of Intellectual and Developmental Disabilities
DME .... Durable Medical Equipment

[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.*

DOE .... Department of Education
DQ .... DentaQuest of Tennessee, LLC
ECDS .... Electronic Clinical Data Systems
ECF .... Employment and Community First
ED/ER .... Emergency Department, Emergency Room
EDI .... Electronic data interchange
EPSDT .... Early and Periodic Screening, Diagnostic, and Treatment
EQR/EQRO .... External Quality Review/EQR Organization
FAQ .... Frequently asked questions
FFS .... Fee for service
FFY .... Federal Fiscal Year
FQHC .... Federal Qualified Health Center
FUH .... Follow-Up After Hospitalization for Mental Illness (HEDIS measure)
FUM .... Follow-Up After ED Visit for Mental Illness
FY .... Fiscal Year
GDP .... General Dental Practitioner
HCBS .... Home and Community-Based Services
HbA1c .... Hemoglobin A1c
HD .... HEDIS Determination
HEDIS® .... Healthcare Effectiveness Data and Information Set, a registered trademark of NCQA
HHS .... Health and Human Services
HIPAA .... *Health Insurance Portability and Accountability Act*
HIV .... Human Immunodeficiency Virus
HPV .... Human papillomavirus
HSAG .... Health Services Advisory Group, Inc.
IBCTSS .... Intensive Behavioral Community Transition and Stabilization Services
IBFCTSS .... Intensive Behavioral Family-centered Treatment, Stabilization and Supports
ICD-10 .... International Classification of Diseases, Tenth Revision
ICF .... Intermediate Care Facility
I/DD .... Intellectual/Developmental Disabilities
ID .... Identification
IEP .... Individual Education Plans
IMA .... Immunizations for Adolescents (HEDIS measure)
IRR .... Inter-rater reliability
IS .... Information System(s)
ISCAT .... Information Systems Capabilities Assessment Tool
IT .... Information technology
LEP .... Limited English Proficiency
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
mm HG .... Millimeter of mercury, a unit of pressure
MR/MRR .... Medical Record, Medical Record Review
MY .... Measurement Year
NA .... Not Applicable
NABD .... Notice of Adverse Benefit Determination
NC .... Non-Clinical
NCQA .... National Committee for Quality Assurance
NCQA HEDIS Compliance Audit™ .... a trademark of NCQA
NPI .... National Provider Identifier
NR .... Not Reported
OB/GYN .... Obstetrician/Gynecologist
OIG .... Office of the Inspector General
OPI .... Office of Program Integrity

ORM .... Office Reference Manual
ORx .... OptumRx
OUD-AD .... Use of Pharmacotherapy for Opioid Use Disorder (Adult Core Measure)
P .... Partial
P&P .... Policy and Procedure
PA .... Performance Activity
PBM .... Pharmacy Benefits Manager
PBMC .... Pharmacy Benefits Manager Contract
PCMH .... Patient-Centered Medical Home
PCP .... Primary Care Provider/Practitioner
PCS, HCPCS .... Procedure Coding System, Healthcare PCS
PCSP .... Person-centered Support Plan
PSDA .... Plan-Do-Study-Act, a quality improvement process
PDV .... Provider Data Validation
PH .... Population Health
PHI .... Protected Health Information
PIE .... Provider Incentive Engagement
PIP .... Performance Improvement Project
PKU .... Phenylketonuria
PM .... Performance Measure
PMV .... Performance Measure Validation
PPC .... Prenatal and Postpartum Care (HEDIS measure)
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, etc. .... Remeasurement Year 1, 2, 3
RAC .... Reassessment and Care Plan Update
Roadmap .... Record of Administrative Data Management and Processes
SCP .... Specialty Care Provider
SDF .... Silver Diamine Fluoride
SDOH .... Social Determinants of Health
SFH .... State Fair Hearing
SHC .... Supportive Home Care
SOP .... Standard Operating Procedures
STN .... Short-term Nursing
T .... Timeliness, an aspect of care
Td .... Tetanus and Diphtheria vaccine
TCA .... Tennessee Code Annotated
TCS .... TennCare*Select*, administered by BlueCare Tennessee
TDC .... TennCare Dental Benefits Manager Contract
TDCI .... Tennessee Department of Commerce and Insurance
TennCare .... TN Division of TennCare
THL .... Tennessee Health Link
TN .... Tennessee
TSA .... TennCare*Select* Agreement
TTY/TDD .... Teletypewriter/telecommunications device for the deaf
UHC .... UnitedHealthcare Community Plan
UHCE/UHCM/UHCW .... UHC referenced by operational region: East/Middle/West
UM .... Utilization Management
UMP/UMPD .... UM Program, UM Program Description
UnitedHealthcare® .... a registered mark of UnitedHealth Group, Inc.
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 *2023 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); and
- 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 2022, the measurement year (MY) under review in this report. Qsource's EQR assessment tools review compliance with the following 12 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 438.114: Emergency and Poststabilization;
6. 42 CFR 438.214: Provider selection;
7. 42 CFR 438.224: Confidentiality;
8. 42 CFR 438.402: Grievance and appeal systems;
9. 42 CFR 438.230: Subcontractual relationships and delegation;
10. 42 CFR 438.236: Practice guidelines;
11. 42 CFR 438.242: Health information systems; and
12. 42 CFR 438.330: 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 2022, 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); and
- 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 on the next page shows each MCC's 2023 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 97.7% and 96.8%, respectively.

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

Quality, Access, and Timeliness: AQS

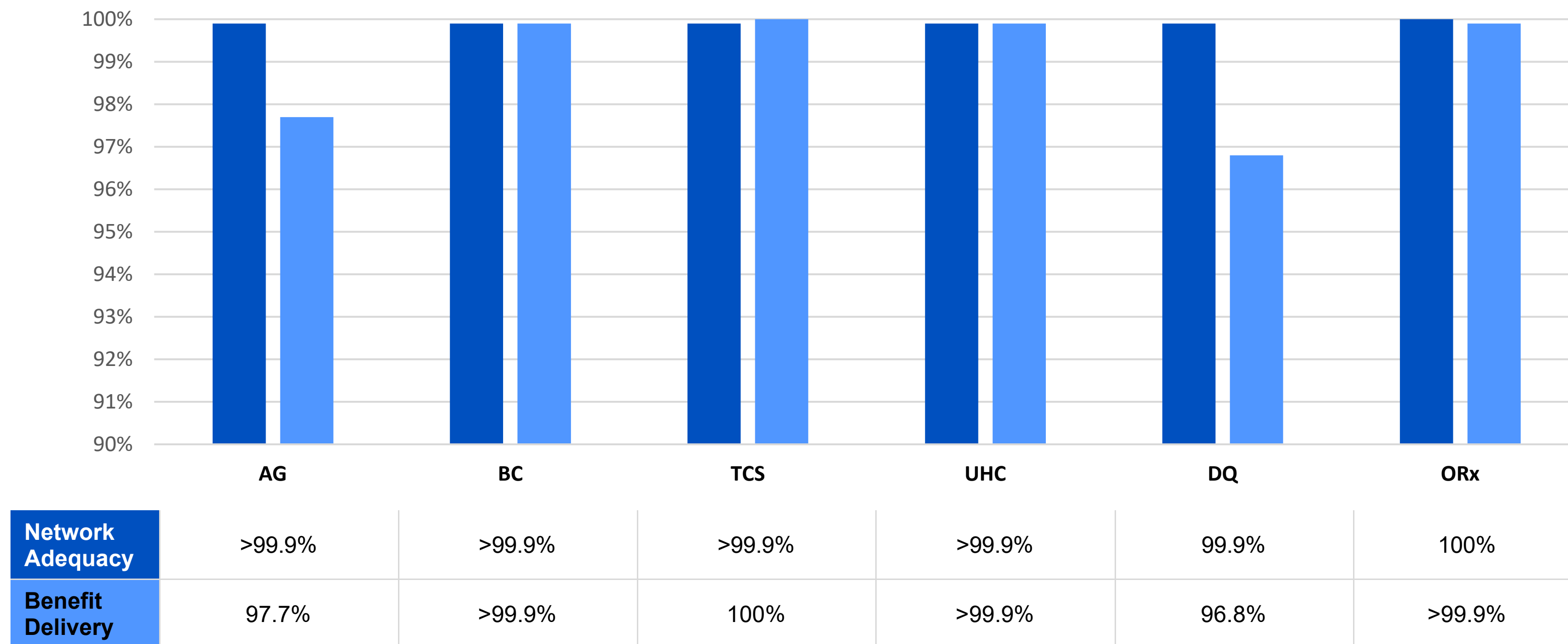
The AQS assessed plans for compliance with statewide quality process (QP) standards and operational performance activities (PAs) based on contractual, regulatory, legislative, and judicial requirements. According to CMS Protocol, in order to avoid duplication, elements that were met through a national accrediting entity were deemed. All plans' credentialing and recredentialing policies and procedures (P&Ps) were assessed during the 2023 ANA. Those results, as well as results for CHOICES credentialing and recredentialing file reviews, were included in detail in the *2023 AQS Technical Papers* and *2023 AQS Summary Report* and are included in the AQS section of this report.

As shown in Table 1**,** 2023 AQS compliance scores were high overall. QP standards are reported as a single statewide score for each MCC. **BC** and **TCS** achieved compliance scores of 100% for all 17 QP standards, while **AG** and **UHC** scored 100% on 16 of 17. Likewise, **DQ** scored 100% on 15 of 16 QP Standards; **ORx** scored

100% on 10 of 14 QP Standards. For the CHOICES credentialing and recredentialing file reviews, all applicable MCOs scored 100% in credentialing quality and recredentialing quantity. For credentialing quantity, **AG** earned less than 100%, while both **AG** and **UHC** earned less than 100% in recredentialing quality. In PA file reviews, **AG** scored 100% in 5 of 6 PAs, while **UHC** and **BC** both scored 100% in 4 of 6 PAs. **TCS** scored 100% in 3 of 4 applicable PAs, while **DQ** had 100% in 2 of 3.

Note: ORx is only assessed for QP Standards.

Figure 1. 2023 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%
Benefit Delivery	97.7%	>99.9%	100%	>99.9%	96.8%	>99.9%

Table 1. 2023 AQS Summary Results

	AG	BC	TCS	UHC	DQ	ORx
QP Standards Range	90.90%–100%	100%	100%	90.90%–100%	50.00%–100%	40.45%–100%
CHOICES Credentialing/ Recredentialing Range	69.23%–100%	100%		75.90%–100%		
PA File Reviews Range	93.55%–100%	97.50%–100%	85.00%–100%	95.00%-100%	92.50%-100%	

Note: Gray cells indicate that a measure was not applicable to the MCC.

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 2023 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: *Controlling High Blood Pressure (CBP)* and *Prenatal and Postpartum Care (PPC)*. 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 MY2022 rates by MCO for CBP, and Figure 3 shows the HEDIS MY2022 rates (two rates each) by MCO for Timeliness of Prenatal Care and Postpartum Care.

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

Figure 2. HEDIS MY2022 Rates for CBP: Totals

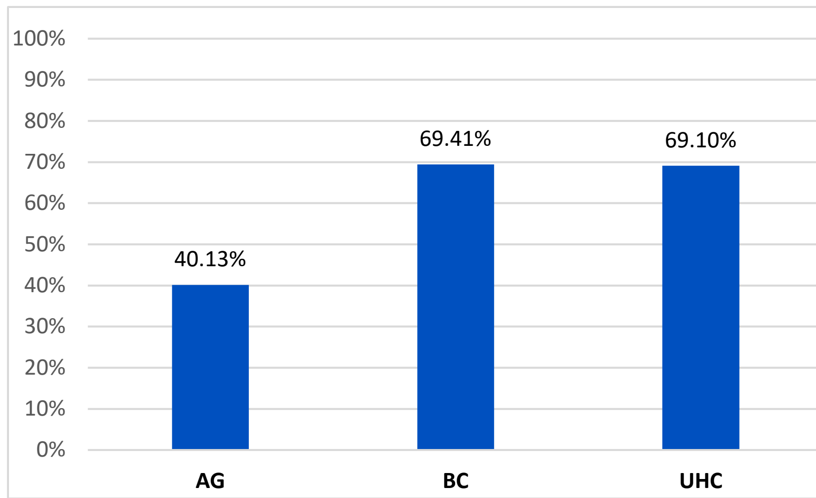
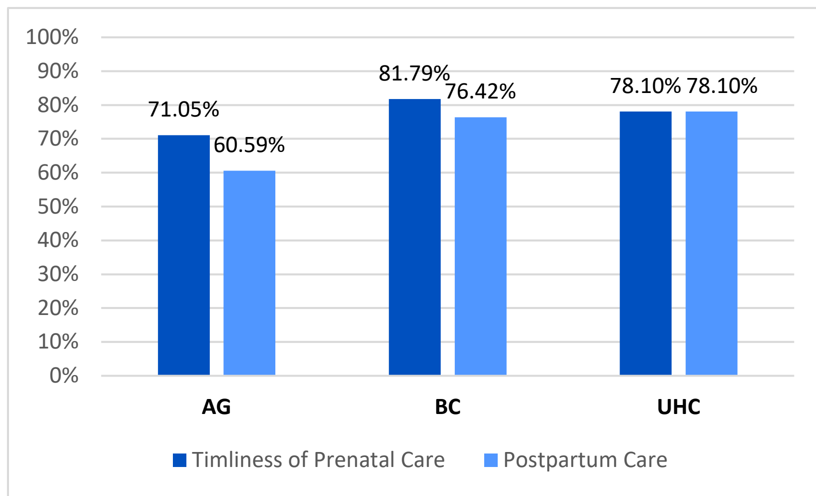


Figure 3. HEDIS MY2022 Rates for PPC



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 2023 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 6. Of the 28 PIPs, all earned a validation status of Met (**Table 2**), and 17 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. 2023 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 2023.

Background

On January 1, 1994, Tennessee implemented a new Medicaid reform program under the authority of a Section 1115 demonstration. This new program, known as TennCare, moved almost the entirety of Tennessee's Medicaid program into managed care. The TennCare 1115 demonstration has been renewed continuously by the state and CMS since 1994.

Since 1994, 100% of Medicaid beneficiaries in Tennessee have enrolled in managed care to receive most or all of their Medicaid benefits. Over time, Tennessee has worked toward more complete integration and more effective coordination of care to improve the member experience, support more cost-effective care delivery, and promote improved health outcomes. In 2009, Tennessee ended the separate carve-out for behavioral health services so that a single entity (the member's managed care organization or MCO) is responsible for administering and coordinating members' medical/surgical and behavioral health care. Long term services and supports (LTSS) for persons who are elderly or who have physical disabilities were carved into the MCO program with the creation of the CHOICES program in 2010, and in 2016, Tennessee integrated certain LTSS for individuals with intellectual and developmental disabilities into the MCO program with the implementation of Employment and Community First CHOICES.

In 2019, a new Katie Beckett Program was established under the demonstration, providing services and supports for children under age 18 with disabilities and/or complex medical needs who are not otherwise eligible for Medicaid because of their parents' income or assets.

In 2020, TennCare and the Department of Intellectual and Developmental Disabilities (DIDD) jointly announced that all Medicaid long-term services and supports (LTSS) programs for people with intellectual and developmental disabilities (I/DD), including the Section 1915(c) Home and Community-Based Services (HCBS) waivers, the Employment and Community First CHOICES Program, and Intermediate Care Facility services for Individuals with Intellectual Disabilities (ICF/IID) will, for the first time, be aligned in the managed care program under the direct operational leadership, management and oversight of DIDD. The primary goal of this integration will be to finally and fully achieve a single, seamless, person-centered system of service delivery for people with I/DD that supports their increase in independence, to more fully participate in their communities, and to achieve their competitive, integrated employment goals. In early 2021, TennCare submitted waiver amendments to the 1115 waiver as well as the three 1915(c) waivers seeking to integrate I/DD services. The 1115 waiver amendment is still pending.

On January 1, 2021, Tennessee transitioned its separate Children's Health Insurance Program (CHIP) program from fee-for-service to managed care, leveraging the state's existing managed care contracts and infrastructure to ensure close coordination and strategic alignment between Medicaid and CHIP. Because Tennessee uses the same managed care contractors to provide care to both its Medicaid and CHIP beneficiaries, its quality strategy addresses the steps taken to improve quality in both programs.

As noted above, Tennessee's managed care program encompasses all of the state's Medicaid and CHIP beneficiaries, and virtually all covered services. The state's managed care system currently consists of six managed care contractors (MCCs) including four statewide managed care organizations (MCOs)/health plans—Amerigroup (**AG**), BlueCare (**BC**), TennCare*Select* (**TCS**), and UnitedHealthcare (**UHC**); a dental benefits manager (DBM)—DentaQuest (**DQ**); and a pharmacy benefits manager (PBM)—OptumRx (**ORx**).

State Quality Strategy Goals

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 value 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. Provide high-quality care that improves health outcomes
2. Ensure enrollee access to health care, including safety net providers
3. Ensure enrollees' satisfaction with services
4. Provide enrollees with appropriate and cost-effective HCBS

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

institutional care. Quality assurance for these services focuses on the following:

- Levels of care
- Service plans
- Qualified Providers
- Health and welfare
- Administrative Authority
- Participant rights

At minimum, states must review and update their quality strategy every three years. 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 annual EQRO Technical Report, which measures, at least triennially, progress toward the strategy's primary goals and objectives.

Table 3 lists the current goals and objectives from TennCare's *2022 Quality Assessment and Performance Improvement Strategy,* which will be evaluated by the EQRO with results published in a future report.

Table 3. Quality Strategy Physical and Behavioral Health Goals and Data Sources

Objective	Objective description	Quality measure	Statewide performance baseline (year)	Statewide performance target for objective (year)
Goal 1: Improve the health and wellness of new mothers and infants				
1.1	Increase the use of prenatal services	Timeliness of Prenatal Care (PPC-CH)	78.4% (2019)	82.4% (2025)
1.2	Increase the use of postpartum services	Postpartum Care (PPC-AD)	69.4% (2019)	73.4% (2025)
1.3	Increase the use of well-child visits in the first 15 months of life	Well-Child Visits in the 1st 30 Months of Life, 1st 15 Months (W30-CH)	53.7% (2020)	56.6% (2025)
Goal 2: Increase use of preventive care services for all members to reduce risk of chronic health conditions				
2.1	Increase child and adolescent well care visits	Child and Adolescent Well- Care Visits, Total Rate (WCV-CH)	51.1% (2020)	53.1% (2025)
2.2	Increase CMS-416 EPSDT screening rate	CMS-416 EPSDT Screening Rate	69.0% (2020)	80.0% (2025)
2.3	Increase child immunizations	Childhood Immunization Status – Combo10 (CIS-CH)	36.7% (2019)	39.7% (2025)
2.4	Improve high blood pressure control in adults	Controlling High Blood Pressure (CBP-AD)	64.2% (2019)	66.2% (2025)

Table 3. Quality Strategy Physical and Behavioral Health Goals and Data Sources				
Objective	**Objective description**	**Quality measure**	**Statewide performance baseline (year)**	**Statewide performance target for objective (year)**
2.5	Increase cervical cancer screening in adults	Cervical Cancer Screening (CCS-AD)	64.2% (2019)	66.2% (2025)
2.6	Increase dental sealant use in children	Sealant Recipient on Permanent First Molars, at least one sealant (SFM-CH)	60.7% (2020)	62.7% (2025)
2.7	Decrease emergency department utilization for children**	Ambulatory Care (AMB-CH), ED visits, Total Rate ages 0-19	49.0 (2019)	46.0 (2025)
2.8	Reduce rate of hospital readmissions	Plan All Cause Readmissions	1.07 (2019)	0.79 (2025)
Goal 3: Integrate patient-centered, holistic care including non-medical risk factors into population health coordination for all members				
3.1	Maintain high member satisfaction with TennCare	Percent of respondents indicating satisfaction with TennCare (UT survey)	94.0% (2019)	94.0% (2025)
3.2	Increase screening for non-medical risk factors	Percent of members screened by the MCO for non-medical risk factors (Custom)	3.2% (2021)	15.0% (2025)
3.3	Ensure CHOICES members receive person-centered care	Percent of members who report the long term services and supports they are getting meet their current needs and goals (NCI-AD, Q 86)	80.0% (2018-2019)	82.0% (2025)
3.4	Ensure ECF CHOICES members receive person-centered care	Percent of members who report their service plan includes things that are important to them (NCI-IPS, Q49)	N/A *	N/A
3.5	Ensure Katie Beckett members receive person-centered care	Percent of members/families who report feeling that supports and services have made a positive difference in the life of their child (NCI-CFS, Q 62)	N/A *	N/A
Goal 4: Improve positive outcomes for members with LTSS needs				
4.1	Maintain or improve quality of life for CHOICES members	Percent of members who report their paid service and supports help them live the life they want (NCI-AD, Q 85)	88.0% (2018-2019)	90.0% (2025)
4.2	Maintain or improve quality of life for individuals with I/DD	Percent of members who report services and supports are helping to live a good life (NCI-IPS, Q 57)	N/A *	N/A

Table 3. Quality Strategy Physical and Behavioral Health Goals and Data Sources				
Objective	**Objective description**	**Quality measure**	**Statewide performance baseline (year)**	**Statewide performance target for objective (year)**
4.3	Maintain or improve quality of life for eligible children in the Katie Beckett program	Percent of members who report they are satisfied with the services and supports their child currently receives (NCI-CFS, Q 68)	N/A *	N/A
4.4	Increase percentage of older adults and adults with physical disabilities receiving LTSS in the community (HCBS) as compared to those receiving LTSS in an institution	CHOICES baseline data	39.3% (2021)	41.3% (2025)
4.5	Increase percentage of individuals with I/DD receiving LTSS in the community (HCBS) as compared to those receiving LTSS in an institution	ECF CHOICES baseline data	70.0% (2021)[1]	72.0% (2025)
Goal 5: Provide additional support and follow-up for patients with behavioral health care needs				
5.1	Improve follow-up after hospitalization for mental illness in adults	Follow-up After Hospitalization for Mental Illness (FUH-AD), 30-Day Follow-up	55.4% (2019)	57.4% (2025)
5.2	Improve follow-up after hospitalization for mental illness in children	Follow-up After Hospitalization for Mental Illness (FUH-CH), 30-Day Follow-up	73.3% (2019)	75.3% (2025)
5.3	Increase the use of medication assisted treatment of opioid dependance and addiction	Use of Pharmacotherapy for OUD, Total Rate (OUD-AD)	32.4% (2019)	34.4% (2025)
Goal 6: Maintain robust member access to health care services				
6.1	Ensure all members can access care according to time and distance standards	TennCare custom measure	100% (2021)	100% (2022)
6.2	Ensure adult members can access care, tests, or treatments timely	"Getting Needed Care" (CAHPS)	85.6% (2020)	87.6% (2025)
6.3	Ensure child members can access care, tests, or treatments timely	"Getting Needed Care" (CAHPS)	89.6% (2020)	90.6% (2025)
6.4	Maintain high compliance scores for access and availability (MCO)	EQRO Annual Technical Report, Annual Network Adequacy, MCO Access/Availability	97.0% (2020)	99.0% (2025)
6.5	Maintain high compliance scores for access and availability (DBM)	EQRO Annual Technical Report, Annual Network Adequacy, DBM Access/Availability	99.0% (2020)	100% (2025)

Table 3. Quality Strategy Physical and Behavioral Health Goals and Data Sources

Objective	Objective description	Quality measure	Statewide performance baseline (year)	Statewide performance target for objective (year)
Goal 7: Maintain financial stewardship through increasing value-based payments and cost-effective care				
7.1	Maintain the percentage of TennCare members attributed to PCMH organizations	TennCare custom measure	40.7% (2019)	40.0% (2025)
7.2	Increase the percentage of TennCare members eligible for Tennessee Health Link (THL) who are active in THL	TennCare custom measure	49.0% (2019)	51.0% (2025)
7.3	Increase the percentage of nursing facilities showing quality improvement	QuILTSS for NF	45.61% (2020 QuILTSS 13 cycle)	47.61% (2025)
7.4	Increase the average Tier Score for facilities supporting members with ventilators or tracheostomies (Enhanced Respiratory Care)	TennCare custom measure	1.44 (October 2020-March 2021)***	1.3 (2025)

** Baseline data not available at this time*
***Lower rates are better.*
**** Closer to 1 is better*
[1] This includes only individuals enrolled in the Employment and Community First CHOICES program until CMS approves the pending waiver amendments to integrate the 1915(c) waiver programs into the 1115 Waiver. If 1915(c) waiver programs were included, this would be 91.0%.

EQR Activity Descriptions and Objectives

Based on the 2019 CMS EQR Protocols, which were in effect for the entirety of MY 2022, 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 2023.

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; and
- Monitoring quality of care via PIP validation.

Qsource is responsible for the production of this *2023 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 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; and
- 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 2022. Applicable trending results are presented in the individual activity sections of this report.

Table 4. MY 2022 Audit Periods for EQR Activities

Activity	Audit Period
ANA Review	February–March 2023
AQS	February–May 2023
PMV	March–August 2023
PIP Validation	July–October 2023

The following reports were generated for each of the reviews:

- *2023 ANA Reports* for individual plans;
- *2023 AQS Technical Papers* for individual plans;
- *2023 AQS Summary Report* for all plans;
- *2023 Annual PMV Reports* for individual plans;
- *2023 Annual PIP Validation Technical Papers* for individual PIP topics, by plan; and
- *2023 Annual PIP Validation Summary Report* for all plans.

This *2023 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: *Controlling High Blood Pressure (CBP)* and *Prenatal and Postpartum Care (PPC)*. 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 2023 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 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 and conducts PIP training for MCC staff.

Qsource performs additional activities as part of its EQRO contract with TennCare. These include the following 2023 deliverables:

- annual Abortion, Sterilization, and Hysterectomy (ASH) Audit Report;
- 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; and
- 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 2023 meetings featured presentations from experts on *Community Health Access and Navigation in Tennessee*, *Optimizing Performance Improvement Projects*, *Intersections of Oral and Overall Health*, *Health Equity in Tennessee*, *Sickle Cell Disease*, *Adolescent Depression, Self-Harm and Suicide*, and *The Intersectionality of Disability, LTSS, and Equity*. Qsource posts highlights online following each health plan meeting, which were held on February 22, June 22, and September 21, 2023. (*Note: 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 *2023 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. 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 *2022 Quality Assessment and Performance Improvement 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 2023.

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 2023 TennCare approved onsite reviews to be replaced by virtual reviews if the MCC so desired. 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 *2023 Annual Network Adequacy Report*. ANA assessment tool templates can be found in Appendix B of this report.

Description of Data Obtained

The 2023 ANA measurement period was January 1 to December 31, 2022, 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; and
- 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 2023, with most plans earning 99.9% 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. 2023 ANA Network Adequacy Scores: MCO Access/Availability

Measure	AG	BC	TCS	UHC
Primary Care Provider (PCP) Average	99.9%	100%	100%	>99.9%
Specialty Care Provider (SCP) Average	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 Average	99.9%	99.6%	100%	>99.9%
Special Programs Average	100%	100%	100%	100%
CHOICES HCBS Providers Average	100%	99.8%		>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. 2023 ANA Network Adequacy Scores: DBM Access/Availability

Evaluation Area	Standard 1	% of Members (Standard 1)	Standard 2	% of Members (Standard 2)	Overall Score[1]
GDP Ratio for all non-ECF CHOICES members (Members < Age 21)	2,500:1	100%			100%
GDP Distance for all non-ECF CHOICES members (Members < Age 21)	30 miles or 45 minutes	100%			100%
Oral Surgery Distance for all non-ECF CHOICES members (Members < Age 21)	60 miles or 60 minutes	99.8%			99.8%
Orthodontic Services Distance for all non-ECF CHOICES members (Members < Age 21)	60 miles or 60 minutes	99.9%			99.9%
Pediatric Dental Services Distance for all non-ECF CHOICES members (Members < Age 21)	70 miles or 70 minutes	100%			100%

Table 6. 2023 ANA Network Adequacy Scores: DBM Access/Availability

Evaluation Area	Standard 1	% of Members (Standard 1)	Standard 2	% of Members (Standard 2)	Overall Score[1]
Dental Provider Distance for ECF CHOICES members[2]	30 miles or 45 minutes	98.1%	60 miles or 60 minutes	99.8%	99.9%
Network Adequacy Score		**99.6%**		**99.8%**	**99.9%**

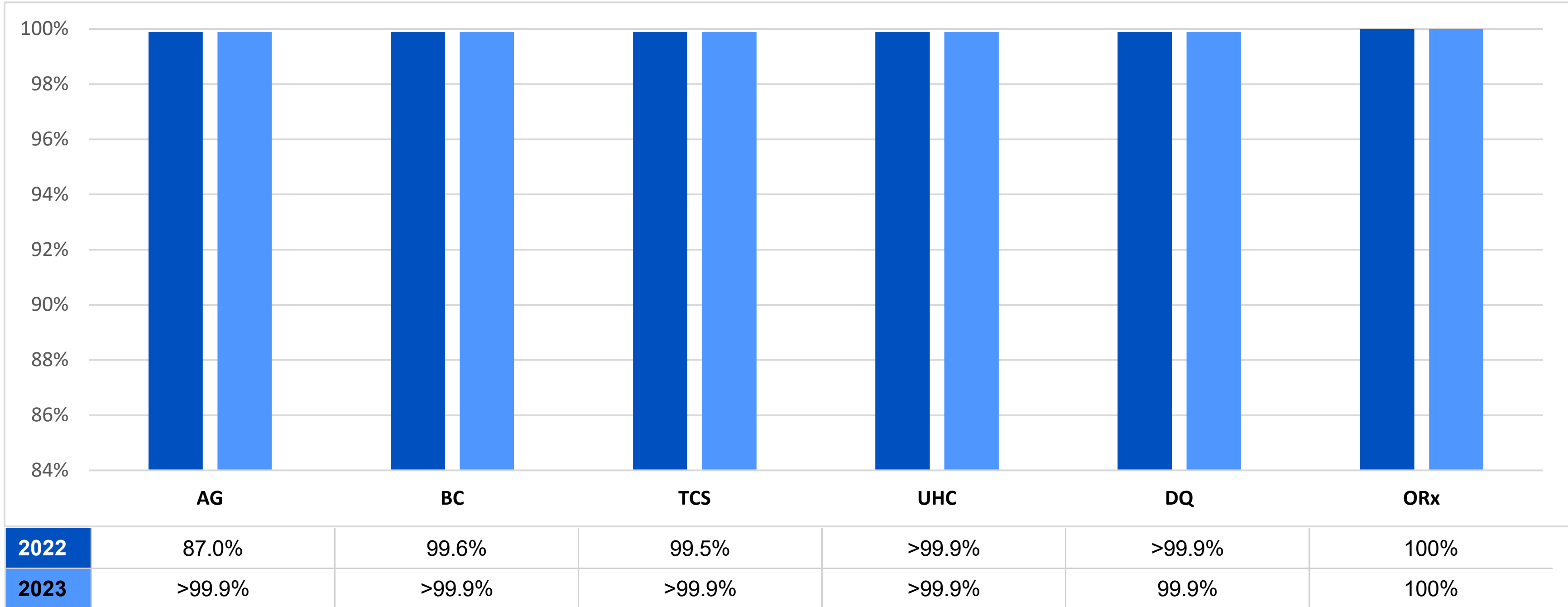
[1] The overall score is based on the combination of scores for Standard 1 (75% of members within 30 miles travel distance or 45 minutes travel time) and Standard 2 (100% of members within 60 miles travel distance or 60 minutes travel time). However, because Standard 1 is based on 75% of the non-dual 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.
[2] 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.
Note: Cells in gray are NA.

Table 7. 2023 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 maintained their high scores in overall Network Adequacy in 2023. **AG** and **UHC** remained high at >99.9%. **BC** and **TCS** increased their scores from 99.6% and 99.5%, respectively, to >99.9% for each. DQ and ORx's Network Adequacy scores also remained high, at 99.9% and 100%, respectively. (See Figure 4.)

Figure 4. 2022–2023 Overall Network Adequacy Scores



	AG	BC	TCS	UHC	DQ	ORx
2022	87.0%	99.6%	99.5%	>99.9%	>99.9%	100%
2023	>99.9%	>99.9%	>99.9%	>99.9%	99.9%	100%

Benefit Delivery

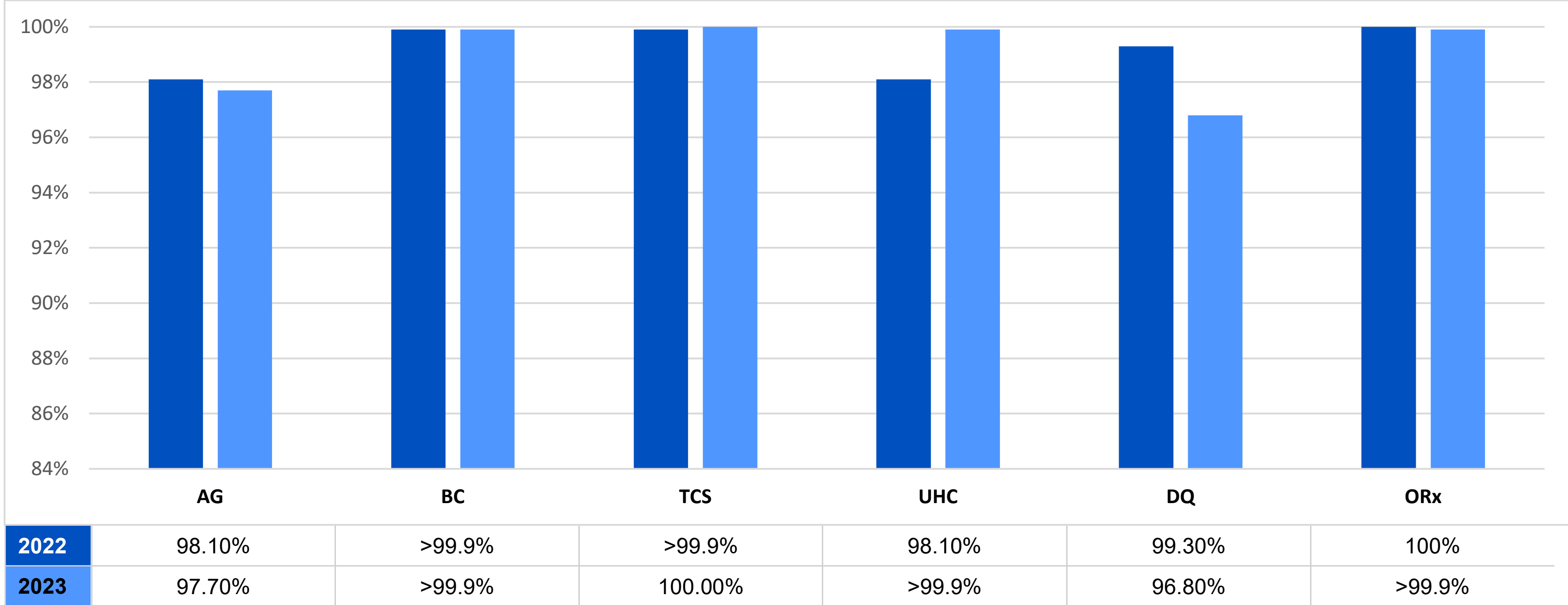
The information in Table 8 was obtained from reviews of the six areas used to determine the effectiveness of the plans' delivery of covered benefits. TennCare plans earned high compliance scores for Overall Benefit Delivery in 2023, ranging from 96.8% (**DQ**) to 100% (**TCS**).

Table 8. 2023 ANA Benefit Delivery Scores: Plan Averages						
Measure	**AG**	**BC**	**TCS**	**UHC**	**DQ**	**ORx[1]**
Covered Benefit—Member Handbook	100%	100%	100%	100%	100%	
Covered Benefits—Provider Manual	96.0%	100%	100%	100%	100%	
Appointment Availability—Policies and Procedures	100%	100%	100%	100%	100%	100%
Appointment Availability—Complaints	>99.9%	>99.9%	100%	>99.9%	>99.9%	>99.9%
MCO Provider Contracts—Quantity	95.0%	100%	100%	100%	92.1%	
MCO Provider Contracts—Quality	95.0%	100%	100%	100%	88.6%	
Overall Benefit Delivery Results	**97.7%**	**>99.9%**	**100%**	**>99.9%**	**96.8%**	**>99.9%**

[1] Gray-shaded cells indicate areas not assessed for the PBM.
Note: The value >99.9% was used to distinguish the performance of plans for which at least one member was outside the expected access standard. The overall score, however, is aggregated based on the value rounded to the whole integer. In this case, the value was 100%.

As shown in Figure 5, several plans raised their compliance percentages from 2022, however **AG** and **DQ** declined in performance by -0.4 percentage points (pp) and -2.5 pp, respectively. **UHC** showed the largest improvement in Benefit Delivery by 1.8 pp.

Figure 5. 2022–2023 Overall Benefit Delivery Scores



	AG	BC	TCS	UHC	DQ	ORx
2022	98.10%	>99.9%	>99.9%	98.10%	99.30%	100%
2023	97.70%	>99.9%	100.00%	>99.9%	96.80%	>99.9%

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 2023 ANA review. All strengths and AONs for the ANA review are related to **Access** and **Timeliness** of care.

Table 9. 2023 ANA Review Strengths and AONs
Amerigroup
Strengths
*Qsource did not identify any strengths for **AG** in the 2023 ANA review.*

Table 9. 2023 ANA Review Strengths and AONs

AONs	
Network Adequacy	**AG** achieved a score of 100% in 82 of 85 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 distance/time standards. ♦ Ensure that all members have access to optometry providers within the TennCare required distance/time standards. ♦ Ensure that all members have access to hospitals within the TennCare required distance/time standards.
Benefit Delivery	For performance improvement in Benefit Delivery, **AG** should: ♦ Inform providers about the vision benefits for CoverKids mothers of eligible unborn children. ♦ Must inform providers about the DME benefits for CoverKids. ♦ Inform providers about the medical supplies benefits for CoverKids.
File Review	For performance improvement in file reviews, **AG** should ensure that all participating providers have an executed provider contract.
BlueCare	
Strengths	
Benefit Delivery	**BC** used the member newsletter to inform members about benefits and coverage related to second opinions. **BC** informed members about specific requirements for coverage of occupational, physical, and speech therapy services on the **BC** website. **BC** informed members about the requirements for coverage of chiropractic services on the **BC** website. **BC** included additional information concerning required benefits and coverage not included in the current member handbooks on its member website. **BC** included additional information concerning required benefits and coverage not included in the current member handbooks on its member website.
AONs	
Network Adequacy	**BC** achieved a score of 100% in 82 of 85 Network Adequacy measures. For performance improvement, **BC** should: ♦ Ensure that all members have access to hospitals within the TennCare required distance/time standards. ♦ Must ensure that all CHOICES members have access to adult day care providers within the TennCare required distance/time standards. ♦ Ensure that all CHOICES members have access to at least two inpatient respite care providers in each TennCare required county. Members in Bedford County did not have access to at least two inpatient respite care providers.
TennCare*Select*	
Strengths	
*As **TCS** is administered by **BC**, its strengths are the same.*	
AONs	
Network Adequacy	**TCS** achieved a score of 100% in 57 of 58 Network Adequacy measures. For performance improvement, **TCS** should: ♦ Ensure that all members have access to hospitals within the TennCare required distance/time standards.

Table 9. 2023 ANA Review Strengths and AONs	
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 was made available to all members on the **UHC** member website. New members were informed about the **UHC** Member Handbook and the Member Handbook Addendum upon enrollment.
AONs	
Network Adequacy	**UHC** achieved a score of 100% in 80 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 hospitals 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.
DentaQuest	
Strengths	
Benefit Delivery	**DQ** included benefits and coverage information not listed in the approved member handbooks on its member website. **DQ** developed a training document and FAQ document explaining benefits not described in the provider manual.
AONs	
Network Adequacy	DQ achieved a score of 99.9% in the Dental Provider Distance for the ECF CHOICES members network adequacy evaluation area. For performance improvement in Network Adequacy, **DQ** should: ♦ Ensure that all ECF CHOICES members have access to ECF CHOICES dental providers within the distance/time standards. ♦ Ensure that all non-ECF CHOICES members have access to oral surgeons within the distance/time standards. ♦ Ensure that all non-ECF CHOICES members have access to orthodontists within the distance/time standards.
File Review	For performance improvement in file reviews, **DQ** should: ♦ Ensure that all contracts have been signed and dated by DQ and the provider. ♦ Ensure that each participating provider has an executed provider contract. ♦ 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 2023 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 2023 AQS was conducted from February through May 2023. 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-survey, survey, and post-survey analyses.

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:

- **AG**, **BC**, and **UHC**: Statewide Contract with Amendment 16—October 31, 2022;
- **TCS** (statewide): An Agreement for The Administration of TennCare Select Between the State Of Tennessee, d.b.a. TennCare And Volunteer State Health Plan, Inc., Blended Document with Amendments 1 Through 52 (Effective October 31, 2022);
- **ORx** (statewide): Contract #61494 Between the State of Tennessee, Department of Finance and Administration, Division of TennCare and OptumRx, Inc.; and
- **DQ** (statewide): Contract #59802 Between the State of Tennessee, Department of Finance and Administration, Division of Health Care Finance and Administration Bureau of TennCare and DentaQuest USA Insurance Co., 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 12 standards of 42 CFR 438, Subparts D and E as shown in Table 10. For more information, please see Appendix A.

Table 10. 2023 AQS Tools to CFR Crosswalk						
#	Standard	42 CFR	Notes	MCO	DBM	PBM
1	Availability of Services	438.206		✓	✓	✓
2	Assurances of Adequate Capacity and Services	438.207		✓	✓	✓
3	Coordination and Continuity of Care and Enrollee Disenrollment	438.208, 438.56		✓	✓	✓
4	Coverage and Authorization of Services	438.210		✓	✓	✓
5	Emergency and Poststabilization	438.114		✓	N/A	N/A
*	Provider Selection	438.214	Included in Annual Network Adequacy evaluation, not reviewed in AQS	N/A	N/A	N/A
6	Confidentiality	438.224		✓	✓	✓
7	Grievance and Appeal Systems	438.228		✓	✓	✓
8	Subcontractual Relationships and Delegation	438.230		✓	✓	✓
9	Practice Guidelines	438.236		✓	✓	✓
10	Health Information Systems	438.242		✓	✓	✓
11	Quality Assessment and Performance Improvement (QAPI) Program	438.330		✓	✓	✓
12	Enrollee Rights	438.100		✓	✓	✓
13	Information Requirements and Advance Directives	438.10, 438.3(j), 422.128(b)(1)(i)		✓	✓	✓
14	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	441.56 – 441.62	Included in 2022 AQS per TennCare request, but not required for review by 438.358(b) or CMS Protocol 3	✓	✓	NA
15	BESMART Program	No CFR		✓	NA	NA
16	Non-Discrimination Compliance	No CFR		✓	✓	✓

Qsource's surveyor team first documented preliminary desktop review findings in the survey tools. During the virtual/onsite surveys, 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/onsite surveys by summarizing initial findings and recommendations with the plans.

After the virtual/onsite surveys, 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 *2023 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 *2023 AQS Summary Report*. AQS assessment tool templates can be found in Appendix B of this report.

Table 11. 2023 AQS Documentation Review

All MCCs
◆ Member Handbooks in English and Spanish; ◆ 2022 Provider Manual; ◆ Quality Improvement Program (QIP) Description (QIPD); ◆ QIP Evaluation of 2021 activities; ◆ 2022 Provider and Member Newsletters; ◆ 2022 Quarterly EPSDT reports; ◆ 2022 Utilization Management (UM) Program Description (UMPD); ◆ UM Program Evaluation of 2021 activities; ◆ 2022 Population Health (PH) Program Description; ◆ Provider satisfaction surveys; ◆ P&Ps that define the MCC's time standards for handling all denials, complaints, and appeals; ◆ 2022 corrective action plans (CAPs) and related documentation, if applicable; and ◆ all additional policies, procedures, and other documentation needed to answer survey tool elements.
MCOs Only
◆ Complete National Committee for Quality Assurance (NCQA) Accreditation Report
PBM only
◆ Sample of a Notice of Adverse Benefit Determination; ◆ provider and subcontractor contracts with the PBM; ◆ PBM web address; ◆ Provider Training Materials; ◆ 2022 Staff Compliance Training Documents; ◆ *Provider Network Directory*; and ◆ quarterly *Non-Discrimination Compliance Report.*

Description of Data Obtained

Table 11 presents the documentation that Qsource requested for desk review for the 2023 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.

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 2023, including performance improvements in several categories. Compliance scores fell only in the BESMART QP standard and ratings of both the CHOICES Credentialing and Recredentialing file review.

Table 12. 2023 AQS Compliance: MCO QP Standard and Credentialing/Recredentialing Results

QP Standards	AG		BC		TCS		UHC	
	2022	2023	2022	2023	2022	2023	2022	2023
Availability of Services	100%	100%	100%	100%	100%	100%	100%	100%
Assurances of Adequate Capacity and Services	84.00%	100%	100%	100%	100%	100%	100%	100%
Coordination and Continuity of Care	91.00%	100%	91.00%	100%	91.00%	100%	82.00%	100%
Coverage and Authorization of Services	100%	100%	100%	100%	100%	100%	100%	100%
Emergency and Poststabilization[1]		100%		100%		100%		100%
Confidentiality	100%	100%	100%	100%	100%	100%	100%	100%
Grievance and Appeal Systems	98.30%	100%	100%	100%	100%	100%	100%	100%
Subcontractual Relationships and Delegation	100%	100%	100%	100%	100%	100%	100%	100%
Practice Guidelines	100%	100%	100%	100%	100%	100%	100%	100%
Health Information Systems	100%	100%	100%	100%	100%	100%	100%	100%
Quality Assessment and Performance Improvement (QAPI) Program	100%	100%	100%	100%	100%	100%	100%	100%
Member Rights[1]		100%		100%		100%		100%
Information Requirements[1]		100%		100%		100%		100%
BESMART Program	100%	90.90%	100%	100%	100%	100%	100%	90.90%

Table 12. 2023 AQS Compliance: MCO QP Standard and Credentialing/Recredentialing Results									
QP Standards		AG		BC		TCS		UHC	
		2022	2023	2022	2023	2022	2023	2022	2023
EPSDT		100%	100%	100%	100%	100%	100%	96.00%	100%
Non-Discrimination Compliance		100%	100%	100%	100%	100%	100%	100%	100%
Credentialing/Recredentialing P&Ps		100%	100%	100%	100%	100%	100%	100%	100%
CHOICES Credentialing/Recredentialing File Reviews[2]									
CHOICES Credentialing Files	Quantity[3]	100%	69.23%	100%	100%			100%	100%
	Quality[3]	100%	100%	100%	100%			93.30%	100%
CHOICES Recredentialing Files	Quantity[3]	100%	100%	100%	100%			100%	100%
	Quality[3]	100%	79.63%	100%	100%			80.30%	75.90%

[1] Not assessed in the 2022 AQS as an independent QP Standard.

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

[3] 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.

Note: Scores in red indicate a decline for the 2022 review, while scores in green indicate increased or maintained scores compared to 2020. Cells in gray indicate that a measure was not assessed.

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: Transition of CHOICES Members Between MCOs where **AG** achieved 93.55%; UM Denials where **BC** achieved 97.87% and **UHC** achieved 97.87%, Appeals where **BC** achieved 97.50%, Grievances where **TCS** achieved 85.00%; and lastly, **UHC** maintained its 95.00% compliance score in CHOICES Annual LOC Assessment.

Table 13. 2022–2023 AQS Compliance: MCO PA File Review Results								
PAs	AG		BC		TCS		UHC	
	2022	2023	2022	2023	2022	2023	2022	2023
UM Denials (ages 20 and younger)	100%	100%	100%	97.87%	100%	100%	100%	97.87%
Grievances	100%	100%	100%	100%	100%	85.00%	100%	100%
Appeals	92.5%	100%	100%	97.50%	100%	100%	100%	100%
EPSDT Information System Tracking	100%	100%	100%	100%	100%	100%	100%	100%
CHOICES Annual LOC Assessment[1]	100%	100%	90.0%	100%			95.0%	95.00%

Table 13. 2022–2023 AQS Compliance: MCO PA File Review Results

PAs	AG		BC		TCS		UHC	
	2022	2023	2022	2023	2022	2023	2022	2023
Transition of CHOICES Members Between MCOs[1]	100%	93.55%	100%	100%			96.4%	100%

Scores in red indicate a decline for the 2023 review, while scores in green indicate increased or maintained scores compared to 2022. Cells in gray indicate that a measure was not assessed.
[1] Not assessed in 2022 AQS or 2023 AQS for TCS due to its small number of CHOICES members.

As shown in **Table 14, DQ** continued its high performance in the 2023 AQS. Due to revisions in the QP tools for the 2023 AQS, there are four standards that cannot be compared from 2022 AQS to 2023 AQS. However, in all four of those standards, **DQ** achieved 100% compliance. The DBM fell short of 100% compliance in one QP standard and one PA file review: Assurances of Adequate Capacity and Services scored 50.00% and Grievances PA file review scored 92.50%.

Table 14. 2022–2023 AQS Compliance: DBM Results

QP Standards	2022	2023
Availability of Services	92.30%	100%
Assurances of Adequate Capacity and Services	100%	50.00%
Coordination and Continuity of Care	90.00%	100%
Coverage and Authorization of Services	95.70%	100%
Emergency and Poststabilization		100%
Confidentiality[1]	100%	100%
Grievance and Appeal Systems	100%	100%
Subcontractual Relationships and Delegation	100%	100%
Practice Guidelines	100%	100%
Health Information Systems	100%	100%
Quality Assessment and Performance Improvement (QAPI) Program	100%	100%
Member Rights[1]		100%
Information Requirements[1]		100%
EPSDT	100%	100%
Non-Discrimination Compliance[1]	96.40%	100%

Table 14. 2022–2023 AQS Compliance: DBM Results		
Credentialing/Recredentialing P&Ps	100%	100%
PA File Reviews		
Appeals	100%	100%
Grievances	100%	92.50%
UM Denials (ages 20 years and younger)	100%	100%

Note: Scores in red indicate a decline for the 2023 review, while scores in green indicate increased or maintained scores compared to 2022.
[1] Not assessed in the 2022 AQS as it is a new standard for the 2023 AQS.

Table 15 displays **ORx**'s scores. Due to revisions in the QP tools for the 2023 AQS, there are four standards that cannot be compared from 2022 AQS to 2023 AQS. However, in all four of those standards, **ORx** achieved 100% compliance. The PBM earned 100% compliance for all QP standards except Coverage and Authorization of Services (93.75%), Grievance and Appeal Systems (70.45%), and Non-Discrimination Compliance (87.50%). *Note: File reviews are not required for the PBM.*

Table 15. 2022-2023 AQS Compliance: PBM Results

QP Standards	2022	2023
Availability of Services	80.00%	100%
Assurances of Adequate Capacity and Services	0.00%	100%
Coordination and Continuity of Care	100%	100%
Coverage and Authorization of Services	100%	93.75%
Confidentiality[1]		100%
Grievance and Appeal Systems	91.20%	70.45%
Subcontractual Relationships and Delegation	100%	100%
Practice Guidelines[1]		100%
Health Information Systems	100%	100%
Quality Assessment and Performance Improvement (QAPI) Program	90.00%	90.00%
Member Rights[1]		100%
Information Requirements[1]		100%
Non-Discrimination Compliance	100%	87.50%

Table 15. 2022-2023 AQS Compliance: PBM Results		
QP Standards	**2022**	**2023**
Credentialing/Recredentialing P&Ps	100%	100%

Scores in red indicate a decline for the 2023 review, while scores in green indicate increased or maintained scores compared to 2022.
1 Not assessed in the 2022 AQS as it is a new standard for the 2023 AQS.

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 EPSDT New Member Welcome Calls. For improvement in AONs, several plans were instructed to ensure that CHOICES credentialing and recredentialing files are correct and completed in a timely manner; and that notifications of Appeal decisions, UM Denials, and Grievances are sent timely. 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. 2023 AQS Strengths and AONs		
Amerigroup		
AONs		**Q/A/T**
BESMART	**Element #9—Quarterly Quality Metric Report:** The MCO should ensure that the quarterly MAT Network Quality Metrics Reports are distributed to providers within the specified time frame and should develop a process that specifies how this is conducted and carried out.	Q
CHOICES Credentialing: Quantity	The MCO should ensure all files are categorized correctly prior to submission. Four credentialing files should have been submitted as recredentialing files. One file was submitted correctly but marked as NA. That file was considered a vendor and did not need to be credentialed.	Q/A/T
CHOICES Recredentialing: Quality	The MCO should ensure Recredentialing occurs as frequently as required by TennCare.	A/T

Table 16. 2023 AQS Strengths and AONs		
Transition of CHOICES Members Between MCOs	The MCO should ensure authorization and implementation of services for members within 30 calendar days. This was not met in two instances.	T
	Strengths	
*No strengths were identified for **AG** in 2023.*		
	BlueCare	
	Strengths	
EPSDT	**Element #6—New Member Calls**: BC provided exceptionally thorough support of new members in regard to first contact. During the welcome call, Member Education Health Navigator confirms receipt of the mailed materials and personally educates members about their benefits, preventive services, Nurseline, and its website. For MCO members, education on TennCare Kids services and transportation is provided. The MCO also encourages members to quickly establish a relationship with their medical home (primary care provider). Members are asked to complete questionnaires assessing for social determinants, opioid risk, and pregnancy (if applicable). Members are offered appointment scheduling assistance and community-based resources as applicable. If needed and member accepts, Health Navigator will connect member with medical, behavioral, social, educational and/or other providers or programs and services.	Q/A/T
	AONs	
PA File Reviews—UM Denials	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.	A/T
PA File Reviews—Appeals	The MCO should ensure that reassessments are completed timely; this issue was noted in one file.	T
	TennCare*Select*	
	Strengths	
EPSDT	**Element #6—New Member Calls**: TCS provided exceptionally thorough support of new members in regard to first contact. During the welcome call, Member Education Health Navigator confirms receipt of the mailed materials and personally educates members about their benefits, preventive services, Nurseline, and its website. For MCO members, education on TennCare Kids services and transportation is provided. The MCO also encourages members to quickly establish a relationship with their medical home (primary care provider). Members are asked to complete questionnaires assessing for social determinants, opioid risk, and pregnancy (if applicable). Members were offered appointment scheduling assistance and community-based resources as applicable. If needed and member accepts, Health Navigator will connect member with medical, behavioral, social, educational and/or other providers or programs and services.	Q/A/T
	AONs	
PA File Reviews—Grievance File Review	The MCO should ensure timely completion of member grievances.	T
	UnitedHealthcare	
	AONs	
BESMART	**Element #3—Quality Policies and Procedures:** The MCO should ensure that its P&Ps address all specified criteria for BESMART Quality Reviews.	Q
PA File Reviews—UM Denials	The MCO should ensure timely notification of UM denials. This was not met in one instance.	T

Table 16. 2023 AQS Strengths and AONs		
PA File Reviews—CHOICES Annual Level of Care Assessment	The MCO should ensure timely CHOICES annual level of care reassessments. This was not met in one instance.	T
CHOICES Recredentialing File Review Tool (Quality)	The MCO should ensure that CHOICES providers are recredentialed at a frequency as specified by TennCare. This was not met in 13 instances.	T
Strengths		
No strengths were identified for UHC in 2023.		
DentaQuest		
AONs		
Assurances of Adequate Capacity and Services	**Element #2—Timing of Documentation:** The DBM should include evidence that specifies compliance with the submission timeline of these elements. Need documentation with timeline of these elements.	T
PA File Reviews—Grievances	The DBM should ensure resolution letters are sent timely.	A/T
Strengths		
No strengths were identified for DQ in 2023.		
OptumRx		
AONS		
Coverage and Authorization of Services	**Element #4—Processing Authorizations:** The PBM should develop and maintain mechanisms or processes to ensure consistent application of review criteria for authorization decisions.	A/T
Grievances and Appeals	**Element #4—Timing to File Grievance and Appeal:** The PBM should clearly state in a P&P that the member may file a grievance any time and has 60 calendar days from the date on the NABD notice to file a TennCare appeal with TennCare.	A/T
	Element #6—Availability of Notices: The PBM should add language in the P&P stating that it makes the NABD available by the following means at no cost to the member: 1) Written translation; 2) Oral interpretation; 3) Alternative formats; and 4) Auxiliary aids and services.	A
	Element #8—Timing of Notice: The PBM should add language in P&P that states that PBM issues the NABD within the following timeframes: 1) If the Adverse Benefit Determination relates to PBM's denial of a prior authorization request, the PBM issues the NABD within 24 hours of receiving a PA request which contains the requisite information for a determination; 2) If the PBM fails to timely render a PA determination, the PBM shall issue the NABD to member on the date that the PA timeframe expires; and 3) The PBM issues the NABD on the date of determination when the action is a denial at a member's request for reimbursement for medications member paid for out-of-pocket.	A/T
	Element #9—Handling of Grievances and Appeals: The PBM should add language in its P&Ps that specifies to members that they can request 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 numbers that have adequate TTY/TDD and interpreter capability.	A/T

Table 16. 2023 AQS Strengths and AONs

	Element #18—Extension Requirements: The PBM should add language in its P&P that, if the PBM extends the timeframes for grievance resolution not at the request of the member, it completes all of the following: 1) Make reasonable efforts to give the member prompt oral notice of the delay; and 2) Within two (2) calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision.	A/T
	Element #19—Format of Grievance Notice: The PBM should add language in their P&P that states PBM uses the TennCare established method to notify a member of the resolution of a grievance and ensure that such methods provide for: 1) Written translation; 2) Oral interpretation; 3) Alternative formats; and 4) Auxiliary aids and services.	A
	Element #21—Content of Notice of Appeal Resolution- Results and Date: The PBM should add language in the P&P that the written notice of the resolution includes the results of the resolution process and the date it was completed.	A/T
	Element #26—Recordkeeping Requirements- Information: The PBM should add language in the P&P containing each criteria's information.	Q/A
	Element #28—Continuation of Benefits: The PBM should add specific timeframes for the criteria in the P&P document.	T
	Element #30—Effectuation of Reversed Appeal Resolutions-Services Not Furnished While Appeal Pending: The PBM should add language in the P&P that states if the TennCare appeal reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, then the PBM will authorizes or provide 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.	Q/A/T
Quality Assessment and Performance Improvement (QAPI) Program	**Element #2—Utilization and Special Health Care Needs:** The PBM should institute mechanisms to assess quality of care furnished to members with special health care needs.	Q/A
Non-Discrimination Compliance	**Element #4—Complaint Resolution and Reporting:** The PBM should create a policy and/or procedure that addresses reporting of a discrimination complaint to TennCare within two days, assisting TennCare with initial investigations if requested, and completing any corrective action as required by TennCare.	A/T
Strengths		
No strengths were identified for ORx in 2023.		

Improvements Since the 2022 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 scoring 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 2022 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.

Table 17. 2023 AQS: Improvements Since the 2022 AQS	
2022 AON	**Improvements**
Amerigroup	
Assurances of Adequate Capacity and Service: Element #1—Appropriate Range of Services and Providers: The MCO should ensure it maintains a sufficient provider network.	The MCO indicated that TennCare had already identified provider network deficiencies and that it completed a TennCare-required CAP. These actions, in addition to listing the responsible party by title, satisfied the CAP. In addition, through the Annual Network Adequacy evaluation, the Tennessee Department of Commerce and Insurance evaluated compliance with network contracting requirements.
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.	The MCO provided a draft P&P, Disenrollment Requests–TN to address the identified AON and specified a completion date of 8/1/22. The MCO should ensure that this policy is communicated to the relevant staff. Qsource verified that the P&P was created and distributed as planned. These actions, in addition to listing the responsible party by title, satisfied the CAP.
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.	The MCO provided staff training related to the identified AON and updated its P&P. These actions satisfied the CAP. During the 2023 AQS, Qsource verified that the training had occurred.
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.	The MCO provided staff training related to the identified AON and updated its P&P. These actions satisfied the CAP. During the 2023 AQS, Qsource verified that the training had occurred.
BlueCare	
Coordination and Continuity of Care: Element # Continuity of Care 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.	The MCO provided a satisfactory CAP, within which it addressed the identified AON with a plan to develop a P&P which was submitted to TennCare for approval. Upon TennCare approval, the MCO planned to present the P&P to its Quality Leadership Council Committee for approval and subsequent publication. The MCO ensured that this policy would be communicated to the relevant staff. During the AQS, Qsource confirmed completion of the presentation to the Quality Leadership Council Committee, including its publication and distribution to staff.
CHOICES Annual LOC File Review	The MCO provided a satisfactory CAP, which included staff training, monthly chart audits to monitor timeliness, accuracy and compliance, and detailed use of its Coordinator Dashboard and Daily Jumpstart compliance monitoring tools to ensure that CHOICES LOC reassessments were completed timely. Qsource verified completion of the training and use of the chart audits throughout the year. The MCO was able to demonstrate use of its Coordinator Dashboard and Daily Jumpstart during the year.
TennCare*Select*	
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.	The MCO provided a satisfactory CAP, within which it addressed the identified AON with a plan to develop a P&P which was submitted to TennCare for approval. Upon TennCare approval, the MCO planned to present the P&P to its Quality Leadership Council Committee for approval and subsequent publication. The MCO ensured that this policy would be communicated to the relevant staff. During the AQS, Qsource confirmed completion of the presentation to the Quality Leadership Council Committee, including its publication and distribution to staff.

Table 17. 2023 AQS: Improvements Since the 2022 AQS	
2022 AON	**Improvements**
UnitedHealthcare	
Provider Selection: Element #10—Provider Visits: The MCO should ensure that semiannual contacts are made with all contract providers.	The MCO addressed the AON and provided its plan and targeted completion date. The MCO indicated that an alternative plan for the current requirement would be developed and submitted to TennCare for review by 10/1/22. Qsource verified that this plan was submitted and accepted.
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.	The policy submitted for this AON addressed the requirement that the MCO should have 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. The MCO included the timeframe and the employees responsible to implement the policy. During the 2023 AQS, Qsource verified that this policy was put into place.
Coordination and Continuity of Care: 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 informs TennCare if it believes that a member satisfies the conditions for termination as described in TennCare rules and regulations.	The policy submitted for this AON addressed the requirement to ensure that the MCO has a policy that does not request disenrollment for any member for any reason. The MCO informs TennCare if it believes that a member satisfies the conditions for termination as described in TennCare rules and regulations. A member may request disenrollment or be disenrolled under specified conditions as described in the TennCare Rules and Regulations, the Contractor Risk Agreement (A.2.5.2), and the Code of Federal Regulations (42 CFR § 438.56). The MCO included the timeframe and the employees responsible to implement the policy. During the 2023 AQS, Qsource verified that this policy was put into place.
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.	The SOP submitted for this AON addressed the requirement to 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. The MCO included the timeframe and the employees responsible to implement the policy. During the 2023 AQS, Qsource verified that this policy was put into place.
EPSDT: 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.	The change in procedure for this AON addressed the requirement to 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 provided the presentation material, and included the timeframe and the employees responsible to implement the procedure. During the 2023 AQS, Qsource verified that this policy was put into place.
CHOICES Annual Level of Care Assessment File Review: The MCO should ensure timely completion of reassessments.	The MCO outlined actions to address the AON, which included the establishment of a timeframe for member contact prior to the due date for member reassessment, staff re-education, and compliance monitoring. During the 2023 AQS, Qsource verified that this policy was put into place.
Transition of CHOICES Members Between MCOs: Criteria for Receiving MCO File Review: The MCO should ensure that the face-to-face assessment for transitioning CHOICES members is conducted within 30 days. The issue was noted in one file.	The MCO identified the cause of the untimely assessment and summarized actions that included an enhanced intake report that identified changes to the enrollment and eligibility dates, revisions to its current job aid, and staff training. During the 2023 AQS, Qsource verified that these changes were made and acted upon.
CHOICES Credentialing File Review (Quality): The MCO should ensure that provider Medicare/Medicaid participation is verified in CHOICES credentialing files.	The MCO identified the cause of the AON as human error and explained that the process for credentialing and recredentialing for Tennessee was transitioned from its analyst's desk to its National Credentialing Center on 3/1/21. The MCO confirmed knowledge and awareness of the process with the National Credentialing Center. During the 2023 AQS, Qsource verified that these processes were followed.
CHOICES Recredentialing File Review (Quality): The MCO should ensure that provider Medicare/Medicaid participation is verified in CHOICES recredentialing files, and that recredentialing occurs annually	The MCO described the root cause for the identified AON and established interventions to address the concern. Qsource verified that these actions were fulfilled and satisfied the CAP. The MCO could consider adding a time frame to its new policy regarding distribution of regulatory guidance and should ensure its

Table 17. 2023 AQS: Improvements Since the 2022 AQS	
2022 AON	**Improvements**
or every three years.	process for validation of provider Medicare/Medicaid participation is tracked and stable.
DentaQuest	
Availability of Services: 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.	The DBM's CAP addressed the identified AON and included updating an existing and related policy, obtaining a review and formal approval, and publishing it to its policy database. The DBM should ensure that relevant staff are aware of the updated policy. The updated policy was reviewed.
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.	The DBM's CAP addressed the identified AON with actions that included updating an existing policy, obtaining a review and formal approval, and publishing it to its policy database. The DBM should ensure that relevant staff are aware of the updated policy. The updated policy was reviewed.
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).	The DBM's CAP addressed the identified AON with actions that included updating an existing policy, obtaining a review and formal approval, and publishing it to its policy database. The DBM should ensure that relevant staff are aware of the updated policy. The updated policy was reviewed.
Non-Discrimination Compliance: Element #4—Written P&P: The DBM should ensure that its helpline processes function to address the member's needs.	The DBM outlined actions to address the identified AON, which included a review of helpline calls and agent coaching on proper interpreter services processes. The DBM provided clarifying information regarding updates to its Knowledge Database that distinguished between those language support services provided by internal agents and those interpreter services provided by an external interpreter. Monitoring was conducted to ensure resolution, however, during the 2023 audit the MCO could not provide its random auditing or a summary of its audit of recorded calls.
OptumRx	
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.	The policy submitted for this AON addressed the requirement that a policy or procedure should be in place that documents how the coordination of payment for out-of-network services occur. The PBM included the timeframe and the responsible parties to implement the policy. When this element was discussed, the PBM provided the provider enrollment document as evidence. These actions satisfy the CAP.
Availability of Services: Element #10—Provider Directory Availability: The PBM should develop a P&P that addresses updates to the Provider Directory and the required timeframes.	The policy submitted for this AON addressed the requirement that a policy or procedure should be in place that documents how the coordination of payment for out-of-network services occur. The PBM included the timeframe and the responsible parties to implement the policy. It was confirmed that these actions satisfy the CAP.
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.	The documentation submitted for this AON was to develop a policy and procedure that detailed when and how its provider network is maintained as well as their monthly reporting to TennCare. The PBM included the timeframe and the responsible parties to implement the policy. It was confirmed that these actions satisfy the CAP.
Assurances of Adequate Capacity and Services: 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.	The PBM updated its Pharmacy Benefits Management Provider Enrollment Process. The procedure included documentation related to network maintenance and TennCare reporting requirements. It also specified that its Provider Directory is updated in real time. It was confirmed that these actions satisfy the CAP.
Coverage and Authorization of Services: Element #4—Processing Authorizations: The PBM should develop mechanisms to ensure	The documentation submitted for this AON was to have a P&P in place to ensure consistent application of review criteria for authorization decisions. The PBM included the timeframe and the responsible parties to

Table 17. 2023 AQS: Improvements Since the 2022 AQS	
2022 AON	**Improvements**
consistent application of review criteria for authorization decisions.	implement the policy. It was confirmed that these actions satisfy the CAP.
Coverage and Authorization of Services: 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.	The PBM provided a follow-up CAP response that included all criteria for Element 9 of the Annual Quality Survey standard, "Coverage and Authorization". An OptumRx document titled TennCare FFS (Fee-for-Service), Medicaid, and CoverKids Member Rights was received and included the specified member rights criteria. It was confirmed that these actions satisfy the CAP.
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.	The documentation submitted for this AON was to have a P&P in place to ensure those who make decisions should neither be involved in any previous level of review nor decision making. The PBM included the timeframe and the responsible parties to implement the policy. It was confirmed that these actions satisfy the CAP.
Grievances and Appeals: Element #28—Punitive Action Prohibited: The PBM should maintain a P&P against punitive action in response to a request for an expedited resolution.	The documentation submitted for this AON was to have a P&P in place to ensure no punitive action was given to providers who request an expedited resolution. The PBM included the timeframe and the responsible parties to implement the policy. It was confirmed that these actions satisfy the CAP.
Grievances and Appeals: 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.	The documentation submitted for this AON was to have a P&P in place that describes the process the PBM takes if they reverse a decision to deny, limit, or delay services and the services were not furnished. The PBM included the timeframe and the responsible parties to implement the policy. It was confirmed that these actions satisfy the CAP.
Grievances and Appeals: 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 SFH officer reverse the decision to deny authorization of services.	The documentation submitted for this AON showed that the PBM updated the policy to reflect that neither the PBM nor TennCare pay for services furnished during a pending appeal unless the decision to deny is reversed and the member requests coordination of benefits and is approved by TennCare for this service. The PBM included the timeframe and the responsible parties to implement the policy. It was confirmed that these actions satisfy the CAP.

State Best Practices

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

Performance Measure Validation (PMV)

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

Assessment Background—MCOs

Qsource's PMV team consisted of both Certified HEDIS Compliance Auditors (CHCAs), and non-certified individuals selected for specified skills, including statistics, analysis, managed care operations, clinical expertise, performance measure reporting, 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* (2019), 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 are allowed to be 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/Onsite Review Activities: In addition to scheduling the 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/Onsite Reviews lasted one day 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; and
- 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 *2023 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 MY2022, TennCare MCOs were required to report a full set of HEDIS measures for NCQA-accreditation purposes, two of which were validated by Qsource in 2023—*Controlling High Blood Pressure (CBP)* and *Prenatal and Postpartum Care (PPC)*.

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 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**
Controlling High Blood Pressure (CBP)	The percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the MY.	NCQA	Administrative
Prenatal and Postpartum Care (PPC)	The percentage of deliveries of live births on or between October 8 of the year prior to the MY and October 7 of the MY. For these women, the measure assesses the following facets of prenatal and postpartum care. ♦ *Timeliness of Prenatal Care*. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. ♦ *Postpartum Care*. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	NCQA	Administrative

Comparative Findings—MCOs

AG, **BC**, **TCS** 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 MY2022 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 MY2022 PMV Measure Rates—MCOs				
	AG	**BC**	**TCS**	**UHC**
Controlling High Blood Pressure (CBP)	40.13%	49.55%	49.55%	47.25%
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	71.05%	71.27%	71.27%	70.40%
Postpartum Care	60.59%	67.28%	67.28%	68.66%

Findings and Conclusions—MCOs

All MCOs passed the 2023 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**, **TCS,** 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 MY2022 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 2022 and 2023 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 2023 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:

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.

Virtual/Onsite 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.

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 2022, 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 MY2022 PMV Audit Measures—PBM

Measure Name	Measure Definitions	Measure Steward	Data Collection Method
Concurrent Use of Opioids and Benzodiazepines (COB-AD)	The percentage of members age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded.	NCQA	Administrative
Use of Pharmacotherapy and Opioid Use Disorder (OUD-AD)	The percentage of Medicaid members 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: ♦ Total (Rate 1) ♦ Buprenorphine (Rate 2) ♦ Oral Naltrexone (Rate 3) ♦ Methadone (Rate 5)	NCQA	Administrative

Findings and Conclusions—PBM

ORx was fully compliant with Qsource's claims data system findings, eligibility data system findings, and data integration findings. Based on all validation activities, Qsource determined the two **ORx** measures met the Adult Core Set technical specifications, and no issues were identified.

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

Table 21. HEDIS MY2022 PMV Measure Rates—PBM	
Measure	**Rate (%)**
Concurrent Use of Opioids and Benzodiazepines-AD: 18-64 years	100%
Use of Pharmacotherapy for Opioid Use Disorder-AD: 18-64 years	
Buprenorphine	92.86%
Oral naltrexone	0.32%
Long-acting, injectable naltrexone	3.08%
Methadone	0.00%
Total	**94.45%**

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 95.00%. 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 99.50%. 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, electronic data interchange (EDI) 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 972,697 in MY2022. This represents a slight –0.26% drop in members compared to the combined member totals for MY2021 of 975,273. 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; and
- 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 2023 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 2023.

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.

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

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.)

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 2023 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 *2023 PIP Validation Technical Papers* as well as the *2023 PIP Validation Summary Report*.

Comparative Findings

TennCare plans achieved a Met validation status for all PIPs submitted in 2022. Of the 28 PIPs validated, 17 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]; Remeasurement 6 [R6]) and classification as clinical (C) or non-clinical (NC).

Table 23. 2023 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 Statewide	R2	C	43/49	87.76%	**Met**
Increase Eye Exam Screening Rates for Members with Diabetes	R2	NC	49/49	100%	**Met**

Table 23. 2023 PIP Validation Results

PIP Study Title	PIP Year	C/NC	Element Scores		Overall PIP Validation Status
			# Met/ Assessed	%	
Increase Statewide the Percentage of Members with Documented LTSS Reassessment and Care Plan Update	R1	NC	44/45	97.78%	**Met**
Increase Well Child Visit (WCV) HEDIS Rate in West TN Region	R1	C	42/43	97.67%	**Met**
Improve the Percentage of Adult Members Adherence to Antidepressant Medication Statewide	B	C	28/28	100%	**Met**
Reducing ER Visits by Increasing the Number of Members with Completed SDOH Assessments and Closed Loop Referrals to Community Based Organization	B	NC	28/28	100%	**Met**
BlueCare					
Long-Term Services and Supports Reassessment/Care Plan Update After Inpatient Discharge (RAC)	R1	NC	44/44	100%	**Met**
Improving HbA1c Control (<8.0%) for Members with Diabetes	B	C	29/29	100%	**Met**
Improving Postpartum Care Rates	B	NC	29/29	100%	**Met**
Decreasing Behavioral Health Readmissions	B	C	30/30	100%	**Met**
Improving Childhood and Adolescents Immunization Rates (CIS/IMA)	R3	C	44/44	100%	**Met**
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	R6	NC	43/43	100%	**Met**
TennCare*Select*					
Improving Comprehensive Diabetes Care (Blood Pressure Control for SelectCommunity)	R3	NC	45/45	100%	**Met**
Improving HbA1c Control (<8.0%) for Members with Diabetes	B	NC	29/29	100%	**Met**
Decreasing Behavioral Health Readmissions	B	C	27/30	90.00%	**Met**
Improving Postpartum Care Rates	B	NC	29/29	100%	**Met**
Improving Childhood and Adolescents Immunization Rates (CIS/IMA)	R3	C	45/45	100%	**Met**
Improving Early Periodic Screening Diagnosis & Treatment (EPSDT)	R6	NC	41/41	100%	**Met**
United Healthcare					
Increasing the Screening Rates of Child and Adolescent Well-Care Visits (WCV)	R2	C	43/44	97.73%	**Met**
Digital Outreach Consent	B	NC	27/27	100%	**Met**
Follow-Up After ED Visit for Mental Illness 7-Day	B	C	27/29	93.10%	**Met**

Table 23. 2023 PIP Validation Results					
PIP Study Title	**PIP Year**	**C/NC**	**Element Scores**		**Overall PIP Validation Status**
			# Met/ Assessed	**%**	
Impact of Member and Provider Outreach on Immunization Rates for CIS Combo 10	R4	C	48/48	100%	**Met**
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	R1	NC	39/44	88.64%	**Met**
Social Determinants of Health	B	NC	26/28	92.86%	**Met**
DentaQuest					
Increasing Provider Use of Silver Diamine Fluoride (SDF) as a Preventive Measure	R5	C	47/48	97.92%	**Met**
Decreasing TennCare Enrollees Receiving Opioid Prescriptions	R5	NC	46/46	100%	**Met**
OptumRx					
Schizophrenia Medication Compliance Improvement Plan	B	C	23/26	88.46%	**Met**
Usage of Diagnosis Code Override by Providers for Preferred Atypical Antipsychotics	R2	NC	*38/44*	86.36%	**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. 2023 PIP Validation Strengths and AONs		
Amerigroup		
Q/A/T	**Strengths**	
A	*Improve Childhood Immunization Status (CIS) Combination 10 Rates Statewide*	**Step 6.** The MCO included a comprehensive presentation that thoroughly detailed guidelines used by staff for data abstraction during medical record reviews.

Table 24. 2023 PIP Validation Strengths and AONs

Q	*Improve the Percentage of Adult Members Adherence to Antidepressant Medication Statewide*	**Step 3.** The MCO demonstrated exemplary attention to detail within the description of the PIP population to include specific characteristics and clear definitions of eligibility terminology.
		Step 5. The MCO included a detailed description of the numerator and denominator used to calculate the performance measure and demonstrated an exemplary assessment of an important aspect of care that will make a difference in members' mental health status.
A	*Increase Eye Exam Screening Rates for Members with Diabetes*	**Step 6.** The MCO exceptionally detailed guidelines developed for data abstraction staff used in medical record reviews.
Q/A/T		**AONs**
A	*Improve Childhood Immunization Status (CIS) Combination 10 Rates Statewide*	**Step 7.** The MCO should include a discussion of lessons learned about less-than-optimal results achieved for performance measures.
		Step 8. The MCO should address the cultural and linguistic appropriateness for member-facing improvement strategies. The MCO should acknowledge the presence or lack of major confounding factors (barriers) that could have an obvious impact on PIP outcomes (e.g., patient risk factors, provider education, or clinic policies). The MCO should objectively evaluate the success of interventions in terms of overall improvement toward the PIP's goals.
		Step 9. The MCO should include a discussion of quantitative evidence that details any process improvements for the PIP. The MCO should include a discussion of whether sustained improvement was demonstrated through repeated measurements.
A	*Increase Statewide the Percentage of Members with Documented LTSS Reassessment and Care Plan Update*	**Step 9.** The MCO should include a discussion of how improvements in performance are likely to be a result of the selected improvement strategies
A	*Increase Well Child Visits in West TN Region*	**Step 7.** The MCO should include a discussion of lessons learned about less-than-optimal performance evidenced during data analysis
		BlueCare
Q/A/T		**Strengths**
A	*Decreasing Behavioral Health Readmissions*	**Step 1.** The MCO exceptionally demonstrated how the PIP topic was selected through comprehensive statewide and regional analysis of TennCare member needs, care, and services that was supported by extensive research of Behavioral Health Readmission catalysts.
Q/A/T		**AONs**
Qsource identified no AONs for BC in 2023.		
		TennCare*Select*
Q/A/T		**Strengths**
A	*Decreasing Behavioral Health Readmissions*	**Step 1.** The MCO provided a comprehensive analysis of the PIP topic including extensive research, references, graphs, and data that was clearly explained.
Q	*Improving Postpartum Care Rates*	**Step 1.** The MCO provided numerous statistics, graphs, and research to support the PIP topic and emphasize the importance of this measure.

Table 24. 2023 PIP Validation Strengths and AONs

Q/A/T		AONs
A	*Decreasing Behavioral Health Readmissions*	**Step 2.** The aim statement should clarify members vs. discharges and admissions vs. readmissions to ensure alignment with the performance measures, variable, and data elements that are collected. This would clearly set the focus on the number of readmissions, as a member could be readmitted more than once during the measurement period. The numerator and denominator defined in Step 6 also suggest that what is being measured is the number of discharges (denominator) that resulted in a readmission (numerator) for the specified population. The MCO should ensure the PIP aim statement is clear, sets the framework for data collection and analysis, and that it is answerable, measurable, and clearly specifies the PIP population.
		Step 5. The MCO should clearly and accurately specify the performance measure and variable for this PIP.
		Step 6. The MCO should ensure the data elements for this PIP are clearly and appropriately noted.
UnitedHealthcare		
Q/A/T		**Strengths**
Qsource identified no strengths for UHC in 2023.		
Q/A/T		**AONs**
T	*Follow-Up after ED Visit for Mental Illness 7-Day*	**Step 5.** The MCO should ensure that the variable is clearly and accurately defined.
		Step 6. The MCO should ensure that the data collection plan aligns with or connects to the data analysis plan by enhancing the data analysis description.
A	*Increasing the Screening Rates of Child and Adolescent Well Care Visits (WCV)*	**Step 2.** The MCO should ensure the general improvement strategy described in the aim statement and implemented in Step 8 are clear. The MCO should modify the aim statement to clarify the focus of the incentives.
Q	*Social Determinants of Health*	**Step 2.** The MCO should refine the aim statement specific to the general improvement strategy to improve clarity and understanding. The MCO should ensure that their aim statement is answerable.
T	*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 1.** The MCO should address if the PIP topic considered input from members or providers who are users of, or concerned with, the specific service area.
		Step 5. The MCO should ensure that the variables for Performance Measures 1 and 2 are clearly and appropriately defined and are not reflected as “the number of members” as a member can appear more than once in the sample.
		Step 7. The MCO should address factors that threaten internal or external validity of findings or state that there are no identified factors.

Table 24. 2023 PIP Validation Strengths and AONs		
		Step 8. The MCO should include existing evidence which supports that the improvement strategy or test of change would be likely to lead to the desired improvement (evidence that suggests creation of the coordinator score card would likely lead to the desired improvement). The MCO should address if barrier analysis was conducted.
DentaQuest		
Q/A/T	**Strengths**	
Qsource identified no strengths for UHC in 2023.		
Q/A/T	**AONs**	
A	*Increasing Provider Use of Silver Diamine Fluoride (SDF) as a Preventative Measure*	**Step 6.** The DBM should include a clear and concise definition of the specific data elements collected for analysis.
OptumRx		
Q/A/T	**Strengths**	
Qsource identified no strengths for ORx in 2023.		
Q/A/T	**AONs**	
Q	*Schizophrenia Medication Compliance Improvement Program*	**Step 2.** The PBM should restate the aim statement to ensure that it is clear and concise.
		Step 5. The PBM should clearly address how the performance measures inform the selection and evaluation of quality improvement strategies. The PBM should address if existing measures were considered during performance measure selection or provide a rationale if an existing measure is not selected.
A	*Usage of Diagnosis Code Override by Providers for Preferred Atypical Antipsychotics*	**Step 7.** The PBM should include a discussion assessing the statistical significance of any differences between baseline and repeat measurements. The PBM should identify any factors that may influence comparability of initial and repeat measurements; if none are identified, analysis should include a statement that no factors influenced comparability. The PBM should identify factors that threaten internal or external validity of the findings. If none are identified, this should be stated.
		Step 8. The PBM should describe the evidence base for the educational intervention. The PBM should address causes/barriers identified through data analysis and quality improvement processes. The PBM should include documentation identifying how the improvement strategy accounts for major confounding variables that could make an impact on outcomes.

Improvements Since the 2022 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, MCCs made improvements to AONs identified in six study topics, as outlined in **Table 25**.

Table 25. 2023 PIP Validation: Improvements Since the 2022 PIP Validation

PIP Topic	2022 AON	2023 Improvements
Increase Statewide the Percent of Members with Documented LTSS Reassessment and Care Plan Update, Including Nine Core Elements, Within 30 Days of Inpatient Discharge	**Step 5: Element 5—AG** 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—AG** should clearly specify the data elements to be collected for each performance measure.	**AG** addressed the AON in terms of performance measure selection and addressing all components of Step 5, Element 5. **The CAP satisfied the AON.** **AG** stated that HEDIS Technical Specifications were used to determine data elements to be collected. The HEDIS Technical Specifications noted the information needed to establish the numerator and denominator necessary to obtain the rates for this measure. **The CAP satisfied the AON.**
Improve Childhood Immunization Status (CIS) Combination 10 Rates—East, Middle, and West Regions	**Step 7: Element 4—AG** should specifically identify any factors that may influence comparability of the 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.	**AG** addressed the AON by revising the verbiage used to include the information required. In addition, **AG** included verbiage to clarify if there were no factors that affected their ability to make comparisons. **The CAP satisfied the AON.**
Decreasing Plan All-Cause Readmissions	**Step 8: Element 2—TCS** should ensure that the barrier analysis aligns with the improvement strategies selected.	**TCS** provided a sample fishbone diagram tool that included the necessary components. Staff education was provided that addressed alignment of the improvement strategies with the identified barriers. **The CAP satisfied the AON.**
Social Determinants of Health Data Collection Process	**Step 8: Element 5—TCS** should address how improvement strategies were designed/modified to account for major confounding variables that could impact PIP outcomes.	**TCS** addressed the identified CAP by providing education to relevant staff and submitting its training roster. **The CAP satisfied the AON.**
LTSS HEDIS Process Improvement for Reassessment and Care Plan Updates within 30 Days After Inpatient Discharge for LTSS Eligible Populations	**Step 2: Element 1—UHC** should ensure that the PIP improvement strategy is clear and easily interpreted and specify if the strategy is member- or provider-focused.	**UHC** updated its PIP Summary Form and stated that training focused on building a clear and concise aim statement would be provided to the team member responsible for the PIP. **The CAP satisfied the AON.**
Usage of Diagnosis Code Override by Providers for Preferred Atypical Antipsychotics	**Step 5: Element 5—ORx** should address how the performance of the selected measure informs the selection and evaluation of quality improvement strategies. **Step 8: Element 1—ORx** should describe how the improvement strategies are evidence-based.	**ORx** revised its PIP Summary Form to include details regarding how the performance of the quality measure was addressed at a point in time, tracked over time, and informed the selection and evaluation of the quality improvement strategies. **ORx** modified its performance measure's data collection timeframe from an annual to semi-annual basis. The revised PIP Summary Form also included discussion regarding how the improvement strategy related to provider education was modified based on the outcome of measure performance. **The CAP satisfied the AON.**

Table 25. 2023 PIP Validation: Improvements Since the 2022 PIP Validation

PIP Topic	2022 AON	2023 Improvements
	Step 8: Element 2—ORx should address any causes or barriers identified through data analysis and quality improvement process. **Step 8: Element 3—ORx** should document the implementation of the improvement strategy for each step in the PDSA process. **Step 8: Element 6—ORx** should include a detailed discussion of the success of the improvement strategy and follow-up activities identified.	**ORx**'s revised PIP Summary Form included details regarding their inability to locate evidence-based resources prior to improvement strategy development. Qsource recommends that the PBM consider use of evidence-based resources during future improvement strategy development. **The CAP satisfied the AON.** **ORx**'s revised PIP Summary Form included details regarding the PBM's assumed barrier associated with improvement strategy development. Qsource recommends that the PBM conduct barrier analysis prior to initial improvement strategy development to ensure that the effectiveness of the improvement strategy directly correlates to barriers identified during the initial phase of performance improvement activities. **The CAP satisfied the AON.** **ORx**'s revised PIP Summary Form included PBM-defined activities conducted during each step of the PDSA cycle of improvement strategy implementation. The measurement years relating to some of the steps of the PDSA cycle were not clearly defined. Qsource recommends that the PBM more clearly define the measurement year that correlates with the detailed activities performed during each step of the PDSA cycle in subsequent PIP submissions. **The CAP satisfied the AON.** **ORx**'s revised PIP Summary Form explained how the improvement strategy impacted the performance outcomes from the baseline year to the remeasurement year. As mentioned in the previous CAP, *the PBM* defined activities conducted during each step of the PDSA cycle of improvement strategy implementation. However, the measurement years relating to some of the steps were not clearly defined. Qsource suggests that the PBM more clearly define the measurement years for all steps included in the PDSA cycle discussion in subsequent PIP submissions. **The CAP satisfied the AON.**

For the 2023 PIP validation, TennCare required MCCs to submit a CAP for any AONs via a similar evaluation and monitoring process to the AQS CAP process. Eleven PIP topics received at least one AON and required CAPs in 2023; the results of these CAP evaluations will be reported next year.

Summary and Conclusions

The results of 2023 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, PMV, 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 2023 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 2022 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. 2023 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 97.7%.
	Q/A/T	**AQS**	**AG** earned 100% compliance with all QP standards except BESMART Program (90.90%). **AG** earned 100% in all Credentialing and Recredentialing File Reviews except credentialing quantity (69.23%) and recredentialing quality (79.63%). **AG** earned 100% in all PA file reviews except Transition of CHOICES Members Between MCOs, for which it earned 93.55%.
	Q	**PMV**	**AG** passed the 2023 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**	All six PIPs for **AG** earned a Met status. Three of six PIPs received a 100% element score this year.
Recommendations	**A/T**	**ANA Review**	Benefit Delivery: **AG** should inform providers about the vision benefits for CoverKids mothers of eligible unborn children; **AG** should inform providers about the DME benefits for CoverKids; **AG** should inform providers about the medical supplies benefits for CoverKids. Network Adequacy: **AG** should ensure that female members older than 13 years of age have access to an OB/GYN within the distance/time standards; **AG** should ensure that all members have access to optometry providers within the TennCare required distance/time standards; **AG** should ensure that all members have access to hospitals within the TennCare required distance/time standards; **AG** should ensure that all participating providers have an executed provider contract.
	Q/A/T	**AQS**	**AG** could ensure that nondiscrimination training is made available, on an annual basis, to all subcontractors that are recipients of federal financial assistance.

Table 26. 2023 Results, Recommendations, and Strengths by Plan			
	Q	**PMV**	No recommendations for improvement were identified.
	Q	**PIP Validation**	For improvements, **AG** should include a discussion of lessons learned about less-than-optimal results achieved for performance measures; **AG** should address the cultural and linguistic appropriateness for member-facing improvement strategies; **AG** should acknowledge the presence or lack of major confounding factors (barriers) that could have an obvious impact on PIP outcomes (e.g., patient risk factors, provider education, or clinic policies); **AG** should objectively evaluate the success of interventions in terms of overall improvement toward the PIP's goals; **AG** should include a discussion of quantitative evidence that details any process improvements for the PIP; **AG** should include a discussion of whether sustained improvement was demonstrated through repeated measurements. Finally, **AG** should include a discussion of how improvements in performance are likely to be a result of the selected improvement strategies.
Strengths & Improvements	**A/T**	**ANA Review**	No particular strengths or improvements were identified.
	Q/A/T	**AQS**	No particular strengths were identified. Since the previous AQS, **AG** indicated that TennCare had already identified provider network deficiencies and that it completed a TennCare-required CAP. In addition, through the Annual Network Adequacy evaluation, the Tennessee Department of Commerce and Insurance evaluated compliance with network contracting requirements. **AG** provided a draft P&P, Disenrollment Requests–TN to address the identified AON and specified a completion date of 8/1/22. **AG** should ensure that this policy is communicated to the relevant staff. Qsource verified that the P&P was created and distributed as planned. **AG** provided staff training related to the identified AON and updated its P&P. During the 2023 AQS, Qsource verified that the training had occurred. **AG** provided staff training related to the identified AON and updated its P&P. During the 2023 AQS, Qsource verified that the training had occurred.
	Q	**PMV**	No particular strengths or improvements were identified.
	Q	**PIP Validation**	**AG** was praised for including a comprehensive presentation that thoroughly detailed guidelines used by staff for data abstraction during medical record reviews, demonstrating exemplary attention to detail within the description of the PIP population to include specific characteristics and clear definitions of eligibility terminology. Additionally, **AG** was lauded for including a detailed description of the numerator and denominator used to calculate the performance measure, demonstrating an exemplary assessment of an important aspect of care that will make a difference in members' mental health status, and for developing exceptionally detailed guidelines for data abstraction staff used in medical record reviews. Since the previous PIP Validation, **AG** addressed the AON in terms of performance measure selection and addressing all components of Step 5, Element 5. **AG** stated that HEDIS Technical Specifications were used to determine data elements to be collected. The HEDIS Technical Specifications noted the information needed to establish the numerator and denominator necessary to obtain the rates for this measure. **AG** addressed the AON by revising the verbiage used to include the information required. In addition, AG included verbiage to clarify if there were no factors that affected their ability to make comparisons. The CAPs satisfied the AONs.
			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. **BC** earned 100% compliance with all Credentialing and Recredentialing file reviews. **BC** earned 100% compliance for all PA file reviews except UM Denials (97.87%) and Appeals (97.50%).
	Q	**PMV**	**BC** passed the 2023 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**	All six PIPs for **BC** earned a Met status. Six of six PIPs received a 100% element score this year.

Table 26. 2023 Results, Recommendations, and Strengths by Plan			
Recommendations	**A/T**	**ANA Review**	Network Adequacy: **BC** should ensure that all members have access to hospitals within the TennCare required distance/time standards. **BC** should ensure that all CHOICES members have access to adult day care providers within the TennCare required distance/time standards. **BC** should ensure that all CHOICES members have access to at least two inpatient respite care providers in each TennCare required county. Members in Bedford County did not have access to at least two inpatient respite care providers.
	Q/A/T	**AQS**	No recommendations for improvement were identified.
	Q	**PMV**	No recommendations for improvement were identified.
	Q	**PIP Validation**	No 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, informing members about specific requirements for coverage of occupational, physical, and speech therapy services on the BC website, informing members about the requirements for coverage of chiropractic services on the BC website, including additional information concerning required benefits and coverage not included in the current member handbooks on its member website, and finally, including additional information concerning required benefits and coverage not included in the current member handbooks on its member website.
	Q/A/T	**AQS**	**BC** was commended for providing exceptionally thorough support of new members in regard to first contact. Since the previous AQS, **BC** provided a satisfactory CAP, within which it addressed the identified AON with a plan to develop a P&P which was submitted to TennCare for approval. Upon TennCare approval, **BC** planned to present the P&P to its Quality Leadership Council Committee for approval and subsequent publication. **BC** ensured that this policy would be communicated to the relevant staff. During the AQS, Qsource confirmed completion of the presentation to the Quality Leadership Council Committee, including its publication and distribution to staff. **BC** provided a satisfactory CAP, which included staff training, monthly chart audits to monitor timeliness, accuracy and compliance, and detailed use of its Coordinator Dashboard and Daily Jumpstart compliance monitoring tools to ensure that CHOICES LOC reassessments were completed timely. Qsource verified completion of the training and use of the chart audits throughout the year. **BC** was able to demonstrate use of its Coordinator Dashboard and Daily Jumpstart during the year.
	Q	**PMV**	No particular strengths or improvements were identified.
	Q	**PIP Validation**	**BC** was praised for an exceptional demonstration of how PIP topics were selected through comprehensive statewide and regional analysis of TennCare member needs, care, and services that was supported by extensive research of applicable catalysts.
TennCare*Select*			
Results	**A/T**	**ANA Review**	**TCS** earned an overall Network Adequacy score of >99.9% and an overall Benefit Delivery score of 100%.
	Q/A/T	**AQS**	**TCS** achieved 100% compliance with all QP standards. **TCS** earned 100% compliance for all applicable PA file reviews, except for Grievances, for which it earned 85.00%.
	Q	**PMV**	**TCS** (reported with **BC** results) passed the 2023 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**	All six PIPs for **TCS** earned a Met status. Five of six PIPs received a 100% element score this year.
Recommendations	**A/T**	**ANA Review**	Network Adequacy: **TCS** should ensure that all members have access to hospitals within the TennCare required distance/time standards.

Table 26. 2023 Results, Recommendations, and Strengths by Plan			
	Q/A/T	AQS	For improvement, **TCS** should ensure timely completion of member grievances.
	Q	PMV	No recommendations for improvement were identified.
	Q	PIP Validation	**TCS** should clarify in the aim statement members vs discharges and admissions vs readmissions to ensure alignment with the performance measures, variable, and data elements that are collected. This would clearly set the focus on the number of readmissions, as a member could be readmitted more than once during the measurement period. The numerator and denominator defined in Step 6 also suggest that what is being measured is the number of discharges (denominator) that resulted in a readmission (numerator) for the specified population. **TCS** should ensure the PIP aim statement is clear, sets the framework for data collection and analysis, and that it is answerable, measurable, and clearly specifies the PIP population. **TCS** should clearly and accurately specify the performance measure and variable for this PIP. **TCS** should ensure the data elements for this PIP are clearly and appropriately noted.
Strengths & Improvements	A/T	ANA Review	*As **TCS** is administered by **BC**, its strengths are the same.*
	Q/A/T	AQS	**TCS** was praised for providing exceptionally thorough support of new members in regard to first contact. During the welcome call, Member Education Health Navigator confirms receipt of the mailed materials and personally educates members about their benefits, preventive services, Nurseline, and its website. Since the previous AQS, **TCS** provided a satisfactory CAP, within which it addressed the identified AON with a plan to develop a P&P which was submitted to TennCare for approval. Upon TennCare approval, **TCS** planned to present the P&P to its Quality Leadership Council Committee for approval and subsequent publication. The MCO ensured that this policy would be communicated to the relevant staff. During the AQS, Qsource confirmed completion of the presentation to the Quality Leadership Council Committee, including its publication and distribution to staff.
	Q	PMV	No particular strengths or improvements were identified.
	Q	PIP Validation	**TCS** was lauded for providing numerous statistics, graphs, and research to support the PIP topic and emphasize the importance of this measure. **TCS** was also praised for providing a comprehensive analysis of the PIP topic including extensive research, references, graphs, and data that was clearly explained. Since the previous PIP Validation, **TCS** provided a sample fishbone diagram tool that included the necessary components. Staff education was provided that addressed alignment of the improvement strategies with the identified barriers. The CAP satisfied the AON. **TCS** addressed the identified CAP by providing education to relevant staff and submitting its training roster. The CAP satisfied the AON.
UnitedHealthcare			
Results	A/T	ANA Review	**UHC** earned an overall Network Adequacy score of 100% and an overall Benefit Delivery score of >99.9%.
	Q/A/T	AQS	**UHC** earned 100% compliance with all QP standards except BESMART Program (90.90%). **UHC** earned a 100% with all CHOICES credentialing and recredentialing file reviews except recredentialing quality (75.90%). **UHC** earned 100% in all PA file reviews except UM Denials (97.87%) and CHOICES Annual LOC Assessment (95.00%).
	Q	PMV	**UHC** passed the 2023 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	All six PIPs for **UHC** earned a Met status. Two of six PIPs received a 100% element score this year.
Recommendations	A/T	ANA Review	Network Adequacy: For improvement, **UHC** should ensure that female members older than 13 years of age have access to an OB/GYN within the distance/time standards; **UHC** should ensure that all members have access to substance abuse outpatient treatment services within the TennCare required distance/time standards; **UHC** should ensure that all members have access to hospitals within the TennCare required distance/time standards; and **UHC** should ensure that all members

Table 26. 2023 Results, Recommendations, and Strengths by Plan			
			have access to adult day care providers within the TennCare required distance/time standards.
	Q/A/T	**AQS**	**UHC** could consider adding the specific chart review requirements to its P&P or specifically reference the TennCare BESMART Quality Review Process Specifications Guide which includes this information in its P&P; **UHC** could consider adding the specific requirements that allow for skipping a provider from the Quality Reviews for a year to its P&P or specifically reference the TennCare BESMART Quality Review Process Specifications Guide in its P&P; **UHC** could consider adding documentation to its P&P regarding notification to TennCare if or when the remediation scale/plan changes or specifically reference the TennCare BESMART Quality Review Process Specifications Guide in its P&P.
	Q	**PMV**	No deficiencies or recommendations for improvement were identified.
	Q	**PIP Validation**	For improvements, **UHC** should ensure that the variable is clearly and accurately defined; **UHC** should ensure that the data collection plan aligns with or connects to the data analysis plan by enhancing the data analysis description. **UHC** should ensure the general improvement strategy described in the aim statement and implemented in Step 8 are clear; **UHC** should modify the aim statement to clarify the focus of the incentives. **UHC** should refine the aim statement specific to the general improvement strategy to improve clarity and understanding. **UHC** should address if the PIP topic considered input from members or providers who are users of, or concerned with, the specific service area; **UHC** should ensure that the variables for Performance Measures 1 and 2 are clearly and appropriately defined and are not reflected as "the number of members" as a member can appear more than once in the sample; **UHC** should address factors that threaten internal or external validity of findings or state that there are no identified factors; **UHC** should include existing evidence which supports that the improvement strategy or test of change would be likely to lead to the desired improvement (evidence that suggests creation of the coordinator score card would likely lead to the desired improvement); **UHC** should address if barrier analysis was conducted.
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 was made available to all members on the **UHC** member website. New members were informed about the **UHC** Member Handbook and the Member Handbook Addendum upon enrollment.
	Q/A/T	**AQS**	No particular strengths were identified. Since the previous AQS, **UHC** addressed AONs and provided its plan and targeted completion date. **UHC** indicated that an alternative plan for the current requirement would be developed and submitted to TennCare for review by 10/1/22. Qsource verified that this plan was submitted and accepted; The policy submitted for AONs addressed the requirement that **UHC** should have 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** included the timeframe and the employees responsible to implement the policy. During the 2023 AQS, Qsource verified that this policy was put into place. The policy submitted for AONs addressed the requirement to ensure that **UHC** has a policy that does not request disenrollment for any member for any reason. **UHC** informs TennCare if it believes that a member satisfies the conditions for termination as described in TennCare rules and regulations. The SOP submitted for AONs addressed the requirement to 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** included the timeframe and the employees responsible to implement the policy. The change in procedure for AONs addressed the requirement to 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 provided the presentation material, and included the timeframe and the employees responsible to implement the procedure. **UHC** outlined actions to address AONs, which included the establishment of a timeframe for member contact prior to the due date for member reassessment, staff re-education, and compliance monitoring. **UHC** identified the cause of the untimely assessment and summarized actions that included an enhanced intake report that identified changes to the enrollment and eligibility dates, revisions to its current job aid, and staff training. **UHC**

Table 26. 2023 Results, Recommendations, and Strengths by Plan			
			identified the cause of some AONs as human error and explained that the process for credentialing and recredentialing for Tennessee was transitioned from its analyst's desk to its National Credentialing Center on 3/1/21. **UHC** confirmed knowledge and awareness of the process with the National Credentialing Center. **UHC** described the root cause for the identified AON and established interventions to address the concern. Qsource verified that these actions were fulfilled and satisfied the CAP. **UHC** could consider adding a time frame to its new policy regarding distribution of regulatory guidance and should ensure its process for validation of provider Medicare/Medicaid participation is tracked and stable. During the 2023 AQS, Qsource verified that this policy was put into place.
	Q	**PMV**	No particular strengths or improvements were identified.
	Q	**PIP Validation**	No particular strengths were identified. Since the previous PIP Validation, **UHC** updated its PIP Summary Form and stated that training focused on building a clear and concise aim statement would be provided to the team member responsible for the PIP. The CAP satisfied the AON.
			DentaQuest
Results	**A/T**	**ANA Review**	**DQ** earned an overall Network Adequacy score of 99.9% and an overall Benefit Delivery score of 96.8%.
	Q/A/T	**AQS**	**DQ** earned 100% compliance with all QP standards except Assurances of Adequate Capacity and Services (50.00%). **DQ** earned 100% on all PA file reviews except Grievances (92.50%).
	Q	**PMV**	**DQ** was fully compliant with Qsource's findings for claims data system, eligibility data system, and data integration.
	Q	**PIP Validation**	Both PIPs for **DQ** earned a Met status. One PIP received a 100% element score this year.
Recommendations	**A/T**	**ANA Review**	Network Adequacy: For improvement, **DQ** should ensure that all ECF CHOICES members have access to ECF CHOICES dental providers within the distance/time standards; **DQ** should ensure that all non-ECF CHOICES members have access to oral surgeons within the distance/time standards; **DQ** should ensure that all non-ECF CHOICES members have access to orthodontists within the distance/time standards; **DQ** should ensure that all contracts have been signed and dated by **DQ** and the provider; **DQ** should ensure that each participating provider has an executed provider contract; and **DQ** should 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** could include the criteria for prevention of duplication in the care management policy. The information to meet element criteria was found in several documents; **DQ** could add additional language that describes the role of TennCare and **DQ** regarding Timing of notice; **DQ** could consider adding in language that clearly indicates how the notice to members is a TennCare function and not **DQ**; **DQ** could ensure that its P&P includes each of the elements or steps noted in the criteria, including the first four criteria.
	Q	**PMV**	No recommendations for improvement were identified.
	Q	**PIP Validation**	For improvement, **DQ** should include a clear and concise definition of the specific data elements collected for analysis.
Strengths & Improvements	**A/T**	**ANA Review**	**DQ** was commended for including benefits and coverage information not listed in the approved member handbooks on its member website; and developing a training document and FAQ document explaining benefits not described in the provider manual.
	Q/A/T	**AQS**	No particular strengths were noted. Since the previous AQS, **DQ**'s CAP addressed the identified AON and included updating an existing and related policy, obtaining a review and formal approval, and publishing it to its policy database. **DQ** should ensure that relevant staff are

Table 26. 2023 Results, Recommendations, and Strengths by Plan

			aware of the updated policy. The updated policy was reviewed. **DQ**'s CAP addressed the identified AON with actions that included updating an existing policy, obtaining a review and formal approval, and publishing it to its policy database. **DQ** should ensure that relevant staff are aware of the updated policy. The updated policy was reviewed. **DQ**'s CAP addressed the identified AON with actions that included updating an existing policy, obtaining a review and formal approval, and publishing it to its policy database. **DQ** should ensure that relevant staff are aware of the updated policy. The updated policy was reviewed. **DQ** outlined actions to address the identified AON, which included a review of helpline calls and agent coaching on proper interpreter services processes. **DQ** provided clarifying information regarding updates to its Knowledge Database that distinguished between those language support services provided by internal agents and those interpreter services provided by an external interpreter. Monitoring was conducted to ensure resolution, however, during the 2023 audit **DQ** could not provide its random auditing or a summary of its audit of recorded calls.
	Q	**PMV**	No particular strengths or improvements were identified.
	Q	**PIP Validation**	No particular strengths or improvements were identified.
OptumRx			
Results	**A/T**	**ANA Review**	**ORx** earned an overall Network Adequacy score of 100% and an overall Appointment Availability & Member Complaint score of >99.9%.
	Q/A/T	**AQS**	**ORx** earned 100% compliance with all QP standards except Coverage and Authorization of Services (93.75%), Grievance and Appeal Systems (70.45%), QAPI Program (90.00%), and Non-Discrimination Compliance (87.50%).
	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**	Both PIPs for **ORx** earned a Met status.
Recommendations	**A/T**	**ANA Review**	No deficiencies or recommendations for improvement were identified.
	Q/A/T	**AQS**	**ORx** could specify within its P&P how the notice is to be provided (telephone/written) to align with the notification requirements; **ORx** could have an appeals P&P with the integrated process documenting **ORx**'s responsibility in the appeal process; **ORx** could have an appeals P&P with the integrated process documenting **ORx**'s responsibility in the appeal process; **ORx** could add in a subordinate along with previous reviewer; **ORx** could document in the P&P how the record is accurately maintained in a manner accessible to TennCare and available upon request to CMS; **ORx** could have an appeals P&P with the integrated process documenting **ORx**'s responsibility in the appeal process; **ORx** could describe how its QAPI program formally measures and tracks the services furnished to its members to ensure quality and appropriate utilization; **ORx** could consider formalizing its processes for monitoring and detecting under- and over-utilization; **ORx** could consider developing a policy and/or procedure for Project Improvement Plan (PIP) development to ensure each PIP includes performance measurement, intervention implementation and evaluation of effectiveness, and activities for sustaining improvements; **ORx** could consider creating a policy that specifically addresses the criteria for this element.
	Q	**PMV**	No recommendations for improvement were identified.
	Q	**PIP Validation**	For improvements, **ORx** should restate the aim statement to ensure that it is clear and concise; **ORx** should clearly address how the performance measures inform the selection and evaluation of quality improvement strategies; **ORx** should address if existing measures were considered during performance measure selection or provide a rationale if an existing measure is not selected. **ORx** should include a discussion assessing the statistical significance of any differences between baseline and repeat measurements; **ORx** should identify any factors that may influence comparability of initial and repeat measurements; if none are identified, analysis should include a statement that no factors influenced comparability; **ORx** should identify factors that threaten internal or external validity of the findings. If none are identified, this should be stated; **ORx** should

Table 26. 2023 Results, Recommendations, and Strengths by Plan			
			describe the evidence base for the educational intervention; **ORx** should address causes/barriers identified through data analysis and quality improvement processes; **ORx** should include documentation identifying how the improvement strategy accounts for major confounding variables that could make an impact on outcomes.
Strengths & Improvements	**A/T**	**ANA Review**	No particular strengths, nor AONs were identified for **ORx**.
	Q/A/T	**AQS**	No particular strengths were identified. Since the previous AQS, **ORx** submitted a policy for AONs addressing the requirement that a policy or procedure should be in place that documents how the coordination of payment for out-of-network services occur. **ORx** included the timeframe and the responsible parties to implement the policy. When this element was discussed, **ORx** provided the provider enrollment document as evidence. The policy submitted for AONs addressed the requirement that a policy or procedure should be in place that documents how the coordination of payment for out-of-network services occur. **ORx** included the timeframe and the responsible parties to implement the policy. The documentation submitted for AONs was to develop a policy and procedure that detailed when and how its provider network is maintained as well as their monthly reporting to TennCare. **ORx** included the timeframe and the responsible parties to implement the policy. **ORx** updated its Pharmacy Benefits Management Provider Enrollment Process. The procedure included documentation related to network maintenance and TennCare reporting requirements. It also specified that its Provider Directory is updated in real time. The documentation submitted for AONs was to have a P&P in place to ensure consistent application of review criteria for authorization decisions. **ORx** included the timeframe and the responsible parties to implement the policy. **ORx** provided a follow-up CAP response that included all criteria for Element 9 of the Annual Quality Survey standard, “Coverage and Authorization”. An **ORx** document titled TennCare FFS (Fee-for-Service), Medicaid, and CoverKids Member Rights was received and included the specified member rights criteria. The documentation submitted for AONs was to have a P&P in place to ensure those who make decisions should neither be involved in any previous level of review nor decision making. **ORx** included the timeframe and the responsible parties to implement the policy. The documentation submitted for AONs was to have a P&P in place to ensure no punitive action was given to providers who request an expedited resolution. **ORx** included the timeframe and the responsible parties to implement the policy. The documentation submitted for AONs was to have a P&P in place that describes the process **ORx** takes if it reverses a decision to deny, limit, or delay services and the services were not furnished. **ORx** included the timeframe and the responsible parties to implement the policy. The documentation submitted for this AON showed that **ORx** updated the policy to reflect that neither **ORx** nor TennCare pay for services furnished during a pending appeal unless the decision to deny is reversed and the member requests coordination of benefits and is approved by TennCare for this service. **ORx** included the timeframe and the responsible parties to implement the policy.
	Q	**PMV**	No particular strengths or improvements were identified.
	Q	**PIP Validation**	No particular strengths were identified. Since the previous PIP Validation, **ORx** informed the selection and evaluation of the quality improvement strategies. **ORx** modified its performance measure’s data collection timeframe from an annual to semi-annual basis. The revised PIP Summary Form also included discussion regarding how the improvement strategy related to provider education was modified based on the outcome of measure performance. **ORx**’s revised PIP Summary Form included details regarding their inability to locate evidence-based resources prior to improvement strategy development. Qsource recommends that **ORx** consider use of evidence-based resources during future improvement strategy development. **ORx**’s revised PIP Summary Form included details regarding **ORx**’s assumed barrier associated with improvement strategy development. Qsource recommends that **ORx** conduct barrier analysis prior to initial improvement strategy development to ensure that the effectiveness of the improvement strategy directly correlates to barriers identified during the initial phase of performance improvement activities. The CAP satisfied the AON. **ORx**’s revised PIP Summary Form included PBM-defined activities conducted during each step of the PDSA cycle of improvement strategy implementation. The measurement years relating to some of the steps of the PDSA cycle were not clearly defined. Qsource recommends that **ORx** more clearly define the measurement year that correlates with the detailed activities performed during each step of the PDSA cycle in subsequent PIP submissions. **ORx**’s revised PIP Summary Form explained how the improvement strategy impacted the performance

Table 26. 2023 Results, Recommendations, and Strengths by Plan			
			outcomes from the baseline year to the remeasurement year. As mentioned in the previous CAP, **ORx** defined activities conducted during each step of the PDSA cycle of improvement strategy implementation. However, the measurement years relating to some of the steps were not clearly defined. Qsource suggests that **ORx** more clearly define the measurement years for all steps included in the PDSA cycle discussion in subsequent PIP submissions. The CAPs satisfied the AONs.

Appendix A | CFR Crosswalk

Qsource's EQR assessment tools review compliance with the 12 standards of 42 CFR 438, Subparts D and E. **Table A-1** provides a crosswalk between the 12 standards and the tools used to conduct the MY 2022 ANA review, AQS, PMV, and PIP validation.

<table>
<tr><th colspan="4">Table A1. CFR-Tool Crosswalk</th></tr>
<tr><th colspan="4">42 CFR 438.206: Availability of services</th></tr>
<tr><td rowspan="3"></td><th>Tool</th><th colspan="2">Standard/Elements</th></tr>
<tr><th>ANA</th><td colspan="2">MCO, DBM, & PBM tool: Standards for Availability and Accessibility</td></tr>
<tr><th>AQS</th><td>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</td><td>#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
#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</td></tr>
<tr><th colspan="4">42 CFR 438.207: Assurances of adequate capacity and services</th></tr>
<tr><td rowspan="3"></td><th>Tool</th><th colspan="2">Standard/Elements</th></tr>
<tr><th>ANA</th><td colspan="2">MCO, DBM, & PBM: Standards for Availability and Accessibility</td></tr>
<tr><th>AQS</th><td colspan="2">MCO, DBM, & PBM: Assurances of Adequate Capacity and Services
#1: Appropriate Range of Services and Providers
#2: Timely Documentation</td></tr>
</table>

Table A1. CFR-Tool Crosswalk

42 CFR 438.208: Coordination and continuity of care

Tool	Standard/Elements	
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 PBM: Coordination and Continuity of Care #1: Protected Health Information

42 CFR 438.210: Coverage and authorization of services

Tool	Standard/Elements	
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)

42 CFR 438.114: Emergency and Poststabilization

Tool	Standard/Elements	
AQS	MCO & DBM: Emergency and Poststabilization #1: Emergency Services – Coverage and Payment #2: Emergency Service Limitations #3: Subsequent Treatment	#4: Transfer or Discharge #5: Financial Responsibility #6: End of Financial Responsibility

Table A1. CFR-Tool Crosswalk

Tool	Standard/Elements	
42 CFR 438.214: Provider selection		
Tool	**Standard/Elements**	
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 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
42 CFR 438.224: Confidentiality		
Tool	**Standard/Elements**	
AQS	MCO, DBM, & PBM: Standards for Confidentiality	
42 CFR 438.228: Grievance and appeal systems		
Tool	**Standard/Elements**	
AQS	MCO, DBM, & PBM: Grievance and Appeal Systems	
42 CFR 438.230: Subcontractual relationships and delegation		
Tool	**Standard/Elements**	
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
42 CFR 438.236: Practice guidelines		
Tool	**Standard/Elements**	
AQS	MCO & DBM: Practice Guidelines #1: Requirements #2: Dissemination of Guidelines	#3: Consistency with Guidelines PBM: Practice Guidelines #1: Requirements

<table>
<tr><th colspan="4">Table A1. CFR-Tool Crosswalk</th></tr>
<tr><th colspan="4">42 CFR 438.242: Health information systems</th></tr>
<tr><td rowspan="4"></td><th>Tool</th><th colspan="2">Standard/Elements</th></tr>
<tr><td>AQS</td><td>MCO, DBM, & PBM: Health Information Systems
#1: System Requirements
#2: Data Collection</td><td>#3: Data Accuracy and Completeness
#4: Data Availability</td></tr>
<tr><td>PIP</td><td colspan="2">Information on PIP methodology and results in the PIP section, with tool in Appendix B and MCC improvement strategies in Appendix C</td></tr>
<tr><td>PMV</td><td colspan="2">Information on methodology and results in the PMV section, with tool in Appendix B</td></tr>
<tr><th colspan="4">42 CFR 438.330: Quality assessment and performance improvement program</th></tr>
<tr><td rowspan="2"></td><th>Tool</th><th colspan="2">Standard/Elements</th></tr>
<tr><td>AQS</td><td>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</td><td>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</td></tr>
</table>

Appendix B | 2023 EQR Tool Templates

ANA Review

ANA Standards Tools—MCOs

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
1) Informing Members of Emergency Medical Services *CRA A.2.7.1.1* *CRA Attachment III* *TCA 56-7-2356(a)(1)* *42 CFR § 438.206(a)* *42 CFR § 438.206(c)(1)(iii)*	There is evidence through a review of P&Ps and the Member Handbook that members are informed that emergency medical services are available at any available emergency care facility 24 hours a day, 7 days a week (including services outside the usual service area).	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
2) Informing Providers of Emergency Medical Services *CRA A.2.7.1.1* *CRA Attachment III* *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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
3) Maximum Members per	The MCO has processes and procedures in	☐ Met	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
Provider *CRA Attachment IV* *TCA 56-7-2356(a)(3)* *42 CFR § 438.206(a)* *42 CFR § 438.207(a)*	place to ensure that ratios of non-dual-eligible members to providers remain below the following maximum limits: **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	☐ Not Met			

Comment:

Strengths:

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
Suggestions: **AONs**:					
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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
4) 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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
5) 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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
6) Direct Access to Women's Health Specialist	The MCO allows female members direct access (without requiring a referral) to a women's	☐ Met	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
CRA A.2.14.4.3 *42 CFR § 438.206(b)(2)*	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.	☐ Not Met			
Comment: **Strengths**: **Suggestions**: **AONs**:					
7) Essential Hospital Services *CRA A 2.11.3.1.1*	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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
8) Center of Excellence (COE) for People with HIV/AIDS *CRA A.2.11.3.1.2*	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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
9) Center of Excellence for BH *CRA A.2.11.3.1.3*	The MCO has a contract with all COEs for BH with each Grand Region.	☐ Met ☐ Not Met	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
Comment: **Strengths**: **Suggestions**: **AONs**:					
10) 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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
11) 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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					

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

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
12) 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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
13) 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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
14) Standards for Timely Access to Inpatient 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 inpatient substance abuse services: a) Within 2 calendar days for detoxification b) Within 4 hours in an emergency c) Within 24 hours for a nonemergency	a) ☐ Met ☐ Not Met b) ☐ Met ☐ Not Met c) ☐ Met ☐ Not Met Variables a & b = .33	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
		Variable c = .34			
Comment: **Strengths**: **Suggestions**: **AONs**:					
15) 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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
16) 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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
17) Access Standards for Timely Access to Intensive Community-Based Treatment	The BH standards include access standards for intensive community-based treatment services within 7 calendar days.	☐ Met ☐ Not Met	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by MCO
			Value	Score	
Network Adequacy: Availability and Accessibility					
Services *CRA Attachment V* *TCA 56-7-2356(e)* *42 CFR § 438.206(c)(1)(i)*					
Comment: **Strengths**: **Suggestions**: **AONs**:					
18) 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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
19) Access Standards for Timely Access to Psychosocial Rehabilitation *CRA Attachment V* *TCA 56-7-2356(e)* *42 CFR § 438.206(c)(1)(i)*	The BH standards include access standards for psychosocial rehabilitation within 10 business days.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by MCO
			Value	Score	
Network Adequacy: Availability and Accessibility					
20) 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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
21) Access Standards for Timely Access to Illness Management and Recovery *CRA Attachment V* *TCA 56-7-2356(e)* *42 CFR § 438.206(c)(1)(i)*	The BH standards include access standards for illness management and recovery within 10 business days.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment: **Strengths**:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by MCO
			Value	Score	
Network Adequacy: Availability and Accessibility					
Suggestions:					
AONs:					
22) 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**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
23) 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**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
24) 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**	**0.0**	
Comment:					
Strengths:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
Suggestions:					
AONs:					
25) 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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
26) 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	a) ☐ Met ☐ Not Met b) ☐ Met ☐ Not Met Each Variable = .50	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
27) 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)*	Through a review of plan documents, there is evidence that the MCO requires the following geographic access standards for hospitals: Travel distance is ≤ 30 miles and ≤ 45 minutes travel time unless exceptions are justified and documented based on community standards.	☐ Met ☐ Not Met	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
42 CFR § 438.207(b)(2)					
Comment: **Strengths**: **Suggestions**: **AONs**:					
28) 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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
29) 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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
30) 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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
31) 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)* *42 CFR § 438.207(b)(2)*	The BH standards include access standards for intensive outpatient *(*may include day treatment [adults], intensive day treatment [children and adolescents] or partial hospitalization): Travel distance is ≤ 90 miles and ≤ 90 minutes travel time for 75% of the members; and is ≤ 120 miles and ≤ 120 minutes travel time for all members.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
32) 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)*	The BH standards include access standards for inpatient substance abuse services: Travel distance is ≤ 90 miles and ≤ 120 minutes travel time for all members.	☐ Met ☐ Not Met	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by MCO
			Value	Score	
Network Adequacy: Availability and Accessibility					
42 CFR § 438.207(b)(2)					
Comment: **Strengths**: **Suggestions**: **AONs**:					
33) 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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
34) 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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
Electronic Provider Information *CRA A.2.17.8.3*	The MCO furnishes an online searchable electronic provider directory.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
35) 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 i) hospital privileges j) cultural competency training	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 h) ☐ Met ☐ Not Met	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by MCO
			Value	Score	
Network Adequacy: Availability and Accessibility					
		☐ NA i) ☐ Met ☐ Not Met ☐ NA j) ☐ Met ☐ Not Met ☐ NA Each Variable= .10			
Comment: **Strengths**: **Suggestions**: **AONs**:					
36) Monthly Provider Enrollment File *CRA A.2.30.8.1*	The MCO submits a monthly Provider Enrollment File.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
37) 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	a) ☐ Met ☐ Not Met ☐ NA b) ☐ Met ☐ Not Met ☐ NA c) ☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by MCO
			Value	Score	
Network Adequacy: Availability and Accessibility					
	Individuals with Intellectual Disabilities (ICF/IID), and 1915(c) Waiver, Member Complaints Reports e) HCBS Settings Report f) Provider Complaints and Appeals Report	d) ☐ Met ☐ Not Met ☐ NA e) ☐ Met ☐ Not Met ☐ NA f) ☐ Met ☐ Not Met ☐ NA Variable a–d = .167 Variable e & f = .166			
Comment: **Strengths**: **Suggestions**: **AONs**:					
38) 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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by MCO
			Value	Score	
Network Adequacy: Availability and Accessibility					
39) 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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
40) 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 ☐ NA	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
41) 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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
42) Exchange of Information	There is evidence that the MCO has a system in place to document the exchange of member	☐ Met	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
CRA Attachment III	information if a provider, other than the PCP, provides healthcare (e.g., a school-based clinic or health department clinic) furnishes health care.	☐ Not Met			
Comment: **Strengths**: **Suggestions**: **AONs**:					
43) 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 ability to change PCPs is limited, the MCO includes provisions for more frequent PCP changes with good cause.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
44) 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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
45) 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.	☐ Met ☐ Not Met	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
	The MCO ensures that the cost to the enrollee is no greater than it would be if the services were furnished within the network.				
Comment: **Strengths**: **Suggestions**: **AONs**:					
Network Adequacy: Availability and Accessibility Score		**<##>%**	**49.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met‡**	**Element**		**Documentation/Evidence as Provided by MCO**
			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* *CRA A.2.6.1.9*	TENNCARE MEDICAID and COVERKIDS: 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	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	

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

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met‡**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
	alternative.				
Comment: **Strengths**: **Suggestions**: **AONs**:					
2) Outpatient Hospital Services *CRA A.2.6.1.3* *CRA A.2.6.1.9*	TENNCARE MEDICAID and COVERKIDS: As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
3) Physician Inpatient Services *CRA A.2.6.1.3* *CRA A.2.6.1.9*	TENNCARE MEDICAID: s medically necessary COVERKIDS: Medically necessary physician services	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					

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<tr><th rowspan="2">Evaluation Elements</th><th rowspan="2">Criteria</th><th rowspan="2">Criteria Met‡</th><th colspan="2">Element</th><th rowspan="2">Documentation/Evidence as Provided by MCO</th></tr>
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<tr><td>4) Physician Outpatient Services/Community Health Clinic Services/ Other Clinic Services
CRA A.2.6.1.3
CRA A.2.6.1.9</td><td>TENNCARE MEDICAID: As medically necessary

COVERKIDS: Medically necessary physician services</td><td>☐ Member Handbook
☐ Explanation of Benefits
☐ Other (Describe)</td><td>1.0</td><td>0.0</td><td></td></tr>
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Suggestions:
AONs:</td></tr>
<tr><td>5) Lab and X-Ray Services
CRA A.2.6.1.3
CRA A.2.6.1.9</td><td>TENNCARE MEDICAID and COVERKIDS: As medically necessary</td><td>☐ Member Handbook
☐ Explanation of Benefits
☐ Other (Describe)</td><td>1.0</td><td>0.0</td><td></td></tr>
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Strengths:
Suggestions:
AONs:</td></tr>
<tr><td>6) Maternity/Postpartum Services
TCA 56-7-2350</td><td>TENNCARE MEDICAID: As medically necessary</td><td>☐ Member Handbook
☐ Explanation of Benefits
☐ Other (Describe)</td><td>1.0</td><td>0.0</td><td></td></tr>
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2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	Criteria	Criteria Met‡	Element Value	Element Score	Documentation/Evidence as Provided by MCO
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* *CRA A.2.6.1.9*	TENNCARE MEDICAID and COVERKIDS: As medically necessary (must be provided by a Medicare-Certified Hospice)	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
8) Vision Services *CRA A.2.6.1.3* *CRA A.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	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met‡**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
	conditions, diseases, and disorders of the eye. One pair of cataract glasses or lenses following cataract surgery. COVERKIDS CHILDREN UNDER ATE 19: 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; prescription contact lenses in lieu of eyeglasses limited to one pair per calendar year with $150 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.				

Comment:
Strengths:
Suggestions:
AONs:

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met‡**	**Element Value**	**Element Score**	**Documentation/Evidence as Provided by MCO**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
9) Home Healthcare *CRA A.2.6.1.3* *CRA A.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	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
10) Durable Medical Equipment (DME) *CRA A.2.6.1.3* *CRA A.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 calendar year up to age 5, and limited to one per ear every two years thereafter. Specified DME services covered/non-covered in	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
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			Value	**Score**	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
	accordance with TennCare rules and regulations				
Comment: **Strengths**: **Suggestions**: **AONs**:					
11) Medical Supplies *CRA A.2.6.1.3* *CRA A.2.6.1.9*	TENNCARE MEDICAID and COVERKIDS: As medically necessary and covered in accordance with TennCare rules and regulations	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
12) Emergency Air and Ground Ambulance Transportation *CRA A.2.6.1.3*	TENNCARE MEDICAID: As medically necessary COVERKIDS: Air and ground ambulance services covered as medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
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Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
13) Nonemergency Medical Transportation, Including Nonemergency Ambulance Transportation *CRA A.2.6.1.3* *CRA A.2.6.1.9*	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	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
15) TennCare Kids Services/Health Screenings	TENNCARE MEDICAID: Services for members younger than 21 years	☐ Member Handbook	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met‡**	**Element Value**	**Element Score**	**Documentation/Evidence as Provided by MCO**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
CRA A.2.6.1.3	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	☐ Explanation of Benefits ☐ Other (Describe)			
Comment: **Strengths**: **Suggestions**: **AONs**:					
16) Preventive Care Services *CRA 2.6.1.3* *CRA A.2.6.1.9* *CRA A.2.7.5.1*	TENNCARE MEDICAID and COVERKIDS: The MCO provides preventive services, which include, but are not limited to, initial and periodic evaluations, family planning services, prenatal care, laboratory services, and immunizations in accordance with TennCare rules and regulations.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
17) Occupational Therapy	**Occupational Therapy:**	☐ Member	**1.0**	**1.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met‡**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
CRA A.2.6.1.3 *CRA A.2.6.1.9*	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	Handbook ☐ Explanation of Benefits ☐ Other (Describe)			
Comment: **Strengths**: **Suggestions**: **AONs**:					
18) Physical Therapy *CRA A.2.6.1.3* *CRA A.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	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met‡**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
	Kids requirements COVERKIDS: Limited to 52 visits per calendar year				
Comment: **Strengths**: **Suggestions**: **AONs**:					
19) Chiropractic Services *CRA A.2.6.1.3* *CRA A.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	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met‡**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
21) Speech Therapy *CRA A.2.6.1.3* *CRA A.2.6.1.9*	**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	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met‡**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
	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* *CRA A.2.6.1.9*	**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 (Describe)	**1.0**	**0.0**	
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	☐ Member Handbook ☐ Explanation of	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met‡**	**Element Value**	**Element Score**	**Documentation/Evidence as Provided by MCO**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
	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.	Benefits ☐ Other (Describe)			
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. Not applicable for CoverKids	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Comment:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met‡**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
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	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
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 (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met[‡]**	**Element Value**	**Element Score**	**Documentation/Evidence as Provided by MCO**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
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 (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
28) Psychiatric Inpatient Hospital Services (Including Physician Services) *CRA A.2.6.1.4* *CRA A.2.6.1.9*	TENNCARE MEDICAID and COVERKIDS: As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
29) Outpatient Mental Health Services (Including Physician Services) *CRA A.2.6.1.4* *CRA A.2.6.1.9*	TENNCARE MEDICAID and COVERKIDS: As medically necessary	☐ Member Handbook ☐ Explanation of Benefits	**1.0**	**0.0**	

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			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**:					
30) Inpatient/Residential and Outpatient Substance Abuse Benefits *CRA A.2.6.1.4* *CRA A.2.6.1.9*	TENNCARE MEDICAID: As medically necessary: When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services. COVERKIDS: Coverage as medically necessary for inpatient and outpatient substance abuse services	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **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**	**0.0**	

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Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
Comment: **Strengths**: **Suggestions**: **AONs**:					
32) BH Crisis Services *CRA A.2.6.1.4*	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
33) BH Intensive Community Based Treatment *CRA A.2.6.1.4*	TENNCARE MEDICAID: As medically necessary Not covered for CoverKids	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
34) Psychiatric Rehabilitation	As medically necessary	☐ Member	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
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Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
Services *CRA A.2.6.1.4*		Handbook ☐ Explanation of Benefits ☐ Other (Describe)			
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**	**0.0**	
Comment: **Strengths**:					

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

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Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
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).	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
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**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					

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Evaluation Elements	**Criteria**	**Criteria Met‡**	**Element Value**	**Element Score**	**Documentation/Evidence as Provided by MCO**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
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**	**0.0**	
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.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
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	**1.0**	**0.0**	

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Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
		Benefits ☐ Other (Describe) ☐ NA			
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**	**0.0**	
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.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	

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Evaluation Elements	**Criteria**	**Criteria Met‡**	**Element**		**Documentation/Evidence as Provided by MCO**
			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**:					
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**	**0.0**	
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) ☐ NA	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met‡**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
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**	**0.0**	
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**	**0.0**	
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	☐ Member Handbook ☐ Explanation of	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	Criteria	Criteria Met‡	Element Value	Element Score	Documentation/Evidence as Provided by MCO
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
	persons living with 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**	**0.0**	
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**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met‡**	**Element**		**Documentation/Evidence as Provided by MCO**
			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**:					
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**	**0.0**	
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**	**0.0**	
Comment: **Strengths**: **Suggestions**:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met‡**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, 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.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
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.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
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	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met‡**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
		Benefits ☐ Other (Describe) ☐ NA			
Comment: **Strengths**: **Suggestions**: **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.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
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**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	Criteria	Criteria Met‡	Element		Documentation/Evidence as Provided by MCO
			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**:					
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**	**0.0**	
Comment: **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**	**0.0**	
Comment: **Strengths**: **Suggestions**:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met‡**	**Element Value**	**Element Score**	**Documentation/Evidence as Provided by MCO**
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
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**	**0.0**	
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 ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
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,	☐ Member Handbook ☐ Explanation of	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met‡**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
	and 8.	Benefits ☐ Other (Describe) ☐ NA			
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**	**0.0**	
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,	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met‡**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
	specialized consultation services are limited to $10,000 per person per calendar year.				
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**	**0.0**	
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**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	Criteria	Criteria Met‡	Element Value	Element Score	Documentation/Evidence as Provided by MCO
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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
67) Intensive Behavioral Community Transition and Stabilization Services	As medically necessary for ECF CHOICES members in Group 8.	☐ Met ☐ Not Met	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met‡**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
(IBCTSS) *CRA A.2.6.1.6.3*		☐ NA			
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 Physician specialists Inpatient hospital admissions	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
69) Cost Sharing *Attachment II*	The MCO informs CoverKids members of the cost-sharing requirements for the following services:	☐ Met ☐ Not Met	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met‡**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
	Chiropractic care Emergency room services Hospital admissions and other inpatient 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				
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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met[‡]**	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
71) Regulator Approval: CoverKids Handbook *CRA A.2.17.1.1*	The MCO's CoverKids Member Handbook was approved by TennCare. Date of Approval: <MM/DD/YY>	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
Benefit Delivery: Accessibility—Member Score		**<##>%**	**71.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met[**]**	**Element**		**Documentation/Evidence as Provided by MCO**
			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* *CRA A.2.6.1.9*	TENNCARE MEDICAID and COVERKIDS: As medically necessary Under age 21: Includes rehabilitation hospital facility Age 21 and older: Inpatient rehabilitation hospital facility services are not covered for	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	

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

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**[**]	**Element Value**	**Element Score**	**Documentation/Evidence as Provided by MCO**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
	adults unless determined to be a cost effective alternative.				
Comment: **Strengths**: **Suggestions**: **AONs**:					
2) Outpatient Hospital Services *CRA A.2.6.1.3* *CRA A.2.6.1.9*	TENNCARE MEDICAID and COVERKIDS: As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
3) Physician Inpatient Services *CRA A.2.6.1.3* *CRA A.2.6.1.9*	TENNCARE MEDICAID and COVERKIDS: As medically necessary COVERKIDS: Medically necessary physician services	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**[**]	**Element Value**	**Element Score**	**Documentation/Evidence as Provided by MCO**
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* *CRA A.2.6.1.9*	TENNCARE MEDICAID: As medically necessary COVERKIDS: Medically necessary physician services	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
5) Lab and X-Ray Services *CRA A.2.6.1.3* *CRA A.2.6.1.9*	TENNCARE MEDICAID and COVERKIDS: As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
6) Maternity/Postpartum Services *TCA 56-7-2350*	TENNCARE MEDICAID: As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**[**]	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
AONs:					
7) Hospice Care *CRA A.2.6.1.3* *CRA A.2.6.1.9*	TENNCARE MEDICAID and COVERKIDS: As medically necessary (must be provided by a Medicare-Certified Hospice)	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
8) Vision Services *CRA A.2.6.1.3* *CRA A.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.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met****	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
	COVERKIDS CHILDREN UNDER ATE 19: 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; prescription contact lenses in lieu of eyeglasses limited to one pair per calendar year with $150 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.				
Comment: **Strengths**: **Suggestions**: **AONs**:					
9) Home Healthcare *CRA A.2.6.1.3* *CRA A.2.6.1.9*	TENNCARE MEDICAID: As medically necessary for those younger or older than 21 years of age in accordance with the definition	☐ Provider Manual ☐ Contract	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**[**]	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
	of home health care in the Tennessee rules. COVERKIDS: Prior approval required with visits limited to 125 visits per enrollee per calendar year	☐ Other (Describe)			
Comment: **Strengths**: **Suggestions**: **AONs**:					
10) Durable Medical Equipment (DME) *CRA A.2.6.1.3* *CRA A.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 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**	**0.0**	
Comment: **Strengths**:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**[**]	**Element Value**	**Element Score**	**Documentation/Evidence as Provided by MCO**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
Suggestions:					
AONs:					
11) Medical Supplies *CRA A.2.6.1.3* *CRA A.2.6.1.9*	TENNCARE MEDICAID and COVERKIDS: As medically necessary and covered in accordance with TennCare rules and regulations	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
12) Emergency Air and Ground Ambulance Transportation *CRA A.2.6.1.3*	TENNCARE MEDICAID: As medically necessary COVERKIDS: Air and ground ambulance services covered as medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
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.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**[**]	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
CRA A.2.6.1.9	Nonemergency transportation services are provided to convey members to and from TennCare covered services. Not applicable for CoverKids				
Comment: **Strengths**: **Suggestions**: **AONs**:					
14) Renal Dialysis Services *CRA A.2.6.1.3*	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
15) TennCare Kids Services/Health Screenings *CRA A.2.6.1.3*	TENNCARE MEDICAID: 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	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met****	**Element Value**	**Element Score**	**Documentation/Evidence as Provided by MCO**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
	as medically necessary in accordance with federal and state requirements				
Comment: **Strengths**: **Suggestions**: **AONs**:					
16) Preventive Care Services *CRA 2.6.1.3* *CRA A.2.6.1.9* *CRA A.2.7.5.1*	TENNCARE MEDICAID and COVERKIDS: The MCO provides preventive services, which include, but are not limited to, initial and periodic evaluations, family planning services, prenatal care, laboratory services, and immunizations in accordance with TennCare rules and regulations.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
17) Occupational Therapy *CRA A.2.6.1.3* *CRA A.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	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**[**]	**Element Value**	**Element Score**	**Documentation/Evidence as Provided by MCO**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
	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**:					
18) Physical Therapy *CRA A.2.6.1.3* *CRA A.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**	**0.0**	
Comment: **Strengths**:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**[**]	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
Suggestions:					
AONs:					
19) Chiropractic Services *CRA A.2.6.1.3* *CRA A.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**	**0.0**	
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.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**[**]	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
	Not applicable for CoverKids				
Comment: **Strengths**: **Suggestions**: **AONs**:					
21) Speech Therapy *CRA A.2.6.1.3* *CRA A.2.6.1.9*	**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	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**[**]	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
Suggestions: **AONs**:					
22) Organ and Tissue Transplants and Donor Organ Procurement *CRA A.2.6.1.3* *CRA A.2.6.1.9*	**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**	**0.0**	
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 establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**[**]	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
	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. Not applicable for CoverKids	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
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	☐ Provider Manual ☐ Contract	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**[**]	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
	special dietary formulas. Not applicable for CoverKids	☐ Other (Describe)			
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	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
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.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met****	**Element Value**	**Element Score**	**Documentation/Evidence as Provided by MCO**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
	Not covered for CoverKids				
Comment: **Strengths**: **Suggestions**: **AONs**:					
28) Psychiatric Inpatient Hospital Services (Including Physician Services) *CRA A.2.6.1.4* *CRA A.2.6.1.9*	TENNCARE MEDICAID and COVERKIDS: As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
29) Outpatient Mental Health Services (Including Physician Services) *CRA A.2.6.1.4* *CRA A.2.6.1.9*	TENNCARE MEDICAID and COVERKIDS: As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
30) Inpatient/Residential and Outpatient Substance Abuse	TENNCARE MEDICAID: As medically necessary:	☐ Provider Manual	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	Criteria	Criteria Met**	Element Value	Element Score	Documentation/Evidence as Provided by MCO
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
Benefits *CRA A.2.6.1.4* *CRA A.2.6.1.9*	When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services. COVERKIDS: Coverage as medically necessary for inpatient and outpatient substance abuse services.	☐ Contract ☐ Other (Describe)			
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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
32) BH Crisis Services *CRA A.2.6.1.4*	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths**:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met****	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
Suggestions:					
AONs:					
33) BH Intensive Community Based Treatment *CRA A.2.6.1.4*	TENNCARE MEDICAID: As medically necessary Not covered for CoverKids	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
34) Psychiatric Rehabilitation Services *CRA A.2.6.1.4*	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
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	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**[**]	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
	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.	☐ NA[††]			
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**	**0.0**	
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	☐ Provider Manual	**1.0**	**0.0**	

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

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**[**]	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
	CHOICES members in Groups 2 and 3.	☐ Contract ☐ Other (Describe) ☐ NA			
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**	**0.0**	
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**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	Criteria	Criteria Met**	Element		Documentation/Evidence as Provided by MCO
			Value	Score	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
Comment: **Strengths**: **Suggestions**: **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**	**0.0**	
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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
42) In-Home Respite Care	As medically necessary (up to 216	☐ Provider	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met****	**Element Value**	**Element Score**	**Documentation/Evidence as Provided by MCO**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
CRA A.2.6.1.5.3	hours per calendar year) for CHOICES members in Groups 2 and 3.	Manual ☐ Contract ☐ Other (Describe) ☐ NA			
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.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
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	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**[**]	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
	8.				
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**	**0.0**	
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.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	Criteria	Criteria Met**	Element Value	Element Score	Documentation/Evidence as Provided by MCO
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
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**	**0.0**	
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**	**0.0**	
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.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**[**]	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
		☐ NA			
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**	**0.0**	
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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**[**]	**Element Value**	**Element Score**	**Documentation/Evidence as Provided by MCO**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
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**	**0.0**	
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**	**0.0**	
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**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**[**]	**Element Value**	**Element Score**	**Documentation/Evidence as Provided by MCO**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
Comment: **Strengths**: **Suggestions**: **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**	**0.0**	
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**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
57) Health Insurance Counseling	As medically necessary for health	☐ Provider	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met****	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
CRA A.2.6.1.6.3	insurance counseling/forms assistance (up to 15 hours per calendar year) for ECF CHOICES members in Groups 4 and 7.	Manual ☐ Contract ☐ Other (Describe) ☐ NA			
Comment: **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.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
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**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**[**]	**Element Value**	**Element Score**	**Documentation/Evidence as Provided by MCO**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
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**	**0.0**	
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.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
62) Peer-to-Peer Support and Navigation for Person-	As medically necessary (up to $1,500 per lifetime) for ECF	☐ Provider	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met****	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
Centered Planning, Self-Direction, Integrated Employment/Self-Employment, and Independent Community Living *CRA A.2.6.1.6.3*	CHOICES members in Groups 5, 6, and 8.	Manual ☐ Contract ☐ Other (Describe) ☐ NA			
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**	**0.0**	
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	☐ Provider Manual	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**[**]	**Element Value**	**Element Score**	**Documentation/Evidence as Provided by MCO**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
	calendar years) for ECF CHOICES members in Groups 4, 5, 6, and 8. Group 4 benefits limited to adults age 21 and older	☐ Contract ☐ Other (Describe) ☐ NA			
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**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	Criteria	Criteria Met**	Element		Documentation/Evidence as Provided by MCO
			Value	Score	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
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.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	1.0	0.0	
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	0.0	
Comment: **Strengths**: **Suggestions**: **AONs**:					
68) Non-Pharmacy Copayment	The MCO informs CoverKids	☐ Met	1.0	0.0	

Evaluation Elements	Criteria	Criteria Met**	Element Value	Element Score	Documentation/Evidence as Provided by MCO
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
Schedule *Attachment II*	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	☐ Not Met ☐ NA			
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 Hospital admissions and other inpatient services Inpatient mental health and substance abuse treatment services Outpatient mental health and substance abuse treatment	☐ Met ☐ Not Met	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**[**]	**Element**		**Documentation/Evidence as Provided by MCO**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
	services Physical, speech, and occupational therapy Physician office visits Prescription drugs Vision services				
Comment: **Strengths**: **Suggestions**: **AONs**:					
70) Regulator Approval: Provider Manual *CRA A.2.17.1.1*	The MCO's Provider Manual was approved by TennCare. Date of Approval: <MM/DD/YY>	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Comment: **Strengths**: **Suggestions**: **AONs**:					
Benefit Delivery: Accessibility—Provider Score		**<##>%**	**70.0**	**0.0**	

ANA Standards Tools—DBM

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element Value	Element Score	Documentation/Evidence as Provided by DBM
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**	**0.0**	
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**	**0.0**	
Comment: **Strengths:** **Suggestions:** **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**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
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**	**0.0**	
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**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by DBM
			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**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
7) Emergency Services *TDC A.20.* *42 CFR § 438.206(c)(1)(iii)*	The DBM is responsible for the provision of treatment for emergency medical conditions 24-hours a day, seven days a week.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
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 providers with a sufficient number of providers who accept new TennCare members in accordance with the required standards: Appointment wait times do not exceed three weeks for regular appointments Appointment wait times do not exceed 48 hours for urgent care	☐ Met ☐ Not Met ☐ Met ☐ Not Met Each Variable = 0.50	**1.0**	**0.0**	
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**	**0.0**	
Comment: **Strengths:**					

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by DBM
			Value	Score	
Network Adequacy: Availability and Accessibility					
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 ☐ NA ☐ Met ☐ Not Met ☐ NA ☐ Met ☐ Not Met ☐ NA Each Variable = 0.20	**1.0**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
11) Office Wait Time *TDC A.24.*	Through a review of plan documents, there is evidence that	☐ Met ☐ Not Met	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
42 CFR § 438.206(c)(1)(i)	the office wait time does not exceed 45 minutes.				
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**	**0.0**	
Comment: **Strengths:** **Suggestions:** **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 enrollee'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**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by DBM
			Value	Score	
Network Adequacy: Availability and Accessibility					
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 to a particular enrollee, the DBM must adequately and timely cover the services out-of-network for the enrollee, for as long as the DBM is unable to furnish the services with an in-network provider.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
15) Charges for Out-of-Network Services *TDC A.26.* *42 CFR § 438.206(b)(5)*	The DBM ensures that the cost to the enrollee 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**	**0.0**	
Comment: **Strengths:** **Suggestions:**					

2023 Annual Network Adequacy Review Standards Tool: <DBM>

Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by DBM
			Value	Score	
Network Adequacy: Availability and Accessibility					
AONs:					
16) Mobile Dental Clinics *TDC A.20.f.*		☐ Met ☐ Not Met ☐ NA[‡‡]	**1.0**	**0.0**	
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 enrollees, including those with LEP and diverse cultural and ethnic backgrounds.	☐ Met ☐ Not Met	**1.0**	**0.0**	
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	☐ Met ☐ Not Met ☐ Met	**1.0**	**0.0**	

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

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element Value	Element Score	Documentation/Evidence as Provided by DBM
Network Adequacy: Availability and Accessibility					
	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.	☐ Not Met Each Variable = 0.50			
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 enrollee to obtain a second opinion outside the network at no cost to the member.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
20) Direct Access to Specialists *TDC A.46.b.*	The DBM has a mechanism to allow special needs enrollee and enrollees who require an ongoing course of treatment direct access	☐ Met ☐ Not Met	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
	to specialists, as appropriate.				
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 physicians, 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. Non-traditional providers will be reimbursed for such services within the range of six months through five years only if fluoride varnish application and dental screening are conducted at the same visit.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
22) Notification to New Members: Distributing the	The DBM distributes the Member Handbooks to members within 30	☐ Met	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
Member Handbook *TDC A.10.a.1.*	days of receipt of notice of enrollment in a State DBM Program.	☐ Not Met			
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 to new enrollees within 30 calendar days of receipt of notification of enrollment in the DBM.	☐ Met ☐ Not Met	**1.0**	**0.0**	
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**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by DBM
			Value	Score	
Network Adequacy: Availability and Accessibility					
Comment: **Strengths:** **Suggestions:** **AONs:**					
25) Requirements of the Provider Directory *TDC A.10.c.1.*	The provider directories include: Name Locations Telephone numbers Office hours Non-English languages spoken by the current network providers Specialty Identification of providers accepting new patients	☐ 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	0.0	
Comment: **Strengths:** **Suggestions:** **AONs:**					

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
26) Provider Satisfaction Survey *TDC A. 37.* *Attachment C*	The DBM conducts a provider satisfaction survey of the participating network dentists and dental specialists for both Medicaid and CoverKids, 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**	**0.0**	
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 and includes information for the TennCare Programs and CoverKids Program.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
Network Adequacy: Availability and Accessibility Score		**<##>%**	**27.0**	**0.0**	

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<tr><td colspan="6">Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)</td></tr>
<tr><td>1) Member Education
TDC A.115.</td><td>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</td><td>☐ Member Handbook
☐ Explanation of Benefits
☐ Other (Describe)</td><td>1.0</td><td>0.0</td><td></td></tr>
<tr><td colspan="6">Comment:
Strengths:
Suggestions:
AONs:</td></tr>
<tr><td>2) Preventive Treatment: Dental Cleanings
TDC A.5.a.1.
TDC A.5.d. (Amendment #1)</td><td>Dental cleanings

TENNCARE MEDICAID: As medically necessary

COVERKIDS: Coverage for two cleanings per calendar year</td><td>☐ Member Handbook
☐ Explanation of Benefits
☐ Other (Describe)</td><td>1.0</td><td>0.0</td><td></td></tr>
<tr><td colspan="6">Comment:
Strengths:
Suggestions:
AONs:</td></tr>
<tr><td>3) Non-Traditional Fluoride Varnish and Dental Screening Program
TDC A.5.a.4.</td><td>Fluoride treatments

TENNCARE MEDICAID: Two visits per year (ages 6 months through 5 years); fluoride varnish application and dental</td><td>☐ Member Handbook
☐ Explanation of Benefits</td><td>1.0</td><td>0.0</td><td></td></tr>
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2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by DBM
			Value	Score	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)					
TDC A.5.d. (Amendment #1) *TCA A.6.a.*	screenings must be conducted at the same visit	☐ Other (Describe)			
Comment: **Strengths:** **Suggestions:** **AONs:**					
4) Preventive Treatment: Dental Sealants *TDC A.5.a.1.* *TDC A.5.d. (Amendment #1)* *TCA A.6.a.*	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**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
5) Preventive Treatment: Application of Silver Diamine Fluoride *TDC A.5.a.1.* *TDC A.5.d. (Amendment #1)*	Silver Diamine Fluoride TENNCARE MEDICAID: As medically necessary COVERKIDS: Four applications per tooth per lifetime	☐ Member Handbook ☐ Explanation of Benefits ☐ Other	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by DBM
			Value	Score	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)					
TCA A.6.a.					
Comment: **Strengths:** **Suggestions:** **AONs:**					
6) Preventive Treatment: Diagnostic Services *TDC A.5.a.1.* *TDC A.5.d. (Amendment #1)*	Diagnostic Services TENNCARE MEDICAID: As medically necessary COVERKIDS: Coverage for two oral exams per calendar year	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
7) Laboratory Services: Oral Pathology *TDC A.5.a.1.*	Laboratory services TENNCARE MEDICAID: AS medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other	**1.0**	**0.0**	
Comment: **Strengths:**					

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)					
Suggestions:					
AONs:					
8) Emergency Services *TDC A.5.a.1.* *TDC A.5.d. (Amendment #1)*	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**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
9) Restorative Services *TDC A.5.a.1.* *TDC A.5.d. (Amendment #1)* *TCA A.6.a.*	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**	**0.0**	
Comment:					
Strengths:					
Suggestions:					

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by DBM
			Value	Score	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)					
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**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
11) Radiographs *TDC A.5.a.1.* *TDC A.5.d. (Amendment #1)*	X-rays TENNCARE MEDICAID: As medically necessary COVERKIDS: 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	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Comment:					

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)					
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	**1.0**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
13) Anesthesia *TDC A.5.a.1.* *TDC A.5.d. (Amendment #1)*	Anesthesia TENNCARE MEDICAID: As medically necessary COVERKIDS: As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other	**1.0**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)					
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 lifetime maximum limit of $1,250 per member	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
15) Periodontic Services *TDC A.46.*	Periodontic services REGULAR MEDICAID: As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
16) Annual Benefit Maximum *TDC A.5.d.*	COVERKIDS ONLY: Members are informed of their annual benefit	☐ Member Handbook	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by DBM
			Value	Score	
Benefit Delivery: Accessibility—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)					
	maximum	☐ Explanation of Benefits ☐ Other (Describe)			
Comment: **Strengths:** **Suggestions:** **AONs:**					
17) Member Handbook Approval *TDC A.10.*	The Member Handbooks were approved by TennCare prior to distribution. Date of Approval TENNCARE STANDARD MEDICAID: COVERKIDS: ECF CHOICES:	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
Benefit Delivery: Accessibility—Member Score		**<##>%**	**17.0**	**00.0**	

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			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**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
2) Preventive Treatment: Dental Cleanings *TDC A.5.a.1.* *TDC A.5.d. (Amendment #1)*	Dental cleanings TENNCARE MEDICAID: As medically necessary COVERKIDS: Coverage for two cleanings per calendar year	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
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 (ages 6 months	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)					
TDC A.5.d. (Amendment #1)	through 5 years); fluoride varnish application and dental screenings must be conducted at the same visit				
Comment: **Strengths:** **Suggestions:** **AONs:**					
4) Preventive Treatment: Dental Sealants *TDC A.5.a.1.* *TDC A.5.d. (Amendment #1)* *TCA A.6.a.*	Dental Sealants TENNCARE MEDICAID: As medically necessary COVERKIDS: Coverage for permanent molars-One per tooth per lifetime	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
5) Preventive Treatment: Application of Silver Diamine Fluoride *TDC A.5.a.1.*	Silver Diamine Fluoride TENNCARE MEDICAID: As medically necessary COVERKIDS: Four application	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)					
TDC A.5.d. (Amendment #1) *TCA A.6.a.*	per tooth per lifetime				
Comment: **Strengths:** **Suggestions:** **AONs:**					
6) Preventive Treatment: Diagnostic Services *TDC A.5.a.1.* *TDC A.5.d. (Amendment #1)*	Diagnostic Services TENNCARE MEDICAID: As medically necessary COVERKIDS: Coverage for two oral exams per calendar year	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
7) Laboratory Services: Oral Pathology *TDC A.5.a.1.*	Laboratory services TENNCARE MEDICAID: AS medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths:**					

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by DBM
			Value	Score	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)					
Suggestions:					
AONs:					
8) Emergency Services *TDC A.5.a.1.* *TDC A.5.d. (Amendment #1)*	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**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
9) Restorative Services *TDC A.5.a.1.* *TDC A.5.d. (Amendment #1)* *TCA A.6.a.*	Restorative services TENNCARE MEDICAID: As medically necessary COVERKIDS: Stainless steel crowns; routine fillings (silver or tooth colored)	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Comment:					
Strengths:					

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<tr><td colspan="6">Suggestions:</td></tr>
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<tr><td>10) Extractions
TDC A.5.a.1.
TDC A.5.d.</td><td>Extractions

TENNCARE MEDICAID: As medically necessary

COVERKIDS: As medically necessary</td><td>☐ Provider Manual
☐ Contract
☐ Other (Describe)</td><td>1.0</td><td>0.0</td><td></td></tr>
<tr><td colspan="6">Comment:</td></tr>
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<tr><td colspan="6">Suggestions:</td></tr>
<tr><td colspan="6">AONs:</td></tr>
<tr><td>11) Radiographs
TDC A.5.a.1.
TDC A.5.d. (Amendment #1)</td><td>X-rays

TENNCARE MEDICAID: As medically necessary

COVERKIDS:
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</td><td>☐ Provider Manual
☐ Contract
☐ Other (Describe)</td><td>1.0</td><td>1.0</td><td></td></tr>
</table>

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)					
	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**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
13) Anesthesia *TDC A.5.a.1.* *TDC A.5.d. (Amendment #1)*	Anesthesia TENNCARE MEDICAID: As medically necessary COVERKIDS: As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element Value	Element Score	Documentation/Evidence as Provided by DBM
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)					
Comment: **Strengths:** **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 lifetime maximum limit of $1,250 per member	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
15) Periodontic Services *TDC A.46.*	Periodontic services REGULAR MEDICAID: As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element Value**	**Element Score**	**Documentation/Evidence as Provided by DBM**
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)					
Comment: **Strengths:** **Suggestions:** **AONs:**					
16) Annual Benefit Maximum *TDC A.5.d.*	COVERKIDS ONLY: Members are informed of their annual benefit maximum	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
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**	**0.0**	
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**	**0.0**	
Comment:					

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by DBM
			Value	Score	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)					
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**	**0.0**	
Comment:					
Strengths:					
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**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
ECF CHOICES DBM: Periodontics *TDC A.5.b.2.(a)*	ECF CHOICES DBM Services: Periodontics	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Comment:					
Strengths:					

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)					
Suggestions:					
AONs:					
21) ECF CHOICES DBM: Dentures *TDC A.5.b.2.(a)*	ECF CHOICES DBM Services: Dentures	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
22) 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**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
23) 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**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)					
Comment: **Strengths:** **Suggestions:** **AONs:**					
24) 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**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
25) 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	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					

2023 Annual Network Adequacy Review Standards Tool: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM**
			Value	**Score**	
Benefit Delivery: Accessibility—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)					
26) 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: CoverKids ORM: ECF ORM:	☐ Provider Manual ☐ Contract ☐ Other	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
Benefit Delivery: Accessibility—Provider Score		**<##>%**	**27.0**	**00.0**	

ANA Standards Tools—PBM

2023 Annual Network Adequacy Review Standards Tool: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by PBM**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
1) Statewide Network *PBMC A.10.* *PBMC.A.40.f.* *TCA 56-7-2356(a)(1)*	The PBM maintains and monitors a network of appropriate providers that is sufficient to provide adequate access to all services covered under the TennCare contract for all enrollees.	☐ Met ☐ Not Met	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by PBM**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
42 CFR § 438.206(c)(1)(iv–v) *42 CFR § 438.207(b)(2)*					
Comment: **Strengths:** **Suggestions:** **AONs:**					
2) Statewide Network of Pharmacy Providers *PBMC A.49.a* *TCA 56-7-2356(a)(1)* *42 CFR § 438.206(c)(1)(vi)* *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 and takes corrective action if a pharmacy fails to comply with access requirements.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
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(a)* *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 enrollment c) The expected utilization of services, taking into consideration the pharmaceutical needs of	a) ☐ Met ☐ Not Met ☐ NA b) ☐ Met ☐ Not Met ☐ NA c) ☐ Met ☐ Not Met ☐ NA	**5.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by PBM**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
	specific TennCare populations served by the PBM d) The numbers and types (in terms of training, experience, and specialization) of pharmacies required to provide the contracted TennCare services e) 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	d) ☐ Met ☐ Not Met ☐ NA e) ☐ Met ☐ Not Met ☐ NA			
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**	**0.0**	
Comment:					

2023 Annual Network Adequacy Review Standards Tool: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by PBM**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
Strengths: **Suggestions:** **AONs:**					
5) Hours of Operation *PBMC A.49.a* *42 CFR § 438.206(c)(1)(ii)*	The network providers must offer hours of operation that are no less than the hours of operation offered to commercial members.	☐ Met ☐ Not Met	**1.0**	**0.0**	
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: 3 miles and 15 minutes for urban areas 10 miles and 20 minutes for suburban areas 25 miles and 30 minutes for rural areas	a) ☐ Met ☐ Not Met ☐ NA b) ☐ Met ☐ Not Met ☐ NA c) ☐ Met ☐ Not Met ☐ NA	**3.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
7) Exceptions to the Access	Exceptions to the access distance and time	☐ Met	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by PBM**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
Requirements *PBMC A.49.b*	requirements are justified and documented to the State on the basis of community standards.	☐ Not Met			
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**	**0.0**	
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**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					

2023 Annual Network Adequacy Review Standards Tool: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by PBM**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
10) Out-of-Network Provider Payments *PBMC A.14.* *TCA 56-7-2356(c)* *42 CFR § 438.206(b)(5)*	The PBM coordinates payment with non-network providers and ensures the cost to the enrollee is no greater than it would be if the services were furnished within the network.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
11) Reporting the Use of Out-of-Network Providers *PBMC A.14.*	The PBM reports all claims filled from non-network pharmacies to the State weekly.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
12) 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**	**0.0**	
Comment:					

2023 Annual Network Adequacy Review Standards Tool: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by PBM**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
Strengths:					
Suggestions:					
AONs:					
13) Reasonable Accommodations for Enrollees with Physical or Mental Disabilities *PBMC A.6.i* *42 CFR § 438.206(c)(3)*	The PBM ensures that network pharmacies provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
14) Compliance with State and federal Prescribing Laws *PBMC A.10.c.*	The PBM ensures provider compliance with State and federal prescribing laws requiring written prescriptions only be filled if they are presented on an approved tamper-proof form.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Comment:					
Strengths:					
Suggestions:					
AONs:					
15) Information on the PBM's Website about the Provider Network	The PBM furnishes information regarding its provider network on a website and through its Pharmacy Help Desk.	☐ Met ☐ Not Met	**1.0**	**0.0**	

2023 Annual Network Adequacy Review Standards Tool: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by PBM**
			Value	**Score**	
Network Adequacy: Availability and Accessibility					
PBMC A.14.					
Comment: **Strengths:** **Suggestions:** **AONs:**					
16) Documentation Requirements *TCA 56-7-2356(b)(6)* *PBMC A.17.2* *PBMC A.17.3* *42 CFR § 438.207(a)(2)* *42 CFR § 438.207(c)(3)(i–ii)*	The PBM furnishes documentation to support the network's capacity to serve the TennCare members: On an annual basis Any time there has been a significant change in the network	☐ Met ☐ Not Met	**3.0**	**0.0**	
Comment: **Strengths:** **Suggestions:** **AONs:**					
Network Adequacy: Availability and Accessibility Score		**<##>%**	**24.0**	**0.0**	

ANA Contract File Review Tools—MCOs

MCO: <MCO>	Reviewer:												Date of Review: X/XX/2023												# of Files: ##					
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement[§§]	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
A) Specify that the provider may not refuse to provide covered medically necessary or covered preventive services to a child under the age of twenty-one (21) or a TennCare Medicaid patient under this Contract/ Agreement for non-medical reasons. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship. *CRA A.2.12.9.6* *TSA 2.12.9.6*																														
B) Specify the functions and/or services to be provided by the provider and assure that the functions and/or services to be provided are within the scope of his/her professional/ technical practice. *CRA A.2.12.9.7* *TSA 2.12.9.7*																														
C) Specify the amount, duration and scope of services to be provided by the provider and inform the provider of TennCare non-covered services as described in Section A.2.10 of the CRA and the TennCare rules and regulations. *CRA A.2.12.9.8*																														

[§§] *Y = Yes, N = No, P = Partial*

MCO: <MCO>	Reviewer:												Date of Review: X/XX/2023												# of Files: ##					
File#	1			2			3			4			5			6			7			8			9			10		
Item in Signed Agreement[§§]	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P
TSA.2.12.9.8																														
D) Provide that emergency services be rendered without the requirement of prior authorization of any kind. *CRA A.2.12.9.9* *TSA 2.12.9.9*																														
E) If the provider performs laboratory services, require the provider to meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988. *CRA A.2.12.9.12* *TSA 2.12.9.9*																														
F) Specify that the Contractor shall monitor the quality of services delivered under the provider agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical, behavioral health, or long-term-care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TennCare. *CRA A.2.12.9.22* *TSA 2.12.9.22*																														
G) Require that the provider comply with corrective action plans initiated by the Contractor. *CRA A.2.12.9.23* *TSA 2.12.9.23*																														

MCO: <MCO>	Reviewer:												Date of Review: X/XX/2023												# of Files: ##					
File#	1			2			3			4			5			6			7			8			9			10		
Item in Signed Agreement§§	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P
H) Informs providers of the package of benefits that TennCare Kids offers and which requires providers to make treatment decisions based upon children's individual medical and behavioral health needs. All provider agreements shall contain language that references the TennCare Kids requirements. *CRA A.2.12.9.62* *TSA 2.12.9.62*																														
I) Include a provision which states that providers are not permitted to encourage or suggest, in any way, that TennCare children be placed into state custody in order to receive medical, behavioral, or long-term-care services covered by TennCare. *CRA A.2.12.9.63* *TSA 2.12.9.63*																														
J) Provide for the participation and cooperation in any internal and external quality management/quality improvement, monitoring, utilization review, peer review and/or appeal procedures established by the Contractor and/or TennCare. *CRA A.2.12.9.20* *TSA 2.12.9.20*																														
K) Provide that TennCare, Tennessee Department of Intellectual & Developmental Disabilities (DIDD), the U.S. Department of Health and Human Services Office of the Inspector General (DHHS OIG), Office of																														

MCO: <MCO>	Reviewer:												Date of Review: X/XX/2023												# 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
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 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. Such records are to be provided at no charge to the requesting agency. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. *CRA A.2.12.9.18* *TSA 2.12.9.18*																														
L) Require safeguarding of information about enrollees according to applicable state and federal laws and regulations and as described in CRA Sections A.2.27 and (CRA E.6; TSA 5.33) of the CRA. *CRA A.2.12.9.55*																														

MCO: <MCO>	Reviewer:												Date of Review: X/XX/2023												# of Files: ##					
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement§§	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P
TSA 2.12.9.55																														
M) Specify that unreasonable delay in providing care to a pregnant member seeking prenatal care shall be considered a material breach of the provider's agreement with the Contractor and include the definition of unreasonable delay as described in Section A.2.7.5.2.3 of the CRA. *CRA A.2.12.9.11* *TSA 2.12.9.11*																														
N) Provide for monitoring, whether announced or unannounced, of services rendered to members. *CRA A.2.12.9.19* *TSA 2.12.9.19*																														
O) Specify that the no person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws are excluded from participation in, except as specified in Section A 2.3.5 of the CRA, or be denied benefits of, or be otherwise subjected to discrimination in the performance of the provider's obligation under its agreement with the Contractor or in the employment practices of the provider. *CRA A.2.12.9.65.1* *TSA 2.12.9.65.1*																														
P) Specify that the provider have written																														

MCO: <MCO>	Reviewer:												Date of Review: X/XX/2023												# 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
procedures for the provision of language interpretation and translation services for any enrollee who needs such services, including but not limited to, members with LEP (CRA only: and individuals with disabilities). *CRA A.2.12.9.65.2* *TSA 2.12.9.65.2*																														
Q) Require compliance with applicable access requirements, including but not limited to appointment and wait times as referenced in Section A.2.11 of the CRA. *CRA A.2.12.9.10* *TSA 2.12.9.10*																														
R) Require the provider to conduct criminal background checks (CRA only: and registry checks) in accordance with state law and TennCare policy. *CRA A.2.12.9.41* *TSA 2.12.9.41*																														
S) Require providers to screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. The provider shall be required to immediately report to the Contractor any exclusion information																														

MCO: <MCO>	Reviewer:												Date of Review: X/XX/2023												# 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
discovered. The provider shall be informed by the Contractor that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare members. *CRA A.2.12.9.39* *TSA 2.12.9.39*																														
T) Require that providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees. *CRA A.2.12.9.64* *TSA 2.12.9.64*																														
U) Require the provider to have and maintain documentation necessary to demonstrate that covered services were provided in compliance with state and federal requirements. *CRA A.2.12.9.13* *TSA 2.12.9.13*																														
V) CRA: 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																														

MCO: <MCO>	Reviewer:												Date of Review: X/XX/2023												# 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**
sixty (60) days from the date the overpayment was identified may be a violation of state or federal law. TSA: Require that the provider comply with the Affordable Care Act and TennCare P&Ps, including but not limited to, reporting overpayments, the requirement to report provider initiated refunds of overpayments to the Contractor and TennCare Office of Program Integrity and, when it is applicable, return overpayment to the Contractor within 60 days from the date the overpayment is identified. Overpayments that are not returned within 60 days from the date the overpayment was identified may be a violation of state or federal law. *CRA A.2.12.9.36* *TSA 2.12.9.36*																														
W) Require the provider to comply with 42 CFR Part 438, Managed care, including but not limited to 438.3, compliance with the requirements mandating provider ID of provider-preventable conditions as a condition of payment. At a minimum, this shall mean non-payment of provider-preventable conditions as well as appropriate reporting as required by the Contractor and TennCare. *CRA A.2.12.9.56* *TSA 2.12.9.56*																														
Total Number of Points																														
Maximum Number of Points																														

MCO: <MCO>	Reviewer:												Date of Review: X/XX/2023												# 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
Score																														

ANA Contract File Review Tools—DBM

DBM: <DBM>	Reviewer:												Date of Review: X/XX/2023												# 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/																														

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

DBM: <DBM>	Reviewer:												Date of Review: X/XX/2023												# 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
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 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 the standards established by TennCare.																														

DBM: <DBM>	Reviewer:												Date of Review: X/XX/2023												# of Files: ##					
File#	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement***	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
TDC A.66.q.																														
G) Require that the provider comply with corrective action plans initiated by the DBM or be subject to recoupment of funds, termination, or other penalties determined by TennCare. *TDC A.66.q.2.*																														
H) Ensure that all provider agreements include language that informs providers of the package of benefits that EPSDT offers and the periodicity schedule with which those benefits must be provided. All provider agreements must contain language that references the EPSDT benefit package and periodicity schedule. *TDC A.66.ll.*																														
I) Ensure that all provider agreements include a provision stating that providers are not permitted to encourage or suggest, in writing or verbally, that TennCare children be placed into state custody to receive medical or behavioral services covered by TennCare. *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 DBM and/or TennCare. *TDC A.66.p.*																														

DBM: <DBM>	Reviewer:												Date of Review: X/XX/2023												# 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**
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 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																														

AQS Tools

2023 MCO QP Tool

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Availability of Services					
1. Delivery Network 42 CFR § 438.206(b)(1) CRA 2.11.1.1, 2.11.1.2 TSA 2.11.1.1, 2.11.1.2	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 or physical 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 2.14.4.3 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 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.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
3. Second Opinion 42 CFR § 438.206(b)(3) CRA 2.6.4 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 2.11.1.9 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 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**
Comments **Strength** **AON** **Suggestion**					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Availability of Services					
6. 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
Comments					
Strength					
AON					
Suggestion					
7. Timely Access* 42 CFR § 438.206.c(1)(i) CRA Attachment III TSA Attachment III	The MCO meets and 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: 1) Primary Care Physician or Extender – Appointment wait times not to exceed 3 weeks of date of a member's request for regular appointments and 48 hours for urgent care. Waiting times do not exceed 45 minutes; 2) Specialty Care and Emergency Care – Referral appointments to specialists may not exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate. Waiting times do not exceed 45 minutes.	☐ Primary care ☐ Specialty and emergency care	0.50 0.50	1.00	0.00
Comments					
Strength					
AON					
Suggestion					

* *Element can be deemed compliant by NCQA standards.*
* *Element can be deemed compliant by NCQA standards.*

<table>
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<tr><th>Value</th><th>Score</th></tr>
<tr><td colspan="6">Availability of Services</td></tr>
<tr><td>8. Hours of Operation and Access

42 CFR § 438.206(c)(1)(ii)-(iii)
CRA 2.12.9.64, Attachment III
TSA 2.12.9.64, Attachment III</td><td>The MCO ensures that the 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.</td><td>☐ Comparable to hours of operation for commercial

☐ Services available 24 hours a day, seven days a week, when medically necessary</td><td>0.50

0.50</td><td>1.00</td><td>0.00</td></tr>
<tr><td>Comments
Strength
AON
Suggestion</td><td colspan="5"></td></tr>
<tr><td>9. Provider Compliance

42 CFR § 438.206(c)(1)(iv)-(vi)
CRA 2.11.1.10
TSA 2.11.1.10</td><td>The MCO:
1) Establishes mechanisms to ensure compliance by network providers with appointment and wait times;
2) Monitors network providers regularly to determine compliance using surveys and office visits; and
3) Takes corrective action if there is a failure to comply by a network provider and reports findings and corrective actions to TennCare.</td><td>☐ Mechanisms to ensure compliance

☐ Monitoring to determine compliance

☐ Corrective action if failure to comply</td><td>0.33

0.33

0.34</td><td>1.00</td><td>0.00</td></tr>
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Strength
AON
Suggestion</td><td colspan="5"></td></tr>
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<tr><th>Value</th><th>Score</th></tr>
<tr><td colspan="7">Availability of Services</td></tr>
<tr><td rowspan="2">10. Access and Cultural Considerations
42 CFR § 438.20(c)(2)
CRA 2.18.3
TSA 2.18.3</td><td rowspan="2">The MCO participates in the TennCare's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex.</td><td>☐</td><td>Yes</td><td>1.00</td><td rowspan="2">1.00</td><td rowspan="2">0.00</td></tr>
<tr><td>☐</td><td>No</td><td>0.00</td></tr>
<tr><td>Comments</td><td colspan="6"></td></tr>
<tr><td>Strength</td><td colspan="6"></td></tr>
<tr><td>AON</td><td colspan="6"></td></tr>
<tr><td>Suggestion</td><td colspan="6"></td></tr>
<tr><td rowspan="2">11. Accessibility Considerations
42 CFR § 438.206(c)(3)
CRA 2.18.3
TSA 2.18.3</td><td rowspan="2">The MCO ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.</td><td>☐</td><td>Yes</td><td>1.00</td><td rowspan="2">1.00</td><td rowspan="2">0.00</td></tr>
<tr><td>☐</td><td>No</td><td>0.00</td></tr>
<tr><td>Comments</td><td colspan="6"></td></tr>
<tr><td>Strength</td><td colspan="6"></td></tr>
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</table>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Assurances of Adequate Capacity and Services					
1. Nature of Supporting Documentation 42 CFR § 438.207(b)(1)-(2) CRA 2.30.8.1.1, 2.30.8.1.2 TSA 2.30.8.1, 2.30.8.1.2	The MCO submits documentation to TennCare, in a format specified by TennCare, to demonstrate that it complies with the following requirements: 1) Offers an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of members for the service area; and 2) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
2. Timing of Documentation 42 CFR § 438.207(c)(1)-(3) CRA 2.30.8.1 TSA 2.30.8.1	The MCO submits the documentation described in element one as specified by TennCare, but no less frequently than the following: 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: a) Changes in MCO services, benefits, geographic service area, composition of or payments to its provider network; and, b) Enrollment of a new population in the MCO.	☐ Time of contract execution ☐ On a monthly basis ☐ At time of significant change in operations	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
		Assurances of Adequate Capacity and Services Score	**0.00%**	**2.00**	**0.00**

2023 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 2.11.2.1 TSA 2.11.2.1	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 member receives information on how to contact their designated person or entity.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
2. Coordination of Services 42 CFR § 438.208(b)(2) CRA 2.9.1 TSA 2.9.1	The MCO coordinates the services the MCO furnishes to the member: 1) Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays; 2) With the services the member receives from any other MCO; and 3) With the services the member receives from community and social support providers.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
3. Initial Screening 42 CFR § 438.208(b)(3) CRA 2.8.3.1 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 within 30 days of the of the initial attempt if the initial attempt to contact the member is unsuccessful.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength**					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Coordination and Continuity of Care					
AON					
Suggestion					
4. Prevent Duplication of Services 42 CFR § 438.208(b)(4)	The MCO shares with TennCare, or other MCOs and DBMs 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					
5. Medical Records 42 CFR § 438.208(b)(5) CRA 2.24.8.1 TSA 2.24.6.1	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. Privacy Requirements 42 CFR § 438.208(b)(6) CRA 2.27 TSA 2.27	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					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Coordination and Continuity of Care					
AON					
Suggestion					
7. Comprehensive Assessment Mechanisms 42 CFR § 438.208(c)(2) CRA 2.9.5.5 TSA 2.9.6.5	1) The MCO implements mechanisms to comprehensively assess each Medicaid member identified by TennCare as needing LTSS or having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. 2) The assessment mechanisms use appropriate providers or individuals meeting LTSS service coordination requirements of TennCare or the MCO as appropriate.	☐ Assessment mechanisms for members with LTSS and special healthcare needs ☐ Assessment mechanisms include appropriate providers or individuals who meet service coordination requirements	0.50 0.50	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
8. Treatment/ Service Plans 42 CFR § 438.208(c)(3) CRA 2.9.7.1.1-.2, 2.9.7.11.3.1-1.1.1, 2.9.9.1-.1.1, 2.9.9.7 TSA 2.9.7.1.1-.2, 2.9.6.9.3.1-.1.1.1, 2.9.8.1.1	The MCO produces a treatment or service plan meeting the criteria below for members who require LTSS and for members with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan must be: 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; and 5) Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the member's circumstances or needs change significantly, or at the request of the member.	☐ Developed by individual meeting LTSS requirements ☐ Developed by person trained in person-centered planning ☐ Approved by MCO in timely manner ☐ In accordance with TennCare standards ☐ Reviewed and revised as required	0.20 0.20 0.20 0.20 0.20	1.00	0.00

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coordination and Continuity of Care					
Comments **Strength** **AON** **Suggestion**					
9. Direct Access to Specialists 42 CFR § 438.208(c)(4) CRA 2.14.3.3 TSA 2.14.3.3	For members with special health care 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 to directly access a specialist (for example, 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. Notification for Disenrollment 42 CFR § 438.56 CRA 2.5.4, 2.5.2 TSA 2.5.4, 2.5.2	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. Although the MCO may not request disenrollment of a member, the MCO informs TennCare promptly when the MCO 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. A member may request disenrollment or be disenrolled if: 1) The member selects another MCO during the ninety (90) day change period after enrollment with the MCO and is enrolled in another MCO; 2) The member selects another MCO during the annual choice period and is enrolled in another MCO; 3) A request by the member to change MCOs based on hardship criteria is approved by TennCare, and the member is enrolled in another MCO;	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Coordination and Continuity of Care					
	4) An appeal by the member to change MCOs based on hardship criteria decided by TennCare in favor of the member, and the member is enrolled in another MCO; 5) The member is assigned incorrectly to the contractor's MCO by TennCare and enrolled in another MCO; 6) The member moves outside the MCO's service area and is enrolled in another MCO; 7) A CHOICES I/DD MLTSS Programs member may request reassignment and shall have cause to change MCO assignment if all requirements are met; 8) During the appeal process, if TennCare determines it is in the best interest of the member and TennCare; 9) The member loses eligibility or is terminated from the TennCare program; 10) TennCare grants members the right to terminate enrollment and the member is enrolled in another MCO; 11) The MCO no longer participates in TennCare; and/or 12) The contract expires or is terminated.				
Comments					
Strength					
AON					
Suggestion					
		Coordination and Continuity of Care Score	**0.00%**	**10.00**	**0.00**

2023 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)(3)(i) CRA 2.6.3.3 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 2.6.3.3 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					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Coverage and Authorization of Services					
3. Service Limitations[*] 42 CFR § 438.210(a)(4)(i) CRA 2.6.3.1 TSA 2.6.3.1	The MCO is permitted to place appropriate limits on a service on the basis of criteria applied under the TennCare plan, 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)(ii) CRA 2.6.3.1, 2.14.1.6.5 TSA 2.6.3.1, 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**					

[*] *Element can be deemed compliant by NCQA standards.*

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
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)(i) CRA Definitions TSA Definitions	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 policies and procedures.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments **Strength** **AON** **Suggestion**					
6. Medically Necessary Services 42 CFR § 438.210(a)(5)(ii) CRA 2.6.3.1; 2.7.5.1; 2.7.6.3.1-.3.5; 2.7.6.4.1-.5, 2.6.1.9 TSA 2.6.3.1; 2.7.5.1; 2.7.6.3.1-.3.5; 2.7.6.4.1-.5	The MCO specifies "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**					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Coverage and Authorization of Services					
7. Authorization of Services Policies and Procedures 42 CFR § 438.210(b)(1) CRA 2.14.2.1 TSA 2.14.2.1	For the processing of requests for initial and continuing authorizations of services, the MCO and its subcontractors have in place, and follow, written policies and procedures.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
8. Processing Authorizations* 42 CFR § 438.210(b)(2) CRA 2.14.2.1, 2.14.5.1 TSA 2.14.2.1, 2.14.5.1	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 based on needs	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

* *Element can be deemed compliant by NCQA standards.*

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
9. Appropriate Expertise for Denials 42 CFR § 438.210(b)(3) CRA 2.14.1.8 TSA 2.14.1.8	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**					
10. Notice of Adverse Benefit Determination (NABD) 42 CFR § 438.210(c) CRA 2.19.9.6, 2.19.2 TSA 2.14.7.1, 2.19.2	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.	☐ Written notice to provider and member ☐ Includes required information	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
11. Notification Timeframes – Standard	For standard authorization decisions, the MCO provides notice as expeditiously as the member's condition requires and within 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days if: 1) The member or provider requests extension; or 2) The MCO justifies (to TennCare upon request) a need for additional information and how the extension is in the member's interest.	☐ Notice within required timeframe ☐ Extension for member request or MCO need for additional information	**0.50** **0.50**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Coverage and Authorization of Services					
Authorization Decisions 42 CFR § 438.210(d)(1) CRA 2.19.3.5, 2.19.3.6 TSA 2.19.3.5, 2.19.3.6					
Comments **Strength** **AON** **Suggestion**					
12. Notification Timeframes–Expedited Authorization Decisions 42 CFR § 438.210(d)(2) CRA 2.19.3.10 2.19.3.11 TSA 2.19.3.10, 2.19.3.11	If the MCO determines that following the standard authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited service authorization decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service, with a possible extension of up to 14 additional calendar days if: 1) The member or provider requests extension; or 2) The MCO justifies (to TennCare upon request) a need for additional information and how the extension is in the member's interest.	☐ Makes decision and provides notice within required timeframe ☐ Extension for member request or MCO need for additional information	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Coverage and Authorization of Services					
13. Compensation for Utilization Management (UM) 42 CFR § 438.210(e) CRA 2.14.1.11 TSA 2.14.1.11	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					
		Coverage and Authorization of Services Score	**0.00%**	**13.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Emergency and Poststabilization					
1. Emergency Services – Coverage and Payment 42 CFR § 438.114(c)(1) CRA 2.7.1.3, 2.7.1.6 TSA 2.7.1.3, 2.7.1.6	The MCO - 1) Covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO; and 2) Does not deny payment for treatment obtained under either of the following circumstances: a) 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; or b) The member's PCP or a representative of the MCO instructs the member to seek emergency services.	☐ Covers and pays for emergency services ☐ Does not deny payment for emergency treatment	0.50 0.50	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
2. Emergency Service Limitations 42 CFR § 438.114(d)(1) CRA 2.7.1.2 TSA 2.7.1.2	The MCO does not do either of the following: 1) Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms; and 2) Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, MCO, or TennCare of the member's screening and treatment within 10 calendar days of presentation for emergency services.	☐ Does not limit on basis of diagnoses or symptoms ☐ No refusal to cover based on no notification	0.50 0.50	1.00	0.00
Comments					
Strength					
AON					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Emergency and Poststabilization					
Suggestion					
3. Subsequent Treatment 42 CFR § 438.114(d)(2) CRA 2.7.1.4 TSA 2.7.1.4	Members who have an emergency medical condition 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					
4. Transfer or Discharge 42 CFR § 438.114(d)(3) CRA 2.7.1.4 TSA 2.7.1.4	The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
5. Financial Responsibility 42 CFR § 438.114(e), 422.113(c)(2) CRA 2.7.1.3 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	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Emergency and Poststabilization					
	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: a) Does not respond to a request for pre-approval within one hour; b) The MCO cannot be contacted; or c) 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 member until a plan physician is reached.				
Comments					
Strength					
AON					
Suggestion					
6. End of MCO Financial Responsibility 42 CFR § 438.114(e), 422.113(c)(3) CRA 2.14.4.1 TSA 2.14.4.1	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; or 4) The member is discharged.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Emergency and Poststabilization					
Strength					
AON					
Suggestion					
		Emergency and Poststabilization Score:	**0.00%**	**6.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Confidentiality					
1. Privacy Requirements 42 CFR § 438.224 CRA 2.27.5, 2.27.5.14 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; and 4) Process for members to request an accounting of disclosures of their PHI.	☐ Access to PHI ☐ Process to request restrictions ☐ Process to request amendments ☐ Process to request accounting	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
		Confidentiality Score	**0.00%**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Grievance and Appeal Systems					
1. Grievance and Appeal System 42 CFR § 438.402(a) CRA 2.19 TSA 2.19	The MCO has a grievance system in place for members.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments **Strength** **AON** **Suggestion**					
2. Authority to File 42 CFR § 438.402.(c)(1)(i) CRA 2.19.10.1 TSA 2.19.10.1	A member may file a grievance with the MCO. A member may contest an MCO-proposed adverse benefit determination by filing an appeal with TennCare.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments **Strength** **AON** **Suggestion**					
3. Provider or Authorized Representative 42 CFR § 438.402.(c)(1)(ii) CRA 2.19.4.2 TSA 2.19.4.2	With the written consent of the member, a provider or an authorized representative may file a TennCare appeal on behalf of a member.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments **Strength** **AON**					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Grievance and Appeal Systems					
Suggestion					
4. Timing to File Grievance and Appeal 42 CFR § 438.402(c)(2) CRA 2.19.10.1, 2.19.5.1 TSA 2.19.10.2, 2.19.5.1	A member may file a grievance with the MCO at any time. Following receipt of a notice of adverse benefit determination (NABD), a member has 60 calendar days from the date on the NABD notice to file a TennCare appeal with TennCare.	☐ May file a grievance at any time ☐ Has 60 calendar days to file an appeal after receiving NABD	**0.50** **0.50**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
5. Procedures 42 CFR § 438.402(c)(3) CRA 2.19.6.1, 2.19.10.1 TSA 2.19.6.1, 2.19.10.1	A member may file a grievance with the MCO either orally or in writing. A member may file an appeal contesting the MCO's proposed adverse benefit determination either orally or in writing at the TennCare phone number or address listed on the MCO-issued notice of adverse determination.	☐ May file grievance orally or in writing ☐ May file appeal orally or in writing	**0.50** **0.50**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Grievance and Appeal Systems					
6. Availability of Notices 42 CFR § 438.404(a) CRA 2.19.3, 2.19.2.7 TSA 2.19.3, 2.19.2.7	The MCO gives members a timely and adequate notice of an adverse benefit determination 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; and 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**					
7. Content of Notice of Adverse Benefit Determination (NADB) 42 CFR § 438.404(b)(1)-(6) CRA 2.19.2 TSA 2.19.2	The notice explains the following: 1) The adverse benefit determination the MCO has made or intends to make; 2) The reasons for the adverse benefit determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit 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 file a TennCare appeal of the MCO's adverse benefit determination; 4) The procedures for exercising the rights; 5) The circumstances under which an appeal process can be expedited and how to request it; and 6) The member's right to have benefits continue pending resolution of the appeal, how to request	☐ Determination made or intends to make ☐ Reasons for determination ☐ Right to file appeal ☐ Procedures for exercising rights ☐ Circumstances for which an appeal can be expedited ☐ Right to continuing benefits pending appeal resolution	0.16 0.16 0.17 0.17 0.17 0.17	1.00	0.00

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Grievance and Appeal Systems					
	that benefits be continued.				
Comments					
Strength					
AON					
Suggestion					
8. Timing of Notice 42 CFR § 438.404(c)(1-2) CRA 2.19.3.1, 2.19.3.4 TSA 2.19.3.1, 2.19.3.4	The MCO mails the NADB at the following times: 1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least 10 days before the date of action; and 2) For denial of payment, at the time of any action affecting the claim.	☐ At least 10 days before the date of action ☐ At the time of any action affecting the claim	**0.50** **0.50**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

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<tr><td>9. Timing for Standard Service Authorization*
42 CFR § 438.404(c)(3)
CRA 2.19.3
TSA 2.19.3</td><td>For standard service authorization decisions that deny or limit services, the MCO mails the notice within 14 calendar days following the receipt of request for service.</td><td>☐ Yes
☐ No</td><td>1.00
0.00</td><td>1.00</td><td>0.00</td></tr>
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Strength
AON
Suggestion</td><td colspan="5"></td></tr>
<tr><td>10. Extension of Standard Service Authorization Decisions
42 CFR § 438.404(c)(4)
CRA 2.19.3.8, 2.19.3.9
TSA 2.19.38, 2.19.3.8.9</td><td>If the MCO meets the criteria set forth for extending the timeframe for standard service authorization decisions, compliance requires that it:
1) Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and
2) Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.</td><td>☐ Written notice
☐ Makes determination timely</td><td>0.50
0.50</td><td>1.00</td><td>0.00</td></tr>
<tr><td>Comments
Strength
AON
Suggestion</td><td colspan="5"></td></tr>
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* *Element can be deemed compliant by NCQA standards.*

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Grievance and Appeal Systems					
11. Service Authorizations not Reached Within Timeframe 42 CFR § 438.404(c)(5)	For service authorization decisions not reached within the 14-calendar day timeframe, (which constitutes a denial and is thus an adverse benefit determination) the MCO mails the notice on the date that the timeframes expire.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
12. Timing for Expedited Service Authorizations* 42 CFR § 438.404(c)(6) CRA 2.19.3.10 TSA 2.19.3.10	For expedited service authorization decisions, the MCO mails the notice within 72 hours of receipt of the request for service.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

* *Element can be deemed compliant by NCQA standards.*

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Grievance and Appeal Systems					
13. Exceptions from Advance Notice 42 CFR § 431.213 CRA 2.19.3.3 TSA 2.19.3.3	The MCO may send a notice not later than the date of action if – 1) The MCO has factual information confirming the death of a member; 2) The MCO receives a clear written statement signed by a member that – a) The member no longer wishes services; or b) Gives information that requires termination or reduction of services and indicates that the member understands that this must be the result of supplying that information; 3) The member has been admitted to an institution where the member is ineligible under the plan for further services; 4) The member's whereabouts are unknown, and the post office returns agency mail directed to the member indicating no forwarding address; 5) The MCO establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth; 6) A change in the level of medical care is prescribed by the member's physician; or 7) The date of action will occur in less than 10 days.	☐ Death of member ☐ No longer wishes services, or information requires termination or reduction of services ☐ Admitted to institution and ineligible for further services ☐ Whereabouts unknown ☐ Accepted by another Medicaid jurisdiction ☐ Change in level of care prescribed ☐ Date of action will occur in less than ten days	0.15 0.15 0.14 0.14 0.14 0.14 0.14	1.00	0.00

Comments
Strength
AON
Suggestion

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Grievance and Appeal Systems					
14. Notice in Cases of Possible Fraud 42 CFR § 431.214 CRA 2.19.3.2 TSA 2.19.3.2	The MCO may shorten the period of advance notice to 5 days before the date of action if – 1) The MCO has facts indicating that action should be taken because of probable fraud by the member; and 2) The facts have been verified, if possible, through secondary sources.	☐ Facts indicating probably fraud ☐ Facts verified	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
15. Handling of Grievances and Appeals 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 numbers that have adequate TTY/TDD and interpreter capability.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
16. Acknowledging Grievances and Forwarding Appeals 42 CFR § 438.406(b)(1) CRA 2.19.1.6.1, 2.19.1.6.2 TSA 2.19.1.6.4	The MCO's process for handling member grievances and for satisfying TennCare requirements for appeals of adverse benefit determinations includes acknowledging receipt of each grievance and forwarding appeal of adverse benefit determinations to TennCare and informing the member that TennCare will contact them about their appeal.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
17. Reviewer Requirements 42 CFR § 438.406(b)(2) CRA 3 2.19.1.7 TSA 2.19.1.76	The MCO's process for handling member grievances and appeals of adverse benefit determinations includes ensuring that the individuals 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, in treating the member's condition or disease: a) An appeal of a denial that is based on lack of medical necessity, b) A grievance regarding denial of expedited resolution of an appeal, c) A grievance or appeal that involves clinical issues; 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	☐ Not involved in previous review or subordinate ☐ Appropriate clinical expertise ☐ Take into account all information	**0.33** **0.33** **0.34**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Grievance and Appeal Systems					
	was submitted or considered in the initial adverse benefit determination.				
Comments					
Strength					
AON					
Suggestion					
18. Oral Inquiries Treated as Appeals 42 CFR § 438.406(b)(3)1	The MCO's process for and for satisfying TennCare's requirements for appeals of adverse benefit determinations includes providing that oral inquiries seeking to appeal an adverse benefit determination are forwarded to TennCare and treated as appeals.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
19. Resolution and Notification 42 CFR § 438.408(a) CRA 2.19.7, 2.19.10.2 TSA 2.19.7.1	The MCO resolves each grievance and appeal process-related obligations, and provides notice, as expeditiously as the member's health condition requires, within TennCare-established timeframes.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Grievance and Appeal Systems					
20. Grievance Resolution Timeframe 42 CFR § 438.408(b)(1) CRA 2.19.10.2 TSA 2.19.10.2	For standard resolution of a grievance and notice to the affected parties, the timeframe established by TennCare is not to exceed 90 calendar days from the day the MCO receives the grievance.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
21. Standard Appeal Resolution Timeframe 42 CFR § 438.408(b)(3) CRA 2.19.7.1 TSA 2.19.7.1	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**
Comments **Strength** **AON** **Suggestion**					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
22. Expedited Appeal Resolution Timeframe 42 CFR § 438.408(b)(3) CRA 2.19.7.1 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					
23. Extension of Appeal Timeframes 42 CFR § 438.408(c)(1) CRA 2.19.3.7 TSA 2.19.3.7	The MCO may extend the timeframes for standard and expedited appeal resolution by up to 14 calendar days if – 1) The member requests the extension; and 2) 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.	☐ Extension justified ☐ Requirements following extension	**0.50** **0.50**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Grievance and Appeal Systems					
24. Extension – Requirements 42 CFR § 438.408(c)(2) CRA 2.19.3.9 TSA 2.19.3.9	If the MCO extends the timeframes not at the request of the member, compliance requires that it complete all of the following: 1) Make reasonable efforts to give the member prompt oral notice of the delay; 2) Within 2 calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and 3) Complete the reconsideration phase of the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.	☐ Prompt oral notice ☐ Written notice ☐ Complete reconsideration phase timely	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
25. Format of Grievance Notice 42 CFR § 438.408(d)(1) CRA 2.19.10.4 TSA 2.19.10.4	The MCO uses the TennCare established method to notify a member of the resolution of a grievance and ensures that such methods provide for: 1) Written translation; 2) Oral interpretation; 3) Alternative formats; and 4) Auxiliary aids and services.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
26. Format of Appeal Notice 42 CFR § 438.408(d)(2) CRA 2.19.8.1 TSA 2.19.8.1	For all appeals, the MCO provides written notice of resolution in a format and language that provider for: 1) Written translation; 2) Oral interpretation; 3) Alternative formats; and 4) Auxiliary aids and services	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
27. Content of Notice of Appeal Resolution – Results and Date 42 CFR § 438.408(e)(1) CRA 2.19.8 TSA 2.19.8	The written notice of the 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**					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Grievance and Appeal Systems					
28. Expedited Resolution of Appeals 42 CFR § 438.410(a) CRA 2.19.6.2.2 TSA 2.19.6.2	The MCO establishes and maintains an expedited review process for appeals, 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					
29. Punitive Action Prohibited 42 CFR § 438.410(b) CRA 2.19.6.5 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					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Grievance and Appeal Systems					
30. Expedited Resolution of Appeals Requirements 42 CFR § 438.410(c) CRA 2.19.6 TSA 2.19.6	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) Within 2 calendar days gives the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision; and 4) Completes the reconsideration phase of the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.	☐ Transfer to standard timeframe ☐ Give prompt oral notice ☐ Provide written notice ☐ Complete reconsideration no later than the date extension expires	0.25 0.25 0.25 0.25	1.00	0.00
Comments **Strength** **AON** **Suggestion**					
31. Provider Information 42 CFR § 438.414 CRA 2.19.12.1 TSA 2.19.12.1	The MCO provides information about the grievance and TennCare appeal procedures and filing timeframes to all providers and subcontractors at the time they enter into a contract.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments **Strength** **AON** **Suggestion**					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Grievance and Appeal Systems					
32. Recordkeeping Requirements – Ongoing Monitoring 42 CFR § 438.416(a) CRA 2.19.11 TSA 2.19.11	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 TennCare's Quality Strategy.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
33. Recordkeeping Requirements - Information 42 CFR § 438.416(b) CRA 2.19.11 TSA 2.19.11	The record of each grievance or appeal contains, at a minimum, all of the following information: 1) A general description of the reason for the appeal or grievance; 2) The date received; 3) The date of each review or, if applicable, review meeting; 4) Resolution at each level of the appeal or grievance, if applicable; 5) Date of resolution at each level, if applicable; and 6) Name of the member for whom the appeal or grievance was filed.	☐ Reason for appeal or grievance ☐ Date received ☐ Date of each review ☐ Resolution ☐ Date of resolution ☐ Name of member	**0.16** **0.16** **0.17** **0.17** **0.17** **0.17**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Grievance and Appeal Systems					
34. Recordkeeping Requirements - Accuracy and Accessibility 42 CFR § 438.416(c) CRA 2.19.11 TSA 2.19.11	The record must be accurately maintained 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. Continuation of Benefits 42 CFR § 438.420(b) CRA 2.19.9 TSA 2.19.9	The MCO continues the member's benefits if all of the following occur: 1) The member files the request for an appeal timely; 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; and 5) The member timely files for continuation of benefits.	☐ Member files timely request ☐ Appeal involves change in previously authorized service ☐ Services ordered by authorized provider ☐ Period covered by authorization not expired ☐ Member files timely for continuation of benefits	**0.20** **0.20** **0.20** **0.20** **0.20**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Grievance and Appeal Systems					
36. Duration of Continued or Reinstated Benefits 42 CFR § 438.420(c) CRA 2.19.9 TSA 2.19.9	If, at the member's request, the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs: 1) The member withdraws the appeal or request for appeal; 2) The member fails to request an appeal and continuation of benefits within 10 calendar days after the MCO sends the notice of an adverse resolution to the member's appeal; or 3) An appeal results in a decision adverse to the member.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
37. Effectuation of Reversed Appeal Resolutions – Services not Furnished while Appeal Pending 42 CFR § 438.424(a) CRA 2.19.9.4, TSA 2.19.9.4	If the TennCare appeal 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.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Grievance and Appeal Systems					
38. Effectuation of Reversed Appeal Resolutions Services Furnished While Appeal Pending 42 CFR § 438.424(b) CRA 2.19.9.5 TSA 2.19.9.5	If the TennCare appeal reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO pays for those services.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
Grievance and Appeal Systems Score			0.00%	38.00	0.00

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Subcontractual Relationships and Delegation					
1. Subcontractor Activities* 42 CFR § 438.230.(c)(1)(i) CRA 2.26.1.2 TSA 2.26.1.2	Each contract or written arrangement with any subcontractor must specify that if any of the MCO's activities or obligations under its contract with TennCare are delegated to a subcontractor, the delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments **Strength** **AON** **Suggestion**					
2. Subcontractor Contract Requirements* 42 CFR § 438.230.(c)(1)(ii) CRA 2.26.1 TSA 2.26.1	Each contract or written arrangement with any subcontractor must specify that if any of the MCO's activities or obligations under its contract with TennCare are delegated to a subcontractor: 1) The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's contract obligations; and 2) The contract or written arrangement must either provide for revocation of the delegation of activities or obligations or specify other remedies in instances where TennCare or the MCO determine that the subcontractor has not performed satisfactorily.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments **Strength** **AON** **Suggestion**					

* *Element can be deemed compliant by NCQA accreditation standards.*
* *Element can be deemed compliant by NCQA accreditation standards.*

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Subcontractual Relationships and Delegation					
3. Subcontractor Regulatory Compliance 42 CFR § 438.230(c)(2) CRA 2.26.1 TSA 2.26.1	The subcontractor agreement specifies that the subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
4. Subcontractor Audit Requirements 42 CFR § 438.230(c)(3) CRA 2.26.1 TSA 2.26.1	The subcontractor agreements specifies that - 1) TennCare, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCO's contract with the TennCare; 2) The subcontractor will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members; 3) The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later; and 4) If TennCare, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, TennCare, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.	☐ Right to audit ☐ Make available premises, records, etc. for purpose of audit, evaluation, or inspection ☐ Right to audit exists through 10 years ☐ May inspect, audit, evaluate at any time if suspicion of fraud or similar risk	0.25 0.25 0.25 0.25	1.00	0.00

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Subcontractual Relationships and Delegation					
Comments					
Strength					
AON					
Suggestion					
5. Subcontractor Evaluation CRA 2.26.1.1 TSA 2.26.1.1	The MCO evaluates the prospective subcontractor's ability to perform the activities to be delegated.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
6. Subcontractor Monitoring 42 CFR § 438.230(c)(2) CRA 2.26.1.3 TSA 2.26.1.4	The MCO monitors the subcontractor's performance on an ongoing basis and subjects it to formal review, on at least an annual basis, consistent with NCQA standards and TennCare MCO laws and regulations.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Subcontractual Relationships and Delegation					
7. Subcontractor Corrective Action CRA 2.26.1.4 TSA 2.26.1.5	The MCO identifies deficiencies or areas for improvement and the MCO and the subcontractor take corrective action, as necessary.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
		Subcontractual Relationships and Delegation Score	**0.00%**	**7.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Practice Guidelines					
1. Adoption of Practice Guidelines 42 CFR § 438.236(b) CRA 2.15.4 TSA 2.15.4	The MCO adopts practice guidelines that meet the following requirements: 1) Are based on valid and reliable clinical evidence or a consensus of providers in the particular field; 2) Consider the needs of the MCO's members; 3) Are adopted in consultation with network providers; and 4) Are reviewed and updated whenever the guidelines change and at least every two years.	☐ Based on evidence or a consensus ☐ Consider members' needs ☐ Adopted in consultation with network providers ☐ Reviewed and updated as required	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**
Comments					
Strength					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Practice Guidelines					
AON					
Suggestion					
2. Dissemination of Guidelines 42 CFR § 438.236(c) CRA 2.15.4 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					
3. Application of Guidelines 42 CFR § 438.236(d) CRA 2.15.4 TSA 2.15.4	Decisions for utilization management, member education, coverage of services, population health programs, and other areas to which the guidelines apply are consistent with the guidelines.	☐ Decisions for utilization management ☐ Member education ☐ Coverage of services ☐ Population health programs	0.25 0.25 0.25 0.25	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
		Practice Guidelines Score	**0.00%**	**3.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Health Information Systems					
1. General Rule 42 CFR § 438.242(a)	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. Basic Elements* 42 CFR § 438.242(b)(2) CRA 2.23.4 TSA 2.23.4	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					

* *Element can be deemed compliant by NCQA standards.*

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<tr><td>3. Data Accuracy and Completeness[*]
42 CFR § 438.242(b)(3)
CRA 2.23.4.3.1
TSA 2.23.4.3.1</td><td>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.</td><td>☐ Verify accuracy and timeliness
☐ Screen for completeness, logic, and consistency
☐ Collect data in standardized formats</td><td>0.33
0.33
0.34</td><td>1.00</td><td>0.00</td></tr>
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<tr><td>Strength</td><td colspan="5"></td></tr>
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<tr><td>Suggestion</td><td colspan="5"></td></tr>
<tr><td>4. Data Availability
42 CFR § 438.242(b)(4)
CRA 2.23.4
TSA 2.23.4</td><td>The MCO makes all collected data available to TennCare and, upon request, to CMS.</td><td>☐ Yes
☐ No</td><td>1.00
0.00</td><td>1.00</td><td>0.00</td></tr>
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<tr><td>Strength</td><td colspan="5"></td></tr>
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</table>

[*] *Element can be deemed compliant by NCQA standards.*

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Quality Assessment and Performance Improvement (QAPI) Program					
1. QAPI Program[*] 42 CFR § 438.330(a)(1) CRA 2.15.1.1 TSA 2.15.1.1	The MCO establishes and implements an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its members.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
2. Utilization and Special Health Care Needs 42 CFR § 438.330(b)(3)-(4)	The comprehensive quality assessment and performance improvement program must include at least the following elements: 1) Mechanisms to detect both underutilization and overutilization of services; and 2) Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. as defined by TennCare in the Quality Strategy.	☐ Mechanisms to detect under and overutilization ☐ Mechanisms to assess quality of care furnished to members with special health care needs	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

[*] *Element can be deemed compliant by NCQA standards.*

2023 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. Long Term Services and Supports 42 CFR § 438.330(b)(5) CRA 2.15.7 TSA 2.15.7	The comprehensive quality assessment and performance improvement program includes at least the following elements for MCOs providing long-term services and supports: 1) Mechanisms to assess the quality and appropriateness of care furnished to members using long-term services and supports, including assessment of care between care settings and a comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable; and 2) Participate in efforts by TennCare to prevent, detect, and remediate critical incidents that are based, at a minimum, on the requirements on TennCare for home and community-based waiver programs.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
4. Performance Measurement 42 CFR § 438.330(c)(2) CRA 2.15.6.1 TSA 2.15.6.1	The MCO annually: 1) Measures and reports to the TennCare on its performance, using the standard measures required by TennCare; and 2) Submits data to TennCare which allow TennCare to calculate the MCO's performance using the standard measures identified by TennCare.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Quality Assessment and Performance Improvement (QAPI) Program					
5. Performance Improvement Projects 42 CFR § 438.330(d)(2) CRA 2.15.3 TSA 2.15.3	Each performance improvement project must be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and must include the following elements: 1) Measurement of performance using objective quality indicators; 2) Implementation of interventions to achieve improvement in the access to and quality of care; 3) Evaluation of the effectiveness of the interventions based on the performance measures; and 4) Planning and initiation of activities for increasing or sustaining improvement.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
6. Reporting Results to TennCare 42 CFR § 438.330(d)(3) CRA 2.15.3 TSA 2.15.3	The MCO reports the status and results of each project conducted to TennCare as requested, but not 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			**0.00%**	**6.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Member Rights					
1. Member Rights – Policies and Procedures 42 CFR § 438.100(b)(2) CRA 2.17.4.6.26 TSA 2.17.4.7.25	The MCO has written policies on member rights and responsibilities. A member of an MCO has 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; 6) Request and receive a copy of his or her medical records and request that they be amended or corrected; and 7) Freely exercise rights, and that the exercise of those rights does not adversely affect the way the MCO and its network providers treat the member.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
		Member Rights Score:	**0.00%**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Information Requirements					
1. Member Information Requirements - General 42 CFR § 438.10(c)(1) CRA 2.17.2 TSA 2.17.2	The MCO provides all required information to be provided to members and potential members in a manner and format that may be easily understood and is readily accessible by such members and potential members.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
2. Electronic Member Information 42 CFR § 438.10(c)(6) CRA 2.17.2.4 TSA 2.17.2.4	All required member information provided electronically by MCO meets all of the following: 1) The format is readily accessible; 2) The information is placed in a location on the MCO's, Web site that is prominent and readily accessible; 3) The information is provided in an electronic form which can be electronically retained and printed; 4) The information is consistent with the content and language requirements; and 5) The member is informed that the information is available in hard copy form without charge upon request and provides it upon request within 5 business days.	☐ Format is readily accessible ☐ Prominent location ☐ Electronically retained and printed ☐ Consistent with content and language requirements ☐ Informed of availability in hard copy form within 5 business days	**0.20** **0.20** **0.20** **0.20** **0.20**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Information Requirements					
3. Assistance with Understanding Plan 42 CFR § 438.10(c)(7)	The MCO has in place mechanisms to help members and potential members understand the requirements and benefits of the plan.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
4. Written Materials 42 CFR § 438.10.d(3) CRA 2.17.2 TSA 2.17.2	The MCO makes its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its particular service area. Written materials that are critical to obtaining services must also be made available in alternative formats upon request of the potential member or member at no cost, include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and include the toll-free and TTY/TDY telephone number of the MCO's member/customer service unit. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Information Requirements					
5. Interpretation Services 42 CFR § 438.10(d)(4) CRA 2.18.2.1 TSA 2.18.2.1	The MCO has written policies and procedures to make interpretation services available to each potential member free of charge to each member. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. Oral interpretation requirements apply to all non-English languages, not just those that TennCare identifies as prevalent.	☐ Yes ☐ No	**1.00** 0.00	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
6. Communication Assistance 42 CFR § 438.10(d)(5) CRA A2.17.2-.4 TSA A2.17.2-.4	The MCO notifies potential members- 1) That oral interpretation is available for any language and written translation is available in prevalent languages; 2) That auxiliary aids and services are available upon request and at no cost for members with disabilities; and 3) How to access these services.	☐ Oral interpretation available ☐ Auxiliary aids available ☐ How to access services	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

<table>
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<tr><th>Value</th><th>Score</th></tr>
<tr><td colspan="6">Information Requirements</td></tr>
<tr><td>7. Written Material Requirements

42 CFR § 438.10(d)(6)
CRA 2.17.2
TSA 2.17.2</td><td>The MCO provides all written materials for potential members and members consistent with the following:
1) Use easily understood language and format;
2) Use a font size no smaller than 12 points; and
3) Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency.</td><td>☐ Easily understood language and format
☐ Font size no smaller than 12 points
☐ Available in alternative formats and through auxiliary aids</td><td>0.33
0.33
0.34</td><td>1.00</td><td>0.00</td></tr>
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<tr><td>Strength</td><td colspan="5"></td></tr>
<tr><td>AON</td><td colspan="5"></td></tr>
<tr><td>Suggestion</td><td colspan="5"></td></tr>
<tr><td>8. Notice of Provider Termination

42 CFR § 438.10(f)(1)
CRA 2.11.11.1.1, 2.11.11.1.2
TSA 2.11.11.1, 2.11.11.1.2</td><td>The MCO makes a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Notice to the member must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice.</td><td>☐ Written notice of termination
☐ 30 calendar days prior to effective date or 15 calendar days after receipt of termination notice</td><td>0.50
0.50</td><td>1.00</td><td>0.00</td></tr>
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2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Information Requirements					
Comments					
Strength					
AON					
Suggestion					
9. Physician Incentive Plans 42 CFR § 438.10(f)(3) CRA 2.17.4.6.37 TSA 2.17.4.7.36	The MCO makes available, upon request, any physician incentive plans in place.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
10. Member Handbook Timing 42 CFR § 438.10(g)(1) CRA 2.17.4.2 TSA 2.17.4.2	The MCO provides each member a member handbook, within 30 calendar days after receiving notice of the member's enrollment and annually thereafter, which serves a similar function as the summary of benefits and coverage.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Information Requirements					
11. Member Handbook Delivery[*] 42 CFR § 438.10(g)(3) CRA 2.17.4.2 TSA 2.17.4.2	Member handbook information is considered to be provided if the MCO: 1) Mails a printed copy of the information to the member's mailing address; 2) Provides the information by email after obtaining the member's agreement to receive the information by email; or 3) Posts the information on the Web site of the MCO and advises the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or 4) Provides the information by any other method that can reasonably be expected to result in the member receiving that information.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments **Strength** **AON** **Suggestion**					
12. Member Handbook Changes 42 CFR § 438.10(g)(4) CRA 2.17.4.1 TSA 2.17.4.1	The MCO gives each member notice of any change that TennCare defines as significant in the member handbook information at least 30 days before the intended effective date of the change.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments **Strength** **AON**					

[*] *Element can be deemed compliant by NCQA standards.*

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Information Requirements					
Suggestion					
13. Provider Directory Information 42 CFR § 438.10(h)(1) CRA 2.17.8.5 TSA 2.17.8.5	The MCO makes available in hard copy form upon request and electronic form, the following information about its network providers: 1) The provider's name as well as any group affiliation; 2) Street address(es); 3) Telephone number(s); 4) Web site URL, as appropriate; 5) Specialty, as appropriate; 6) Whether the provider will accept new members; 7) The provider's 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 8) Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
14. Provider Directory – Provider Types 42 CFR § 438.10(h)(2) CRA 2.17.8.5 TSA 2.17.8.5	The provider directory must include the information for each of the following provider types covered under the contract: 1) Physicians, including specialists; 2) Hospitals; 3) Behavioral health providers; and 4) LTSS providers, as appropriate.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					
Strength					
AON					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Information Requirements					
Suggestion					
15. Provider Directory Updates 42 CFR § 438.10(h)(3) CRA 2.17.8.3 TSA 2.17.8.3	Information included in: 1) A hard copy provider directory is updated at least monthly; and 2) An electronic provider directory is updated a minimum of 3 days a week and available on the MCO's Web site in a machine-readable file and format	☐ Hard copy updates monthly ☐ Electronic directory updates at least 3 days a week in machine-readable file and format	**0.50** **0.50**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
16. Provider Visits CRA 2.18.6.19 TSA 2.18.6.20	The MCO's provider relations staff contacts all contract providers on a semi-annual basis to update contract providers 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 two semi-annual contacts made in a year shall be face-to-face with the provider. Face-to-face contacts made with the provider may be satisfied by virtual visits conducted via WebEx, Zoom, Microsoft Teams, etc., if the provider agrees with the virtual format and does not request an in-person face-to-face meeting. Semi-annual contacts that are not conducted face-to-face shall be conducted via a phone conversation with the provider. The MCO maintains a records to show when and how contacts are made. The MCO may submit an alternative plan to accomplish the intent of this requirement for review and approval by TennCare.	☐ Semiannual contacts made using appropriate methods ☐ Records maintained	**0.50** **0.50**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Information Requirements					
17. Advance Directives 42 CFR § 438.3(j), 422.128(b)(1)(i) CRA 2.7.7 TSA 2.7.7	1) The MCO maintains written policies and procedures for advance directives that comply with all federal and state requirements concerning advance directives. Any written information provided by the MCO reflects changes in state law by the effective date specified in the law, if not specified then within thirty (30) calendar days after the effective date of the change. 2) The MCO provides its policies and procedures to all members eighteen (18) years of age and older and educates members about their ability to direct their care using advance directives and specifically designate which staff members and/or contract providers are responsible for providing this education. 3) The MCO, for behavioral health services, provides its policies and procedures to all members sixteen (16) years of age and older and educates members about their ability to direct their care using advance directives. The MCO specifically designates staff members and/or providers responsible for providing this education. 4) For CHOICES members, the care coordinator educates members about their ability to use advance directives during the face-to-face intake visit for current members or the face-to-face visit with new members, as applicable.	☐ Written policies and procedures and provides changes in state law within 30 days of change ☐ Provides policies and procedures to all members 18 and older ☐ For behavioral health services, provides policies and procedures to all members 16 and older ☐ For CHOICES members, care coordinator education provided	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
		Information Requirements	**0.00%**	**17.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
1. EPSDT Program Information 42 CFR § 441.56(a)(2)	Using clear and nontechnical language, the MCO provides information about the following - 1) The benefits of preventive health care; 2) The services available under the EPSDT program and where and how to obtain those services; 3) That the services provided under the EPSDT program are without cost to eligible up to age 21, except for any enrollment fee, premium, or similar charge that may be imposed on medically needy members; and 4) That necessary transportation and scheduling assistance is available to the EPSDT eligible individual upon request.	☐ Benefits of preventive care ☐ Services available and where and how to obtain them ☐ Services are without cost ☐ Transportation and scheduling assistance available	0.25 0.25 0.25 0.25	1.00	0.00
Comments **Strength** **AON** **Suggestion**					
2. Screening Components 42 CFR § 441.56(b)(1) CRA 2.7.6.3.2 – 2.7.6.3.3.6. TSA 2.7.6.3.2, 2.7.6.3.2 - 2.7.6.3.3.6.	The MCO provides to eligible EPSDT members who request it, screening (periodic comprehensive child health assessments); that is, regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. As a minimum, these screenings must include, but are not limited to: 1) Comprehensive health and developmental history; 2) Comprehensive unclothed physical examination; 3) Appropriate vision testing; 4) Appropriate hearing testing; 5) Appropriate laboratory tests; 6) Dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age; 7) Appropriate immunizations; and 8) Health education.	☐ Health and developmental history ☐ Physical exam ☐ Vision testing ☐ Hearing testing ☐ Laboratory tests ☐ Dental screening ☐ Immunization ☐ Health education	0.12 0.12 0.12 0.13 0.13 0.13 0.13 0.13	1.00	0.00
Comments					

2023 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)					
Strength **AON** **Suggestion**					
3. Services Deemed Necessary 42 CFR § 441.56(c) CRA 2.7.6.4.2, 2.7.6.4.3, 2.7.6.3.3.3 TSA 2.7.6.4.2, 2.7.6.4.3, 2.7.6.3.3.3	In addition to any diagnostic and treatment services included in the plan, the MCO provides to eligible EPSDT members, the following services, the need for which is indicated by screening, even if the services are not included in the plan: 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; and 3) Appropriate immunizations. (If it is determined at the time of screening that immunization is needed and appropriate to provide at the time of screening, then immunization treatment must be provided at that time.)	☐ Vision and hearing services ☐ Dental care ☐ Appropriate immunizations	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
4. Continuing Care Provider 42 CFR § 441.60(a)-(e), 441.62(a)-(b) CRA 2.11.2.1 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					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
Strength					
AON					
Suggestion					
5. Utilization of Providers and Coordination with Related Programs 42 CFR § 441.61	1) The MCO provides referral assistance for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening and diagnosis. This referral assistance must include giving the family or member the names, addresses, and telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family. 2) The MCO makes available a variety of individual and group providers qualified and willing to provide EPSDT services. 3) The MCO makes appropriate use of State health agencies, State vocational rehabilitation agencies, and Title V grantees (Maternal and Child Health/Crippled Children's Services). Further, the MCO makes use of other public health, mental health, and education programs and related programs, such as Head Start, Title XX (Social Services) programs, and the Special Supplemental Food Program for Women, Infants and Children (WIC), to ensure an effective child health program.	☐ Treatment and referral assistance ☐ Variety of EPDST providers ☐ Use of public health agencies	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
6. New Member Calls CRA 2.7.6.2.2.1 TSA 2.7.6.22.1	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**

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
Comments					
Strength					
AON					
Suggestion					
7. Member Outreach Contacts CRA 2.7.6.2.2, 2.17.4.2 TSA 2.7.6.2.2, 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); and 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					
8. Additional Outreach CRA 2.7.6.2.4 TSA 2.7.6.2.4	The MCO makes at least two efforts per year in excess of the six “outreach contacts” to schedule a screening for the members who do not get their screenings timely, and the efforts are in different formats.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 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)					
9. Re-Notification If No Services Used CRA 2.7.6.2.5 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**					
10. Accurate Provider Lists CRA 2.7.6.2.6 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**					
11. Targeted Activities for Smoking Cessation CRA 2.7.4.1.3 TSA 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**					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
Suggestion					
12. Prenatal Appointment Assistance CRA 2.7.5.2.1, 2.7.6.2.7 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					
13. Coordinating Services CRA 2.7.6.1.3, 2.7.6.1.5.2 TSA 2.7.6.1.3, 2.7.6.1.5.2	The MCO has policies and procedures 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.	☐ Policies and procedures in place ☐ Staff described efforts	**0.50** **0.50**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 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)					
14. Notify MCO If Unable to Make Referral CRA 2.7.6.1.6 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					
15. Rehabilitative Services CRA 2.7.6.1.1 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**
Comments					
Strength					
AON					
Suggestion					
16. Referral Providers List CRA 2.14.3.5.1 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**

2023 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					
17. Family Involvement and Accessible Services CRA 2.7.6.1.9 TSA 2.7.6.1.9	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					
18. Follow-Up After Inpatient or Residential Treatment CRA 2.9.11.3.2 TSA 2 2.9.11.3.2	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					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
19. Screening Components Including Follow-Up CRA 2.7.6.1.4 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					
20. Transportation 42 CFR § 441.62 CRA 2.7.6.4.6.1, Attachment XI: A.4.1.1 TSA 2.7.6.4.6.1, Attachment XIA4.1.1	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					
21. Individual Education Plans (IEPs) CRA 2.9.17.8.1 - 2.9.17.8.4.3 TSA 2.9.18.7 – 2.9.18.7.4.3	The MCO is responsible for the delivery of medically necessary covered services to school-aged children. The MCO is also encouraged to work with school-based providers to manage the care of students with special needs. The Department of Education (DOE) and local education agencies are responsible for documenting a school-aged child's need for medical services in an IEP. When the child is enrolled in TennCare, the school is responsible for obtaining parental consent to share the IEP with the MCO and subsequently sending a copy of the parental	☐ 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**

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
	consent and IEP to the MCO in the required manner. The MCO decides whether to receive the IEP and parental consent prior to providing and paying for medically necessary covered services or upon request during a post-payment 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; and 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					
22. IEP Services Provided Without Submission of the IEP CRA 2.9.17.8.2-2.9.17.8.3.1 TSA 2.9.18.7.1-.2.9.18.7.3.1	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**
Comments					

2023 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)					
Strength					
AON					
Suggestion					
23. Tracking System CRA 2.7.6.1.8, 2.7.6.2.3 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	**0.00%**	**23.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
BESMART Program					
1. Annual Engagements	The MCO provides at minimum three annual engagements with the BESMART provider or practice. These three engagements include, at a minimum:	☐ Educational support ☐ Quality review	**0.33** **0.33**	**1.00**	**0.00**

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
2023 Annual Quality Survey—Quality Process Standards: <MCO>					
BESMART Program					
CRA 2.11.4.1.1.1, 2.11.4.1.1.1.1, 2.11.4.1.1.1.11,2.11.4.1.1.1.2 TSA 2.11.4.1.1.1, 2.11.14.1.1.1.11, 2.11.4.1.1.1.2	1) Educational Support meeting with appropriate representatives for topics including, but not limited to, billing or processing, programmatic education, quality metrics, care coordination. MCOs may collaborate to allow a provider or practice to only receive an Educational Support Meeting by one MCO during a calendar year; 2) Quality Review - The MCO conducts one in-person or virtual Quality Review with each contracted BESMART provider or BESMART practice. A “BESMART Practice” is considered a group of providers under one TIN with more than one contracted BESMART provider; and 3) Virtual Education Session.	☐ Virtual education	**0.34**		
Comments					
Strength					
AON					
Suggestion					
2. Quality Review – Inter-Rater Reliability CRA 2.11.4.1.1.1.2.1 TSA 2.11.4.1.1.1.2.1	The MCO has a BESMART Quality Review inter-rater reliability (IRR) assessment policy and procedure in place to evaluate the consistency and validity of the rater with the accepted BESMART Quality Review tool standards used for quality assurance. An accuracy rate of 95% is required. If a reviewer falls below the targeted threshold, additional training is necessary until 95% is achieved. The MCO establishes at minimum an annual periodic Inter-rater Review to confirm consistency of review criteria for new reviewers or after identification of inconsistent determinations and receipt of additional training. To ensure consistent decisions, an action plan is developed by the MCO to include (but not limited to) guideline development, training measures, and process improvement as necessary	☐ IRR policies and procedures and annual periodic IRR review ☐ Accuracy rate of 95% ☐ Additional training (if applicable) ☐ Action plan	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**
Comments					
Strength					
AON					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
BESMART Program					
Suggestion					
3. Quality Policies and Procedures CRA 2.11.4.1.1.2.2 TSA 2.11.4.1.1.1.2.2	The MCO ensures that their BESMART Quality Review Policies & Procedures includes, at a minimum, the following: How the percentage is calculated; How many questions can the reviewers differ on before they reach 95%; How many points each question is worth; Organization oversight and accountability structure for BESMART program Quality Review compliance, when a MCO only has one reviewer.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
4. Quality Review Tool CRA 2.11.4.1.1.2.4 TSA 2.11.4.1.1.1.2.4	The MCO uses the Quality Review Tool as prescribed by TennCare to ensure that the BESMART providers and practices are accurately and consistently implementing the BESMART Program Description and providing high-quality care.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
5. Chart Review CRA 2.11.4.1.1.2.5 TSA 2.11.4.1.1.1.2.5	The number of members charts the MCO reviews per provider, for the BESMART Quality Review, is based on a sliding threshold prescribed by TennCare. The Sliding Scale is based on the number of providers within a practice and/or number of members in order to determine number of charts to review: 1) 1-3 providers in one practice: Minimum of 10 charts per provider (if provider doesn't have 10 charts, review all);	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
BESMART Program					
	2) 4-6 providers in one practice: Minimum of 6 charts per provider (if provider doesn't have 6 charts, review all); 3) 7-9 providers in one practice: Minimum of 4 charts per provider (if provider doesn't have 4 charts, review all); 4) 10 or more providers in one practice: Minimum of 3 charts per provider (if provider doesn't have 3 charts, review all).				
Comments					
Strength					
AON					
Suggestion					
6. Minimum Charts CRA 2.11.4.1.1.1.2.6 TSA 2.11.4.1.1.1.2.6	If a BESMART Provider has fewer than three member charts in the Quality Review timeframe, the MCO does not complete a Quality Review. For a BESMART Practice, a Quality Review is not completed if there are fewer than three member charts across all BESMART providers in the practice. The MCO still provides necessary education and support to the BESMART provider or practice as needed.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
7. Criteria to Skip Quality Review CRA 2.11.4.1.1.1.2.7 TSA 2.11.4.1.1.1.2.7	BESMART Quality Reviews are an annual requirement unless a provider or provider group has met the criteria for skipping a year. The criteria that must be met to skip a year of BESMART Quality Review: 1) Minimum of 2 years of scores > or = to 80% overall and no failed sections (at least 80% for each of the 5 sections); 2) The minimum number of charts (per sliding scale above) must have been reviewed in both years;	☐ Yes ☐ No	1.00 0.00	1.00	0.00

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
BESMART Program					
	3) If a provider or provider group is allowed a "skip," the MCO ensures the restart of annual Quality Review the following year.				
Comments					
Strength					
AON					
Suggestion					
8. Corrective Action Plans CRA 2.11.4.1.1.1.2.8, 2.11.4.11.1.1.2.8.2 TSA 2.11.4.1.1.1.2.8, 2.11.4.11.1.1.2.8.2	The MCO monitors and follows-up on the CAP process. CAPs may be placed at the NPI or TIN level. The MCO informs TennCare if/when a change is made to the remediation scale/plan.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
9. Quarterly Quality Metric Report CRA 2.11.4.1.1.1.3 TSA 2.11.4.1.1.1.2.11	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					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
BESMART Program					
Suggestion					
10. Quality Metrics Summary CRA 2.11.4.1.1.3 TSA 2.11.4.1.1.3	The MCO submits a quarterly BESMART Network Quality Metrics Summary Reports no later than 120 calendar days following the end of each calendar year quarter unless otherwise described by TennCare. The Summary Report synthesizes all key information from the BESMART Network Quality Metric Reports as described by TennCare. Reports assess BESMART providers and collect aggregate data indicative of provider performance, outcomes, and activity.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
11. Facility Meetings CRA 2.11.4.2.3 TSA 2.11.4.2.3	The MCO meets with each TDMHSAS licensed Opioid Treatment Program and offers each facility a contract for Methadone Medication Assisted Treatment. If the MCO has quality of care concerns that may prevent contracting with the Opioid Treatment Program, the MCO informs TennCare of this finding.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
		BESMART Program Score	**0.00%**	**11.00**	**0.00**

2023 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 2.30.21.1 TSA 2.30.21.1	1) The MCO submits a completed Nondiscrimination Compliance Questionnaire to TennCare within 60 calendar days of receipt of the Compliance Questionnaire from TennCare with any requested documentation, which includes the Assurance of Nondiscrimination. 2) The signature date of the Nondiscrimination Compliance Questionnaire is the same as the signature date of the MCO's Assurance of Nondiscrimination.	☐ Non-Discrimination Compliance Questionnaire submitted within 60 calendar days of receipt ☐ Signature dates are the same	0.50 0.50	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
2. Non-Discrimination CRA D.7 TSA 5.32.1	The MCO assures that no person on the grounds of handicap, and/or disability, age, race, color, religion, sex, or national origin, shall be excluded from participation in or be denied benefits of, or be otherwise subjected to discrimination in the performance of this Agreement or in the employment practices of the MCO.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
3. Notices of Non-Discrimination CRA D.7 TSA 5.32.3	The MCO posts notices of non-discrimination in conspicuous places, available to all employees and applicants.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					
Strength					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Non-Discrimination Compliance					
AON					
Suggestion					
4. Provision of Services CRA 2.28.3 TSA 2.28.3	1) The MCO's non-discrimination compliance plan includes written policies and procedures that demonstrate non-discrimination in the provision of services to members. 2) The policy also demonstrates non-discrimination in the provision of language assistance services for members with Limited English Proficiency and those requiring communication assistance in alternative formats.	☐ Written policies and procedures ☐ Non-discrimination in language and communication assistance	0.50 0.50	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
5. Complaints Against MCO - Resolution and Reporting CRA 2.28.6.1 TSA 2.28.6.1	1) When complaints concerning alleged acts of discrimination committed by the MCO and/or its employees related to the provision of and/or access to TennCare covered services are reported to the MCO, the MCO's nondiscrimination compliance officer sends such complaints within two business days of receipt to TennCare. TennCare investigates and resolves all alleged acts of discrimination committed by the MCO and/or its employees. 2) The MCO assists TennCare during the investigation and resolution of such complaints. TennCare reserves the right to request that the MCO's nondiscrimination compliance officer assist with conducting the initial investigations and to suggest resolutions of alleged discrimination complaints. 3) If a request for assistance with an initial investigation is made by TennCare, the MCO's nondiscrimination compliance officer provides TennCare with all requested information, including but not limited to, the identity of the party filing the complaint; the complainant's relationship to the MCO; the circumstances of the complaint; date complaint filed; and the	☐ Report complaints within two business days ☐ Assist TennCare with investigation and resolution ☐ Provide all requested information	0.33 0.33 0.34	1.00	0.00

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Non-Discrimination Compliance					
	MCO's suggested resolution. TennCare reviews the MCO's initial investigations and determine the appropriate resolutions for the complaints, including corrective action plans. Any documentation or materials related to such investigation shall be considered confidential and not subject to disclosure to any third party unless disclosure is otherwise required by law.				
Comments					
Strength					
AON					
Suggestion					
6. Complaints Against Providers or Contractors - Resolution and Reporting CRA 2.28.6.2 TSA 2.28.6.2	Should complaints concerning alleged acts of discrimination committed by the MCO's providers, provider's employees and/or subcontractors related to the provision of and/or access to TennCare covered services be reported to the MCO, the MCO's nondiscrimination compliance officer informs TennCare of such complaints within two business days from the date MCO learns of such complaints.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Non-Discrimination Compliance					
7. Discrimination Complaint Forms CRA 2.28.7 TSA 2.28.7	1) The MCO uses and has available to TennCare members, TennCare's Discrimination complaint form located on TennCare's website under the nondiscrimination link at http://www.tn.gov/tenncare/members.shtml. The discrimination complaint form is provided to TennCare members upon request and in the member handbook. 2) This complaint form is available in English, Arabic, and Spanish. 3) When requests for assistance to file a discrimination complaint are made by members, the MCO assists the members with submitting complaints to TennCare. 4) In addition, the MCO informs its employees, providers, and subcontractors how to assist TennCare members with obtaining discrimination complaint forms and assistance from the MCO with submitting the forms to TennCare and the MCO.	☐ Complaint form available upon request and in member handbook ☐ Complaint form available in English, Arabic, and Spanish ☐ Provides assistance to file discrimination complaint ☐ Informs employees, providers, and subcontractors on obtaining complaint forms and providing assistance	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
8. Health Disparities Projects CRA 2.30.21.4.2 TSA 2.30.21.4.2	The MCO collaborates with TennCare and other entities designated by TennCare to develop and implement projects, such as the annual health disparities action plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability statuses.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Non-Discrimination Compliance					
9. Provider and Subcontractor Compliance Education CRA 2.28.2.1.1 TSA 2.28.2.1.1	On an annual basis, the Nondiscrimination Compliance Coordinator makes nondiscrimination training available to all MCO staff and to its providers and subcontractors; The MCO documents proof that the training was made available to the MCO's staff and to its providers.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
		Non-Discrimination Compliance Score	**0.00%**	**9.00**	**0.00**

2023 DBM QP Tool

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
1. Delivery Network 42 CFR § 438.206(b)(1) DBMC A.19, 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 or physical or mental disabilities.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
2. Second Opinion 42 CFR § 438.206(b)(3) DBMC A.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**					
3. Out-of-Network Services 42 CFR § 438.206(b)(4) DBMC A.26	If the provider network is unable to provide necessary services covered under the contract to a particular member, the DBM adequately and timely covers these services out of network for the member, for as long as the DBM provider network is unable to provide them.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**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**					

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
5. Timely Access 42 CFR § 438.206.c(1)(i) DBMC A.20	The DBM meets and 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 so that appointment waiting times do not exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
6. Hours of Operation and Access 42 CFR § 438.206(c)(1)(ii) DBMC A.20	The DBM ensures that the 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.	☐ Comparable hours of operation commercial ☐ Services available 24 hours a day, seven days a week, when medically necessary	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
7. Provider Compliance 42 CFR § 438.206(c)(1)(iv)-(vi) DBMC A.52.b, A.66.o, A.66.q	The DBM: 1) Establishes mechanisms to ensure compliance by network providers; 2) Monitors network providers regularly to determine compliance; and 3) Takes corrective action if there is a failure to comply by a network provider.	☐ Mechanisms to ensure compliance ☐ Monitoring to determine compliance ☐ Corrective action if failure to comply	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

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<tr><th>Value</th><th>Score</th></tr>
<tr><td colspan="6">Availability of Services</td></tr>
<tr><td>8. Access and Cultural Considerations

42 CFR § 438.20(c)(2)
DBMC A.27, D.9</td><td>The DBM 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, diverse cultural and ethnic backgrounds and/or disabilities, and regardless of sex.</td><td>☐ Yes
☐ No</td><td>1.00
0.00</td><td>1.00</td><td>0.00</td></tr>
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<tr><td>Strength</td><td colspan="5"></td></tr>
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<tr><td>Suggestion</td><td colspan="5"></td></tr>
<tr><td>9. Accessibility Considerations

42 CFR § 438.206(c)(3)
DBMC A.20.e</td><td>The DBM ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.</td><td>☐ Yes
☐ No</td><td>1.00
0.00</td><td>1.00</td><td>0.00</td></tr>
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<tr><td>Strength</td><td colspan="5"></td></tr>
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<tr><td>Suggestion</td><td colspan="5"></td></tr>
<tr><td colspan="3">Availability of Services Score</td><td>0.00%</td><td>9.00</td><td>0.00</td></tr>
</table>

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Assurances of Adequate Capacity and Services					
1. Nature of Supporting Documentation 42 CFR § 438.207(b)(1)-(2) DBMC A.148.c.2	The DBM submits documentation to TennCare, in a format specified by TennCare, to demonstrate that it complies with the following requirements: 1) Offers an appropriate range of preventive, primary care, specialty services that is adequate for the anticipated number of members for the service area; and 2) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated members in the service area.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
2. Timing of Documentation 42 CFR § 438.207(c)(1)-(3) DBMC A148.c.2	The DBM submits the documentation in element one as specified by TennCare, but no less frequently than the following: 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 DBM's operations that would affect the adequacy of capacity and services, including a) Changes in DBM services, benefits, geographic service area, composition of or payments to its provider network; or b) Enrollment of a new population in the DBM.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
		Assurances of Adequate Capacity and Services Score	**0.00%**	**2.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Coordination and Continuity of Care					
1. Primary Care 42 CFR § 438.208(b)(1) DDBMC 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 the member with information on how to contact their designated person or entity.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments **Strength** **AON** **Suggestion**					
2. Coordination of Services 42 CFR § 438.208(b)(2) DBMC A.49, A.49.d, A.49.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**					
3. Prevent Duplication of Services 42 CFR § 438.208(b)(4) DBMC A.49.d.5	The DBM shares with TennCare or other DBMs 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**					

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Coordination and Continuity of Care					
4. Medical Records 42 CFR § 438.208(b)(5) DBMC A.145.b.1-A.145,b,2	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**					
5. Privacy Requirements 42 CFR § 438.208(b)(6) DBMC A.144.h.1 – A.144.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.6	The DBM implements mechanisms to comprehensively assess each Medicaid member identified to the DBM by TennCare as having special dental care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. The assessment mechanisms use appropriate dental professionals.	☐ Assessments for members with special healthcare needs ☐ Use of appropriate dental professionals	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
7. Treatment/ Service Plans 42 CFR § 438.208(c)(3) DBMC A.49.d.7	If applicable, the DBM develops treatment plans for members with special health care needs that are developed by the member's primary care provider, with member participation, and in consultation with any specialists caring for the member. The treatment or service plan is: 1) Approved by the DBM in a timely manner, if this approval is required by the DBM; and 2) In accordance with any applicable TennCare quality assurance and utilization review standards.	☐ Approved by DBM in timely manner ☐ In accordance with TennCare standards	**0.50** **0.50**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
8. Direct Access to Specialists 42 CFR § 438.208(c)(4) DBMC A.46.b	For members with special dental care needs determined to need a course of treatment or regular care monitoring, the DBM allows members to directly access a specialist (for example, 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					
9. Notification for Disenrollment 42 CFR § 438.56 DBMC A.153	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. Although the DBM may not request disenrollment of a member, the DBM informs TennCare promptly when the DBM knows or has reason to believe that a member may satisfy any of the conditions for disenrollment described in TennCare rules and regulations.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Coordination and Continuity of Care					
AON					
Suggestion					
		Coordination and Continuity of Care Score	**0.00%**	**9.00**	**0.00**

2023 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)(3)(i)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					

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Coverage and Authorization of Services					
Suggestion					
3. Service Limitations 42 CFR § 438.210(a)(4)(i) DBMC A.38	The DBM has the ability to place appropriate limits on a service on the basis of criteria applied under the TennCare plan, 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)(ii) DBMC A.38	The DBM is permitted to place appropriate limits on a service for the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
5. Medically Necessary Definition 42 CFR § 438.210(a)(5)(i) DBMC A.106	The DBM specifies a definition of “medically necessary services” in a manner that Is no more restrictive than that used in the TennCare Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in TennCare statutes, regulations, and policy and procedures.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					
Strength					
AON					

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Coverage and Authorization of Services					
Suggestion					
6. Medically Necessary Services 42 CFR § 438.210(a)(5)(ii) DBMC A.106	The DBM specifies "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; and 3) The ability for a member to attain, maintain, or regain functional capacity.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
7. Authorization of Services Policies and Procedures 42 CFR § 438.210(b)(1) DBMC A.38, A.41	For the processing of requests for initial and continuing authorizations of services, the DBM and its subcontractors have in place, and follow, written policies and procedures.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
8. Processing Authorizations 42 CFR § 438.210(b)(2) DBMC A.109	The DBM: 1) Ensures consistent application of review criteria for authorization decisions; and 2) Consults with the requesting provider for dental services when appropriate.	☐ Criteria applied consistently ☐ Requesting provider consulted	**0.50** **0.50**	**1.00**	**0.00**

2023 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**					
9. Appropriate Expertise for Denials 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 dental needs.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
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 notice 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.	☐ Written notice to provider and member ☐ Includes notice requirements	0.50 0.50	1.00	0.00
Comments **Strength** **AON** **Suggestion**					
11. Notification Timeframes – Standard Authorization Decisions	For standard authorization decisions, the DBM provides notice are 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 if:	☐ Notice within required timeframe ☐ Extension for member request or DBM need for additional information	0.50 0.50	1.00	0.00

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Coverage and Authorization of Services					
42 CFR § 438.210(d)(1) DBMC A.41.a	1) The member or provider requests extension; or 2) The DBM justifies (to TennCare upon request) a need for additional information and how the extension is in the member's interest.				
Comments					
Strength					
AON					
Suggestion					
12. Notification Timeframes–Expedited Authorization Decisions 42 CFR § 438.210(d)(2) DBMC A.41.a	For cases in which a provider indicates, or the DBM determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function: 1) The DBM makes an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service; and 2) The DBM may extend the 72-hour time period by up to 14 calendar days if the member requests an extension, or if the DBM justifies (to TennCare upon request) a need for additional information and how the extension is in the member's interest.	☐ Makes decision and provides notice within required timeframe ☐ Extension for member request or DBM need for additional information	**0.50** **0.50**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
13. 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**

2023 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					
		Coverage and Authorization of Services Score	**0.00%**	**13.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Emergency and Poststabilization					
1. Emergency Service Coverage 42 CFR § 438.114(c)(1) 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 has an emergency dental or oral condition or injury, including cases in which the absence of immediate treatment would not have placed the individual in serious jeopardy, seriously impaired bodily functions, or caused any body part to become seriously dysfunctional; or 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					
		Emergency and Poststabilization Score	**0.00%**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Confidentiality					
1. Privacy Requirements 42 CFR § 438.224 DBMC A.49.k, D.20	The DBM has written policies and procedures 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; and 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	**0.00%**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
1. Grievance and Appeal System 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					

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
Strength					
AON					
Suggestion					
2. Authority to File 42 CFR § 438.402.(c)(1)(i) DBMC A.121.b, A.128.a, A.132	A member may file a grievance with the DBM. A member may contest an DBM-proposed adverse benefit determination by filing an appeal with TennCare.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
3. Provider or Authorized Representa-tive 42 CFR § 438.402.(c)(1)(ii) DBMC A.121.c, A.132	With the written consent of the member, a provider or an authorized representative may file a grievance or TennCare appeal on behalf of a member.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
4. Timing to File Grievance and Appeal 42 CFR § 438.402(c)(2) DBMC A.122, A.128.a, A.132	A member may file a grievance with the DBM at any time. Following receipt of a notice of adverse benefit determination (NABD), a member has 60 calendar days from the date on the NABD notice to file a request for a TennCare appeal with TennCare.	☐ May file a grievance at any time ☐ Has 60 calendar days to request an appeal after receiving NABD	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
5. Procedures 42 CFR § 438.402(c)(3) DBMC 128.a, A.123.a	A member may file a grievance with the DBM either orally or in writing. A member may file an appeal contesting the DBM's proposed adverse benefit determination either orally or in writing at the TennCare phone number or address listed on the DBM-issued notice of adverse determination.	☐ May file grievance orally or in writing ☐ May request appeal orally or in writing	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
6. Availability of Notices 42 CFR § 438.404(a) DBMC A.119.f	The DBM gives members timely and adequate notice of an adverse benefit determination 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; and 4) Auxiliary aids and services.	☐ Timely and adequate notice ☐ Available via the listed means	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength**					

<table>
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<tr><td colspan="6">Grievance and Appeal Systems</td></tr>
<tr><td>AON</td><td colspan="5"></td></tr>
<tr><td>Suggestion</td><td colspan="5"></td></tr>
<tr><td>7. Content of Notice of Adverse Benefit Determination (NADB)
42 CFR § 438.404(b)(1)-(6)
DBMC A.119</td><td>♦ The notice explains the following:
1) The adverse benefit determination the DBM has made or intends to make;
2) The reasons for the adverse benefit determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit 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 a TennCare appeal of the DBM's adverse benefit determination;
4) The procedures for exercising the rights;
5) The circumstances under which an appeal process can be expedited and how to request it; and
6) The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued.</td><td>☐ Determination made or intends to make
☐ Reasons for determination
☐ Right to request appeal
☐ Procedures for exercising rights
☐ Circumstances for which an appeal can be expedited
☐ Right to continuing benefits pending appeal resolution</td><td>0.16
0.16
0.17
0.17
0.17
0.17</td><td>1.00</td><td>0.00</td></tr>
<tr><td>Comments</td><td colspan="5"></td></tr>
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<tr><td>AON</td><td colspan="5"></td></tr>
<tr><td>Suggestion</td><td colspan="5"></td></tr>
<tr><td>8. Timing of Notice
42 CFR § 438.404(c)(1)
DBMC A.120</td><td>The DBM mails the NADB at the following times:
1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least 10 days before the date of action; and
2) For denial of payment, at the time of any action affecting the claim.</td><td>☐ At least 10 days before the date of action
☐ At the time of any action affecting the claim</td><td>0.50
0.50</td><td>1.00</td><td>0.00</td></tr>
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<tr><td>Strength</td><td colspan="5"></td></tr>
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2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
AON					
Suggestion					
9. Timing for Standard Service Authorization 42 CFR § 438.404(c)(3) DBMC A.120	For standard service authorization decisions that deny or limit services, the DBM mails the notice within 14-calendar days following the receipt of request for service.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
10. Extension of Standard Service Authorization Decisions 42 CFR § 438.404(c)(4)) DBMC A.120	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.	☐ Written notice ☐ Makes determination timely	**0.50** **0.50**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Grievance and Appeal Systems					
11. Service Authorizations not Reached Within Timeframe 42 CFR § 438.404(c)(5) DBMC A.120	For service authorization decisions not reached within the 14-calendar day timeframe, (which constitutes a denial and is thus an adverse benefit determination) the DBM mails the notice on the date that the timeframes expire.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
12. Timing for Expedited Service Authorizations 42 CFR § 438.404(c)(6) DBMC A.120	For expedited service authorization decisions, the DBM mails the notice within 72 hours of receipt of the request for service.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

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<tr><th>Value</th><th>Score</th></tr>
<tr><td colspan="7">Grievance and Appeal Systems</td></tr>
<tr><td rowspan="7">13. Exceptions from Advance Notice

42 CFR § 431.213</td><td rowspan="7">The DBM may send a notice not later than the date of action if-
1) The DBM has factual information confirming the death of a member;
2) The DBM receives a clear written statement signed by a member that –
a) The member no longer wishes services; or
b) Gives information that requires termination or reduction of services and indicates that the member understands that this must be the result of supplying that information;
3) The member has been admitted to an institution where the member is ineligible under the plan for further services;
4) The member's whereabouts are unknown, and the post office returns agency mail directed to the member indicating no forwarding address;
5) The DBM establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
6) A change in the level of medical care is prescribed by the member's physician;
7) The date of action will occur in less than 10 days</td><td>☐</td><td>Death of member</td><td>0.15</td><td rowspan="7">1.00</td><td rowspan="7">0.00</td></tr>
<tr><td>☐</td><td>No longer wishes services, or information requires termination or reduction of services</td><td>0.15</td></tr>
<tr><td>☐</td><td>Admitted to institution and ineligible for further services</td><td>0.14</td></tr>
<tr><td>☐</td><td>Whereabouts unknown</td><td>0.14</td></tr>
<tr><td>☐</td><td>Accepted by another Medicaid jurisdiction</td><td>0.14</td></tr>
<tr><td>☐</td><td>Change in level of care prescribed</td><td>0.14</td></tr>
<tr><td>☐</td><td>Date of action will occur in less than ten days</td><td>0.14</td></tr>
<tr><td>Comments</td><td colspan="6"></td></tr>
<tr><td>Strength</td><td colspan="6"></td></tr>
<tr><td>AON</td><td colspan="6"></td></tr>
<tr><td>Suggestion</td><td colspan="6"></td></tr>
</table>

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Grievance and Appeal Systems					
14. Notice in Cases of Possible Fraud 42 CFR § 431.214 DBMC A.120.b	The DBM may shorten the period of advance notice to 5 days before the date of action if – 1) The DBM has facts indicating that action should be taken because of probable fraud by the member; and 2) The facts have been verified, if possible, through secondary sources.	☐ Facts indicating probably fraud ☐ Facts verified	0.50 0.50	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
15. Handling of Grievances and Appeals 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 numbers that have adequate TTY/TDD and interpreter capability.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
16. Acknowledging Grievances and Forwarding Appeals 42 CFR § 438.406(b)(1) DBMC A..118, A.123	The DBM's process for handling member grievances and for satisfying TennCare requirements for appeals of adverse benefit determinations includes acknowledging receipt of each grievance and forwarding appeal of adverse benefit determinations to TennCare and informing the member that TennCare will contact them about their appeal.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Grievance and Appeal Systems					
Strength					
AON					
Suggestion					
17. Reviewer Requirements 42 CFR § 438.406(b)(2) DBMC A.118.f	The DBM's process for handling member grievances and appeals of adverse benefit determinations includes ensuring that the individuals 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 the State, in treating the member's condition or disease: a) An appeal of a denial that is based on lack of medical necessity; b) A grievance regarding denial of expedited resolution of an appeal; or c) A grievance or appeal that involves clinical issues; 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 adverse benefit determination.	☐ Not involved in previous review or subordinate ☐ Appropriate clinical expertise ☐ Take into account all information	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Grievance and Appeal Systems					
18. Oral Inquiries Treated as Appeals 42 CFR § 438.406(b)(4) DBMC A.123.a and .c	The DBM's process for and for satisfying TennCare's requirements for appeals of adverse benefit determinations includes providing that oral inquiries seeking to appeal an adverse benefit determination are forwarded to TennCare and treated as appeals (to establish the earliest possible filing date).	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
19. Resolution and Notification 42 CFR § 438.408(a) DBMC A.124, A.128.b	The DBM resolves each grievance and appeal process-related obligations, and provides notice, as expeditiously as the member's health condition requires, within TennCare-established timeframes.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
20. Grievance Resolution Timeframe 42 CFR § 438.408(b)(1) DBMC A.128.b	For standard resolution of a grievance and notice to the affected parties, the DBM resolves each grievance within 90 calendar days from the day the DBM receives the grievance.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Grievance and Appeal Systems					
AON					
Suggestion					
21. Standard Appeal Resolution Timeframe 42 CFR § 438.408(b)(2) DBMC A.124	For standard resolution of an appeal, 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 Resolution Timeframe 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					
23. Extension of Appeal Timeframes 42 CFR § 438.408(c)(1)	The DBM may extend the appeal timeframes by up to 14 calendar days if – 1) The member requests the extension; or 2) 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.	☐ Member requests extension ☐ DBM shows need for additional information	**0.50** **0.50**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Grievance and Appeal Systems					
DBMC A.120.f, A.120.g					
Comments **Strength** **AON** **Suggestion**					
24. Extension – Requirements 42 CFR § 438.408(c)(2) DBMC A.120.f, A.120.h	If the DBM extends the appeal timeframes not at the request of the member, it must complete all of the following: 1) Make reasonable efforts to give the member prompt oral notice of the delay; 2) Within 2 calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and 3) Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.	☐ Prompt oral notice ☐ Written notice ☐ Resolve appeal timely	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
25. Format of Grievance Notice 42 CFR § 438.408(d)(1) DBMC A.128.d	The DBM uses the TennCare established method to notify a member of the resolution of a grievance and ensures that such methods provide for: 1) Written translation, 2) Oral interpretation, 3) Alternative formats, and 4) Auxiliary aids and services.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength**					

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Grievance and Appeal Systems					
AON					
Suggestion					
26. Format of Appeal Notice 42 CFR § 438.408(d)(2) DBMC A.125	For all appeals, the DBM provides written notice of resolution in a format and language that provides for: 1) Written translation, 2) Oral interpretation, 3) Alternative formats, and 4) Auxiliary aids and services.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
27. Content of Notice of Appeal Resolution – Results and Date 42 CFR § 438.408(e)(1) DBMC A.125.a	The written notice of the resolution must include 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					
28. Expedited Resolution of Appeals 42 CFR § 438.410(a)	The DBM establishes and maintains an expedited review process for appeals, 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	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Grievance and Appeal Systems					
DBMC A.123.e	health, or ability to attain, maintain, or regain maximum function.				
Comments					
Strength					
AON					
Suggestion					
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.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
30. Expedited Resolution of Appeals Requirements 42 CFR § 438.410(c)	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) Within 2 calendar days 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 4) Completes the reconsideration phase of the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.	☐ Transfer to standard timeframe ☐ Give prompt oral notice ☐ Provide written notice ☐ Complete reconsideration no later than the date extension expires	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**
Comments					
Strength					

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Grievance and Appeal Systems					
AON					
Suggestion					
31. Provider Information 42 CFR § 438.414 DBMC A.130	The DBM provides information about the grievance and TennCare appeal procedures and filing timeframes to all providers and subcontractors at the time they enter into a contract.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
32. Record-keeping Requirements -Ongoing Monitoring 42 CFR § 438.416(a) DBMC A.129.b, 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 TennCare's Quality Strategy	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
33. Record-keeping Requirements – Information 42 CFR § 438.416(b)		☐ Reason for appeal or grievance ☐ Date received ☐ Date of each review ☐ Resolution ☐ Date of resolution	**0.16** **0.16** **0.17** **0.17** **0.17**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Grievance and Appeal Systems					
DBMC A.129.b	The record of each grievance or appeal contains, at a minimum, all of the following information: 1) A general description of the reason for the appeal or grievance; 2) The date received; 3) The date of each review or, if applicable, review meeting; 4) Resolution at each level of the appeal or grievance, if applicable; 5) Date of resolution at each level, if applicable; and 6) Name of the member for whom the appeal or grievance was filed.	☐ Name of member	**0.17**		
Comments					
Strength					
AON					
Suggestion					
34. Record-keeping Requirements – Accuracy and Accessibility 42 CFR § 438.416(c) DBMC A.129.b	The record must be accurately maintained 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. Continuation of Benefits	The DBM continues the member's benefits if all of the following	☐ Member files timely request ☐ Appeal involves change in previously authorized service	**0.20** **0.20**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Grievance and Appeal Systems					
42 CFR § 438.420(b) DBMC A.126	occur: 1) The member files the request for an appeal timely; 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; and 5) The member timely files for continuation of benefits.	☐ Services ordered by authorized provider ☐ Period covered by authorization not expired. ☐ Member files timely for continuation of benefits	**0.20** **0.20** **0.20**		
Comments **Strength** **AON** **Suggestion**					
36. Duration of Continued or Reinstated Benefits 42 CFR § 438.420(c) DBMC A.126, A.132	If, at the member's request, the DBM continues or reinstates the member's benefits while the appeal is pending, the DBM continues benefits until one of following occurs: 1) The member withdraws the appeal; 2) The member fails to request an appeal and continuation of benefits within 10 calendar days after the DBM sends the notice of an adverse resolution to the member's appeal; and 3) An appeal results in a decision adverse to the member. Not applicable to CoverKids	☐ Member withdraws appeal request ☐ Member fails to request appeal and continuation of benefits timely ☐ Appeal decision adverse to the member	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
	If the TennCare appeal reverses a decision to deny, limit, or	☐ Yes	**1.00**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <DBM>						
Evaluation Elements	Criteria	Criteria Met		Criteria Value	Element	
					Value	Score
Grievance and Appeal Systems						
37. Effectuation of Reversed Appeal Resolutions Services Not Furnished While Appeal Pending 42 CFR § 438.424 DBMC A.126.c	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.	☐	No	0.00		
Comments						
Strength						
AON						
Suggestion						
38. Effectuation of Reversed Appeal Resolutions – Services Furnished While Appeal Pending 42 CFR § 438.424 DBMC A.127.d	If the TennCare appeal reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the DBM pays for those services.	☐ ☐	Yes No	1.00 0.00	1.00	0.00
Comments						
Strength						
AON						
Suggestion						
			Grievance and Appeal Systems Score	0.00%	38.00	0.00

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Subcontractual Relationships and Delegation					
1. Subcontractor Activities 42 CFR § 438.230.(c)(1)(i) DBMC A.83	Each contract or written arrangement with any subcontractor specifies that if any of the DBM's activities or obligations under its contract with the State are delegated to a subcontractor, the delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
2. Subcontractor Contract Requirements 42 CFR § 438.230.(c)(1)(ii)-(iii) DBMC A.83	Each contract or written arrangement with any subcontractor specifies that if any of the DBM's activities or obligations under its contract with TennCare are delegated to a subcontractor: 1) The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the DBM's contract obligations; 2) The contract or written arrangement either provides for revocation of the delegation of activities or obligations or specifies other remedies in instances where the State or the DBM determine that the subcontractor has not performed satisfactorily.	☐ Subcontractor agrees to perform activities and reporting responsibilities ☐ Contract must provide for revocation or specify other remedies for unsatisfactory performance.	**0.50** **0.50**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
3. Subcontractor Contract Regulatory Compliance 42 CFR § 438.230(c)(2)	Each subcontractor agreement specifies that the subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Subcontractual Relationships and Delegation					
DBMC A.83					
Comments					
Strength					
AON					
Suggestion					
4. Subcontractor Audit Requirements 42 CFR § 438.230(c)(3) DBMC A1 A.66.n	The subcontractor agreements specify that - 1) The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computers, or other electronic systems of the subcontractor, or of the subcontractor's contractor, which pertain to any aspect of services and activities performed, or determination of amounts payable under the DBM's contract with the TennCare; 2) The subcontractor will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid members; 3) The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later; and 4) If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.	☐ Right to audit ☐ Make available premises, records, etc. for purpose of audit, evaluation, or inspection ☐ Right to audit exists through 10 years ☐ May inspect, audit, evaluate at any time if suspicion of fraud or similar risk	0.25 0.25 0.25 0.25	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
		Subcontractual Relationships and Delegation Score	**0.00%**	**4.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Practice Guidelines					
1. Adoption of Practice Guidelines 42 CFR § 438.236(b) DBMC A.56	The DBM adopts practice guidelines that meet the following requirements: 1) Are based on valid and reliable clinical evidence or a consensus of providers in the particular field; 2) Consider the needs of the DBM's members; 3) Are adopted in consultation with network providers; 4) Are reviewed and updated periodically as appropriate; 5) Include guidelines specific to oral health and dental needs of individuals with intellectual and developmental disabilities, including appropriate use of IV sedation or other anesthesia; and 6) Comply fully with TennCare medical necessity rule as applicable.	☐ Based on evidence or a consensus ☐ Consider members' needs ☐ Adopted in consultation with network providers ☐ Reviewed and updated periodically ☐ Guidelines specific to individuals with intellectual and developmental disabilities ☐ Comply with medical necessity rule	**0.16** **0.16** **0.17** **0.17** **0.17** **0.17**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
2. Dissemination of Guidelines 42 CFR § 438.236(c) DBMC A.56	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. Application of Guidelines	Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Practice Guidelines					
42 CFR § 438.236(d)					
Comments					
Strength					
AON					
Suggestion					
		Practice Guidelines Score	**0.00%**	**3.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Health Information Systems					
1. General Rule 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. Basic Elements 42 CFR § 438.242(b)(2) DBMC A.146	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					

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Health Information Systems					
AON					
Suggestion					
3. Data Accuracy and Completeness 42 CFR § 438.242(b)(3)	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					
Strength					
AON					
Suggestion					
4. Data Availability 42 CFR § 438.242(b)(4) 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	**0.00%**	**4.00**	**0.00**

2023 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. QAPI Program 42 CFR § 438.330(a)(1) DBMC A.142	The DBM has in place an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its members.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
2. Utilization and Special Health Care Needs 42 CFR § 438.330(b)(3)-(4) DBMC A.143	The comprehensive quality assessment and performance improvement program includes at least the following elements: 1) Mechanisms to detect both underutilization and overutilization of services; and 2) Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs, as defined by TennCare in the Quality Strategy.	☐ Mechanisms to detect under and overutilization ☐ Mechanisms to assess quality of care furnished to members with special health care needs	**0.50** **0.50**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
3. Annual Evaluation 42 CFR § 438.330(c)(2)	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; and/or 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					

2023 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					
4. Performance Improvement Projects 42 CFR § 438.330(d)(2) DBMC A.143	Each performance improvement project is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and must include the following elements: 1) Rationale for selection; 2) Specific population targeted; 3) Relevant clinical practice guidelines; 4) Date of remeasurement; 5) Measurement of performance using objective quality indicators; 6) Implementation of interventions to achieve improvement in the access to and quality of care; 7) Evaluation of the effectiveness of the interventions based on the performance measures in paragraph (d)(2)(i) of this section; and 8) Planning and initiation of activities for increasing or sustaining improvement.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
5. Reporting Results to TennCare 42 CFR § 438.330(d)(3) DBMC Attachment C	The DBM reports the status and results of each project conducted to TennCare as requested, but not less than once per year.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					

2023 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					
		Quality Assessment and Performance Improvement Program (QAPI) Score	**0.00%**	**5.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights					
1. Member Rights 42 CFR § 438.100(b)(2) DBMC A.144	A member of an DBM has 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, practitioners providing care, and member rights and responsibilities 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. 7) Voice grievances and appeals; 8) Exercise an advance directive; and 9) Freely exercise rights, and that the exercise of those rights does not adversely affect the way the DBM and its network providers treat the member.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights					
Comments					
Strength					
AON					
Suggestion					
		Member Rights Score:	**0.00%**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Information Requirements					
1. Member Information Requirements - General 42 CFR § 438.10(c)(1) DBMC A.144 a.9	The DBM provides all required information to members and potential members in a manner and format that may be easily understood and is readily accessible by such members and potential members.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Information Requirements					
2. Electronic Member Information 42 CFR § 438.10(c)(6) DBMC A.13.c	Member information provided electronically by the DBM meets all of the following: 1) The format is readily accessible; 2) The information is placed in a location on the DBM's Web site that is prominent and readily accessible; 3) The information is provided in an electronic form which can be electronically retained and printed; 4) The information is consistent with the content and language requirements; and 5) The member is informed that the information is available in paper form without charge upon request and provides it upon request within 5 business days.	☐ Format is easily accessible ☐ Prominent location ☐ Electronically retained and printed ☐ Consistent with content and language requirements ☐ Informed of availability in paper form within 5 business days	0.20 0.20 0.20 0.20 0.20	1.00	0.00
Comments **Strength** **AON** **Suggestion**					
3. Assistance with Understanding Plan 42 CFR § 438.10(c)(7)	The DBM has in place mechanisms to help members and potential members understand the requirements and benefits of the plan.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments **Strength** **AON** **Suggestion**					
4. Written Materials	The DBM makes its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and	☐ Yes ☐ No	1.00 0.00	1.00	0.00

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Information Requirements					
42 CFR § 438.10.d(3) DBMC A.165.a.7	termination notices, available in the prevalent non-English languages in its particular service area. Written materials that are critical to obtaining services must also be made available in alternative formats upon request of the potential member or member at no cost, include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and include the toll-free and TTY/TDY telephone number of the DBM's member/customer service unit. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost.				
Comments					
Strength					
AON					
Suggestion					
5. Interpretation Services 42 CFR § 438.10(d)(4) DBMC A.30, A.31	The DBM makes interpretation services available to each member and potential member free of charge. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. Oral interpretation requirements apply to all non-English languages, not just those that TennCare identifies as prevalent.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Information Requirements					
6. Communication Assistance 42 CFR § 438.10(d)(5) DBMC A.13	The DBM notifies potential members: 1) That oral interpretation is available for any language and written translation is available in prevalent languages; 2) That auxiliary aids and services are available upon request and at no cost for members with disabilities; and 3) How to access these services.	☐ Oral interpretation available ☐ Auxiliary aids available ☐ How to access services	0.33 0.33 0.34	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
7. Written Material Requirements 42 CFR § 438.10(d)(6) DBMC A.13	The DBM provides all written materials for potential members and members consistent with the following: 1) Use easily understood language and format; 2) Use a font size no smaller than 12 points; and 3) Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency.	☐ Easily understood language and format ☐ Font size no smaller than 12 points ☐ Available in alternative formats and through auxiliary aids	0.33 0.33 0.34	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
8. Notice of Provider Termination 42 CFR § 438.10(f)(1)	The DBM makes a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Notice to the member is provided by the later of 30 calendar days prior to the effective date of the	☐ Written notice of termination ☐ 30 calendar days prior to effective date or 15 calendar days after receipt of termination notice	0.50 0.50	1.00	0.00

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Information Requirements					
DBMC A.58	termination, or 15 calendar days after receipt or issuance of the termination notice.				
Comments					
Strength					
AON					
Suggestion					
9. 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**

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Information Requirements					
Comments					
Strength					
AON					
Suggestion					
10. Member Handbook Timing 42 CFR § 438.10(g)(1) DBMC A.10.a	The DBM provides each member a member handbook, within 30 days after receiving notice of the member's enrollment, which serves a similar function as the summary of benefits and coverage.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
11. Member Handbook Delivery 42 CFR § 438.10(g)(3)	Member handbook information is considered to be provided if the DBM: 1) Mails a printed copy of the information to the member's mailing address; 2) Provides the information by email after obtaining the member's agreement to receive the information by email; 3) Posts the information on the Web site of the DBM and advises the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that member with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or 4) Provides the information by any other method that can reasonably be expected to result in the member receiving that information.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Information Requirements					
Comments **Strength** **AON** **Suggestion**					
12. Provider Directory Information 42 CFR § 438.10(h)(1) DBMC A.10.c	Each DBM makes available in paper form upon request and electronic form, the following information about its network providers: 1) The provider's name as well as any group affiliation; 2) Street address(es); 3) Telephone number(s); 4) Web site URL, as appropriate; 5) Specialty, as appropriate; 6) Whether the provider will accept new members; 7) The provider's 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 8) Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Information Requirements					
13. Provider Directory – Provider Types 42 CFR § 438.10(h)(2) DBMC A.10.c.4	The provider directory must include the information for dentists and dental specialists under contract.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments **Strength** **AON** **Suggestion**					
14. Provider Directory Updates 42 CFR § 438.10(h)(3) DBMC A.10.c	Information included in - 1) A hard copy provider directory is updated at least quarterly; and 2) An electronic provider directory is updated no later than 30 calendar days after the DBM receives updated provider information and is available on the DBM's Web site in a machine-readable file and format	☐ Hard copy updates quarterly ☐ Electronic directory updates within 30 calendar days	0.50 0.50	1.00	0.00
Comments **Strength** **AON** **Suggestion**					
		Information Requirements	**0.00%**	**14.00**	**0.00**

2023 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. EPSDT Program Information 42 CFR § 441.56(a)(2)	Using clear and nontechnical language, the DBM provides information about the following - 1) The benefits of preventive health care; 2) The services available under the EPSDT program and where and how to obtain those services; 3) That the services provided under the EPSDT program are without cost to eligible individuals up to age 21, except for any enrollment fee, premium, or similar charge that may be imposed on medically needy beneficiaries; and 4) That necessary transportation and scheduling assistance is available to the EPSDT eligible individual upon request.	☐ Benefits of preventive care ☐ Services available and where and how to obtain them ☐ Services are without cost ☐ Transportation and scheduling assistance available	0.25 0.25 0.25 0.25	1.00	0.00
Comments **Strength** **AON** **Suggestion**					
2. Screening Components 42 CFR § 441.56(b)(1)	The DBM provides to eligible EPSDT members who request it, screenings which must include, but are not limited to dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments **Strength** **AON** **Suggestion**					
3. Services Deemed Necessary 42 CFR § 441.56(c)	In addition to any diagnostic and treatment services included in the plan, the DBM provides dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health to eligible EPSDT members, the need for which is indicated by screening, even if the services are not included in the plan.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments **Strength**					

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
AON					
Suggestion					
4. Utilization of Providers and Coordination with Related Programs 42 CFR § 441.61	1) The DBM provides referral assistance for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening and diagnosis. This referral assistance must include giving the family or member the names, addresses, and telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family. 2) The DBM makes available a variety of individual and group providers qualified and willing to provide EPSDT services.	☐ Treatment and referral assistance ☐ Variety of EPDST providers	**0.50** **0.50**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
5. Outreach Contacts DBMC A.10.a, 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					
6. Re-Notification If No Services Used DBMC A.10.d	The DBM distributes 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					

2023 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)					
AON					
Suggestion					
7. 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					
Suggestion					
8. Appointment Assistance 42 CFR § 441.62(1) 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					
9. Prior Authorization DBMC A.41	The DBM has policies and procedures 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 policies and	☐ 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	**0.33** **0.33**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
	procedures. Dental management policies and procedures 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; and 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.	☐ UM activities structured so no incentives were provided	**0.34**		
Comments **Strength** **AON** **Suggestion**					
10. Referrals DBMC A.46, A.145.b	A member 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 member 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					

2023 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					
11. 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					
12. Provider Education DBMC A.52.a	The DBM holds at least two training sessions per year for each Grand Region in the state. At a minimum, the training addresses: 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.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
13. Limits/ Capitations/ Delays	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	☐ No limits or capitations imposed unless excluded under TennCare rule ☐ Services based on individual needs	**0.33** **0.33**	**1.00**	**0.00**

2023 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.106	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 utilization control guidelines/limits unless supported by individual member's medical history	**0.34**		
Comments					
Strength					
AON					
Suggestion					
14. 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					
15. 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					
Suggestion					
		☐ Yes	**1.00**	**1.00**	**0.00**

2023 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)					
16. Transportation 42 CFR § 441.62(2) DBMC A.49.a, A.112	It is the responsibility of the member's DBM 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.	☐ No	**0.00**		
Comments					
Strength					
AON					
Suggestion					
17. Coordination with MCOs DBMC A.49	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					
18. 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, 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					

2023 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					
19. 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					
20. EPSDT Provisions DBMC A.66.II	All contracts with dental providers contain language that informs providers of the EPSDT benefit package and periodicity schedule.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
21. 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					
Strength					

2023 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)					
AON					
Suggestion					
		Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Score	**0.00%**	**21.00**	**0.00**

2023 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 DBM'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					

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<tr><th>Value</th><th>Score</th></tr>
<tr><td colspan="6">Non-Discrimination Compliance</td></tr>
<tr><td>Suggestion</td><td colspan="5"></td></tr>
<tr><td>3. Non-Discrimination Written Materials

DBMC A.13, A.165</td><td>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;
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; and
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.</td><td>☐ 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
☐ Staff demonstrated availability of vital documents in alternative formats</td><td>0.20
0.20
0.20
0.20
0.20</td><td>1.00</td><td>0.00</td></tr>
<tr><td>Comments</td><td colspan="5"></td></tr>
<tr><td>Strength</td><td colspan="5"></td></tr>
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<tr><td>Suggestion</td><td colspan="5"></td></tr>
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2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Non-Discrimination Compliance					
4. Written P&P DBMC A.29, A.30, A. 31, A.165.a.3	The DBM has a written policy and procedure 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 helplines.	☐ Language interpretation and translation services addressed	0.25	1.00	0.00
		☐ Communication assistance in alternative formats addressed	0.25		
		☐ Telephone numbers made known to members and providers	0.25		
		☐ Proof of communication assistance demonstrated through available helplines	0.25		
Comments					
Strength					
AON					
Suggestion					
5. Complaint Resolution and Reporting DBMC A.165.b.2, A.165.c	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	0.25	1.00	0.00
		☐ Reports included all required information	0.25		
		☐ All complaints reported within two business days	0.25		
		☐ Provided assistance to TennCare as needed	0.25		
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Non-Discrimination Compliance					
6. Provider and Subcontractor Compliance Education DBMC A.165.a	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 policies and procedures on file that demonstrate services are provided in a non-discriminatory manner.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
		Non-Discrimination Compliance Score	**0.00%**	**7.00**	**0.00**

2023 PBM QP Tool

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
1. Delivery Network 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 or physical 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 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) PBMC A.14	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**
Comments **Strength**					

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
AON Suggestion					
4. Timely Access 42 CFR § 438.206.c(1)(i) PBMC A.49.a, A.49.b	The PBM meets and 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) PBMC A.49.a	The PBM ensures that the 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 commercial ☐ Services available 24 hours a day, seven days a week, when medically necessary	**0.50** **0.50**	**1.00**	**0.00**
Comments					
Strength					
AON Suggestion					
6. Provider Compliance 42 CFR § 438.206(c)(1)(iv)-(vi)	The PBM: 1) Establishes mechanisms to ensure compliance by network providers; 2) Monitors network providers regularly to determine compliance; and 3) Takes corrective action if there is a failure to comply by a network provider.	☐ Mechanisms to ensure compliance ☐ Monitoring to determine compliance ☐ Corrective action if failure to comply	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments					

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Availability of Services					
Strength					
AON					
Suggestion					
7. Access and Cultural Considerations 42 CFR § 438.20(c)2) PBMC A.6.i	The PBM participates in the TennCare's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
8. Accessibility Considerations 42 CFR § 438.206(c)(3) PBMC A.6.i	The PBM ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
		Availability of Services Score	**0.00%**	**8.00**	**0.00**

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<tr><th>Value</th><th>Score</th></tr>
<tr><td colspan="6">Assurances of Adequate Capacity and Services</td></tr>
<tr><td>1. Nature of Supporting Documentation
42 CFR § 438.207(b)(1)-(2)
PBMC A.60.c-A.60.e</td><td>The PBM submits documentation to TennCare, in a format specified by TennCare, to demonstrate that it complies with the following requirements:
1) Offers an appropriate range of pharmacy services that is adequate for the anticipated number of members for the service area; and
2) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.</td><td>☐ Yes
☐ No</td><td>1.00
0.00</td><td>1.00</td><td>0.00</td></tr>
<tr><td>Comments</td><td colspan="5"></td></tr>
<tr><td>Strength</td><td colspan="5"></td></tr>
<tr><td>AON</td><td colspan="5"></td></tr>
<tr><td>Suggestion</td><td colspan="5"></td></tr>
<tr><td>2. Timing of Documentation
42 CFR § 438.207(c)(1)-(3)
PBMC A.17</td><td>The PBM submits the documentation described in element one as specified by TennCare, but no less frequently than the following:
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 PBM's operations that would affect the adequacy of capacity and services, including -
a) Changes in PBM benefits, geographic service area, composition of, or payments to, its provider network, or
b) Enrollment of a new population in the PBM.</td><td>☐ Time of contract execution
☐ On a monthly basis
☐ At time of significant change in operations</td><td>0.33
0.33
0.34</td><td>1.00</td><td>0.00</td></tr>
<tr><td>Comments</td><td colspan="5"></td></tr>
<tr><td>Strength</td><td colspan="5"></td></tr>
<tr><td>AON</td><td colspan="5"></td></tr>
<tr><td>Suggestion</td><td colspan="5"></td></tr>
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2023 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-A.44.h.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. Member Disenrollment 42 CFR § 438.207(b)(1)-(2) PBMC A.44.o	A member may be disenrolled from the PBM only when authorized by TennCare. The PBM shall not request disenrollment of a member for any reason. The PBM shall not disenroll members for any of the following reasons: 1) Adverse changes in the member's health; 2) Pre-existing medical or behavioral health conditions; 3) High cost medical or behavioral health bills; 4) Failure or refusal to pay applicable TennCare cost sharing responsibilities, except when this results in loss of eligibility for TennCare; 5) Member's utilization of medical or behavioral health services; 6) Member's diminished mental capacity; or 7) Member's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the PBM seriously impairs the entity's ability to furnish services to either this particular member or other members).	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Coordination and Continuity of Care					
Suggestion					
		Coordination and Continuity of Care Score	**0.00%**	**2.00**	**0.00**

2023 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)(i) PBMC A.46.b	The PBM is permitted to place appropriate limits on a service on the basis of criteria applied under TennCare, 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)(i) PBMC A.8.b.11	The PBM uses a definition of “medically necessary services” in a manner that Is no more restrictive than that used in the TennCare Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in TennCare statutes, regulations, and policy and procedures.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Coverage and Authorization of Services					
3. Authorization of Services Policies and Procedures 42 CFR § 438.210(b)(1) PBMC A.46.a	For the processing of requests for initial and continuing authorizations of services, the PBM and its subcontractors use written policies and procedures.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
4. Processing Authorizations 42 CFR § 438.210(b)(2) PBMC A.46.b, A.46.c, A.77.b, A.77.c	The PBM: 1) Uses mechanisms to ensure consistent application of review criteria for authorization decisions; and, 2) Consults with the requesting provider for pharmacy services when appropriate.	☐ Criteria applied consistently ☐ Requesting provider consulted	0.50 0.50	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
5. Appropriate Expertise for Denials 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 medical, behavioral health, needs.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					
Strength					

2023 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, A.77.b.2	The PBM notifies the requesting provider, and gives the member written notice 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.	☐ Written notice to provider and member ☐ Includes required information	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON Suggestion**					
7. Notification Timeframes – Covered Outpatient Drug Decisions 42 CFR § 438.210(d)(3) PBMC A.46 a	For all covered outpatient drug authorization decisions, the PBM provides notice by telephone or other telecommunication device within 24 hours of a request for prior authorization.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON Suggestion**					

2023 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					
		Coverage and Authorization of Services	**0.00%**	**8.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Confidentiality					
1. Privacy Requirements 42 CFR § 438.224 PBMC A.44.h.3, A58.g.3, D.20	For medical records and any other health and enrollment information that identifies a particular member, each PBM uses and discloses such individually identifiable health information in accordance with the state and federal privacy requirements	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Confidentiality					
		Confidentiality Score	**0.00%**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Grievance and Appeal Systems					
1. Grievance and Appeal System 42 CFR § 438.402(a) PBMC A.46.d, 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. Authority to File 42 CFR § 438.402.(c)(1)(i) PBMC A.46.d.7.b, A.46.d.14.a, A.77.d	A member may file a grievance with the PBM. A member may contest a PBM-proposed adverse benefit determination by filing an appeal with TennCare.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
3. Provider or Authorized Representative 42 CFR § 438.402.(c)(1)(ii) PBMC A.46.d.9, A.77.d	With the written consent of the member, a provider or an authorized representative may file a grievance or TennCare appeal on behalf of a member.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
4. Timing to File Grievance and Appeal 42 CFR § 438.402(c)(2) 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. Following receipt of a notice of adverse benefit determination (NABD), a member has 60 calendar days from the date on the NABD notice to file a TennCare appeal with TennCare.	☐ May file a grievance at any time ☐ Has 60 calendar days to request an appeal after receiving NABD	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
5. Procedures 42 CFR § 438.402(c)(3) PBMC A.46.d.11, A.46.d.14.b, A.77.d	A member may file a grievance with the PBM either orally or in writing. A member may file an appeal contesting the PBM's proposed adverse benefit determination either orally or in writing at the TennCare phone number or address listed on the PBM-issued notice of adverse determination.	☐ May file grievance orally or in writing ☐ May request appeal orally or in writing	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON**					

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
Suggestion					
6. Availability of Notices 42 CFR § 438.404(a) PBMC A.46.d.7.e	The PBM gives members timely and adequate notice of an adverse benefit determination 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; and 4) Auxiliary aids and services.	☐ Timely and adequate notice ☐ Available via listed means	**0.50** **0.50**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
7. Content of Notice of Adverse Benefit Determination 42 CFR § 438.404(b)(1)-(6) PBMC A.46.d.7, A.77.d	The notice explains the following: 1) The adverse benefit determination the PBM has made or intends to make; 2) The reasons for the adverse benefit determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit 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 a TennCare appeal of the PBM's adverse benefit determination; 4) The procedures for exercising the rights; 5) The circumstances under which an appeal process can be expedited and how to request it; and 6) The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued.	☐ Determination made or intends to make ☐ Reasons for determination ☐ Right to request appeal ☐ Procedures for exercising rights ☐ Circumstances for which an appeal can be expedited ☐ Right to continuing benefits pending appeal resolution	**0.16** **0.16** **0.17** **0.17** **0.17** **0.17**	**1.00**	**0.00**
Comments					

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
Strength					
AON					
Suggestion					
8. Timing of Notice PBMC A.46.f.8	The PBM issues the NADB within the following timeframes: 1) If the Adverse Benefit Determination relates to PBM's denial of a prior authorization request, the PBM issues the NABD within 24 hours of receiving a PA request which contains the requisite information for a determination; 2) If the PBM fails to timely render a PA determination, the PBM shall issue the NABD to member on the date that the PA timeframe expires; and 3) The PBM issues the NABD on the date of determination when the action is a denial member's request for reimbursement for medications member paid for out-of-pocket.	☐ Within 24 hours for PA request ☐ For failure to meet time requirements, on the date the PA timeframe expires ☐ On the date of determination for reimbursement for out-of-pocket expenses	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
9. Handling of Grievances and Appeals 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 numbers that have adequate TTY/TDD and interpreter capability.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Grievance and Appeal Systems					
10. Acknowledging Grievances and Forwarding Appeals 42 CFR § 438.406(b)(1) PBMC A.46.d.5.b	The PBM's process for handling member grievances and for satisfying TennCare requirements for appeals of adverse benefit determinations includes acknowledging receipt of each grievance and forwarding appeal of adverse benefit determinations to TennCare and informing the member that TennCare will contact them about their appeal.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
11. Reviewer Requirements 42 CFR § 438.406(b)(2) PBMC A.46.d.6	The PBM's process for handling member grievances and appeals of adverse benefit determinations includes ensuring that the individuals 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: a) An appeal of a denial that is based on lack of medical necessity; b) A grievance regarding denial of expedited resolution of an appeal; and c) A grievance or appeal that involves clinical issues; 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 adverse benefit determination.	☐ Not involved in previous review or subordinate ☐ Appropriate clinical expertise ☐ Take into account all information	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments **Strength**					

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Grievance and Appeal Systems					
AON					
Suggestion					
12. Oral Inquiries Treated as Appeals 42 CFR § 438.406(b)(3) PBMC A.46.d.11.a, A.46.d.11.c	The PBM's process for handling member appeals of adverse benefit determinations includes providing that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal).	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
13. Resolution and Notification 42 CFR § 438.408(a) PBMC A.46.d.11.e, A.46.d.14.c	The PBM resolves each grievance and appeal process-related obligations, and provides notice, as expeditiously as the member's health condition requires, within TennCare-established timeframes that may not exceed the timeframes for 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					
14. Grievance Resolution Timeframe 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					

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Grievance and Appeal Systems					
Strength **AON** **Suggestion**					
15. Standard Appeal Resolution Timeframe 42 CFR § 438.408(b) PBMC A.46.d.11.e.2	For standard resolution of an appeal, the PBM 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**					
16. Expedited Appeal Resolution Timeframe 42 CFR § 438.408(b) PBMC A.46.d.11.e.1	For expedited resolution of an appeal, 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**					
	The PBM may extend the grievance resolution timeframe by up to 14 calendar days if: 1) The member requests the extension; or	☐ Yes ☐ No	1.00 0.00	1.00	0.00

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Grievance and Appeal Systems					
17. Extension of Grievance Timeframes 42 CFR § 438.408(c)(1) PBMC A.46.d.14.d	2) 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.				
Comments **Strength** **AON** **Suggestion**					
18. Extension Requirements 42 CFR § 438.408(c)(2) PBMC A.46.d.14.e	If the PBM extends the timeframes for grievance resolution not at the request of the member, it completes all of the following: 1) Make reasonable efforts to give the member prompt oral notice of the delay; and 2) Within two (2) calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.	☐ Oral notice ☐ Written notice	0.50 0.50	1.00	0.00
Comments **Strength** **AON** **Suggestion**					
19. Format of Grievance Notice 42 CFR § 438.408(d)(1) PBMC A.46.d.14.f	The PBM uses the TennCare established method to notify a member of the resolution of a grievance and ensure that such methods provide for: 1) Written translation; 2) Oral interpretation; 3) Alternative formats; and 4) Auxiliary aids and services.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Grievance and Appeal Systems					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Grievance and Appeal Systems					
20. Format of Appeal Notice 42 CFR § 438.408(d)(2)	For all appeals, the PBM provides written notice of resolution in a format and language that provides for: 1) Written translation; 2) Oral interpretation; 3) Alternative formats; and 4) Auxiliary aids and services. For notice of an expedited resolution, the PBM makes reasonable efforts to provide oral notice.	☐ Written notice via listed means ☐ Reasonable efforts for oral notice	0.50 0.50	1.00	0.00
Comments **Strength** **AON** **Suggestion**					
21. Content of Notice of Appeal Resolution – Results and Date 42 CFR § 438.408(e)	The written notice of the 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**					
22. Expedited Resolution of Appeals 42 CFR § 438.410 PBMC A.46.d.11	The PBM establishes and maintains an expedited review process for appeals, when the PBM 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

2023 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**					
23. Punitive Action Prohibited 42 CFR § 438.410 PBMC A.15.d, 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**					
24. Provider Information 42 CFR § 438.414 PBMC A.46.d.17.a	The PBM provides information about the grievance and TennCare appeal procedures and filing timeframes to all providers and subcontractors at the time they enter into a contract.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
25. Recordkeeping Requirements – Ongoing Monitoring 42 CFR § 438.416 PBMC A.46.d.15	The PBM 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 TennCare's Quality Strategy.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
26. Recordkeeping Requirements – Information 42 CFR § 438.416 PBMC A.46.d.15.b	The record of each grievance or appeal contains, at a minimum, all of the following information: 1) A general description of the reason for the appeal or grievance; 2) The date received; 3) The date of each review or, if applicable, review meeting; 4) Information on how the grievance or TennCare appeal was resolved; 5) Date of resolution; and, 6) Name of the covered person for whom the appeal or grievance was filed.	☐ Reason for appeal or grievance ☐ Date received ☐ Date of each review ☐ Resolution ☐ Date of resolution ☐ Name of member	**0.16** **0.16** **0.17** **0.17** **0.17** **0.17**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Grievance and Appeal Systems					
27. Recordkeeping Requirements – Accuracy and Accessibility 42 CFR § 438.416 PBMC A.46.d.15.c	The record is accurately maintained 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**					
28. Continuation of Benefits 42 CFR § 438.420(b), A.46.d.12.a	The PBM continues the member's benefits if all of the following occur: 1) The member files the request for TennCare appeal within 60 calendar days following the date on the NADB; 2) The contested issue at the TennCare appeal's fair hearing involves a drug that has been previously prescribed (either on an ongoing basis, or with unlimited refills), but which is now subject to prior authorization; and 3) The request for continuation of benefits is filed within ten calendar days of the date on the NABD.	☐ Request for appeal filed timely ☐ Previously prescribed drug ☐ Request for continuation of benefits filed timely	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
29. Duration of Continued or Reinstated Benefits 42 CFR § 438.420(c) PBMC A.46.d.12	If, at the member's request, the PBM continues or reinstates the member's benefits while the TennCare appeal is pending, the benefits are continued until one of following occurs: 1) The member withdraws the request for TennCare appeal; and 2) A TennCare appeal decision adverse to the member is issued.	☐ Member withdraws appeal request ☐ TennCare decision adverse to member	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
30. Effectuation of Reversed Appeal Resolutions – Services Not Furnished While Appeal Pending 42 CFR § 438.424 PBMC A.46.d.13	If the TennCare appeal reverses a decision to deny, limit, or delay services that were not furnished while the appeal was 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.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Grievance and Appeal Systems					
31. Effectuation of Reversed Appeal Resolutions – Services Furnished While Appeal Pending 42 CFR § 438.424 PBMC A.46.d.13	If the TennCare appeal reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the PBM pays for those services, in accordance with TennCare policy and regulations.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
		Grievance and Appeal Systems Score	**0.00%**	**31.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Subcontractual Relationships and Delegation					
1. Subcontractor Contract Requirements 42 CFR § 438.230.(c)(1)(ii)(iii) PBMC A.7.a.5	Each contract or written arrangement with any subcontractor specifies that, if any of the PBM's activities or obligations under its contract with TennCare are delegated to a subcontractor: 1) The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the PBM's contract obligations; and 2) The contract or written arrangement either provides for revocation of the delegation of activities or obligations or specifies other remedies in instances where TennCare or the PBM determine that the subcontractor has not performed satisfactorily.	☐ Subcontractor agrees to perform activities and reporting responsibilities ☐ Contract provides for revocation or specifies other remedies for unsatisfactory performance.	0.50 0.50	1.00	0.00

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Subcontractual Relationships and Delegation					
Comments					
Strength					
AON					
Suggestion					
2. Subcontractor Regulatory Compliance 42 CFR § 438.230(c)(2) PBMC A.7.a.5	The subcontractor agreement specifies that the subcontractor complies 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					
3. Subcontractor Audit Requirements 42 CFR § 438.230(c)(3) PBMC A.18, A.20	The subcontractor agreement specifies that: 1) TennCare, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the PBM's contract with the TennCare; 2) The subcontractor will make available, for purposes of an audit, evaluation, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members; 3) The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later; and	☐ Right to audit ☐ Make available premises, records, etc. for purpose of audit, evaluation, or inspection ☐ Right to audit exists through 10 years ☐ May inspect, audit, evaluate at any time if suspicion of fraud or similar risk	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Subcontractual Relationships and Delegation					
	4) If TennCare, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, TennCare, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.				
Comments					
Strength					
AON					
Suggestion					
		Subcontractual Relationships and Delegation Score	**0.00%**	**3.00**	**0.00**

2023 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)) PBMC A.8.b.10	Decisions for utilization management, member education, and coverage of services are based on TennCare Pharmacy Advisory Committee recommendations.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
		Practice Guidelines Score	**0.00%**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Health Information Systems					
1. General Rule 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. Basic Elements 42 CFR § 438.242(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)(3) PBMC A.40.f	The PBM ensures that data received from providers are accurate and complete by: 4) Verifying the accuracy and timeliness of reported data, including data from network providers the PBM is compensating on the basis of capitation payments; 5) Screening the data for completeness, logic, and consistency; and 6) 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**

2023 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)(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**

2023 Annual Quality Survey—Quality Process Standards: OptumRx					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program					
1. QAPI Program 42 CFR § 438.330(a)(1) PBMC A.46.a.12	The PBM establishes and implements an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its members.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
2. Utilization and Special Health Care Needs 42 CFR § 438.330(b)(3)-(4) PBMC A.42.e.1.a	The comprehensive quality assessment and performance improvement program includes at least the following elements: 1. Mechanisms to detect both underutilization and overutilization of services; and 2. Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs, as defined by TennCare in the Quality Strategy.	☐ Mechanisms to detect under and overutilization ☐ Mechanisms to assess quality of care furnished to members with special health care needs	**0.50** **0.50**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
	The PBM annually:	☐ Yes	**1.00**	**1.00**	**0.00**

<table>
<tr><th colspan="6">2023 Annual Quality Survey—Quality Process Standards: OptumRx</th></tr>
<tr><th rowspan="2">Evaluation Elements</th><th rowspan="2">Criteria</th><th rowspan="2">Criteria Met</th><th rowspan="2">Criteria Value</th><th colspan="2">Element</th></tr>
<tr><th>Value</th><th>Score</th></tr>
<tr><td colspan="6">Quality Assessment and Performance Improvement (QAPI) Program</td></tr>
<tr><td>3. Performance Measurement

42 CFR § 438.330(c)(2)
PBMC A.54</td><td>1. Measures and reports to the TennCare on its performance, using the standard measures required by TennCare; and
2. Submits data to TennCare which allows TennCare to calculate the PBM’s performance using the standard measures identified by TennCare.</td><td>☐ No</td><td>0.00</td><td></td><td></td></tr>
<tr><td>Comments</td><td colspan="5"></td></tr>
<tr><td>Strength</td><td colspan="5"></td></tr>
<tr><td>AON</td><td colspan="5"></td></tr>
<tr><td>Suggestion</td><td colspan="5"></td></tr>
<tr><td>4. Performance Improvement Projects

42 CFR § 438.330(d)(2)
PBMC A.54</td><td>Each performance improvement project is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and includes the following elements:
1. Measurement of performance using objective quality indicators;
2. Implementation of interventions to achieve improvement in the access to and quality of care;
3. Evaluation of the effectiveness of the interventions based on the performance measures; and
4. Planning and initiation of activities for increasing or sustaining improvement.</td><td>☐ Yes

☐ No</td><td>1.00

0.00</td><td>1.00</td><td>0.00</td></tr>
<tr><td>Comments</td><td colspan="5"></td></tr>
<tr><td>Strength</td><td colspan="5"></td></tr>
<tr><td>AON</td><td colspan="5"></td></tr>
<tr><td>Suggestion</td><td colspan="5"></td></tr>
</table>

2023 Annual Quality Survey—Quality Process Standards: OptumRx					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Quality Assessment and Performance Improvement (QAPI) Program					
5. Reporting Results to TennCare 42 CFR § 438.330(d)(3) PBMC A.54	The PBM reports the status and results of each project conducted to TennCare as requested, but not 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) Score:	**0.0%**	**5.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Member Rights					
1. Member Rights 42 CFR § 438.100(b)(2) 438.100(c)	A member of an PBM has the following rights: 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) Exercise his or her rights, and that the exercise of those rights does not adversely affect the way the PBM and its network providers treat the member.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
		Member Rights Score:	**0.00%**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Information Requirements					
1. Member Information Requirements – General 42 CFR § 438.10(c)(1) PBMC A.8.b	The PBM provides all required information to be provided to members and potential members in a manner and format that may be easily understood and is readily accessible by such members and potential members.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments					
Strength					
AON					
Suggestion					
2. Electronic Member Information 42 CFR § 438.10(c)(6) PBMC A.8.b.3	For required member information the PBM provides to members, all the following apply: 1) The format is readily accessible; 2) The information is placed in a location on the PBM's website that is prominent and readily accessible; 3) The information is provided in an electronic form which can be electronically retained and printed; 4) The information is consistent with the content and language requirements; and 5) The member is informed that the information is available in paper form without charge upon request and provides it upon request within 5 business days.	☐ Format is easily accessible ☐ Prominent location ☐ Electronically retained and printed ☐ Consistent with content and language requirements ☐ Informed of availability in paper form within 5 business days	0.20 0.20 0.20 0.20 0.20	1.00	0.00
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Information Requirements					
3. Assistance with Understanding Plan 42 CFR § 438.10(c)(7)	The PBM has in place mechanisms to help members and potential members understand the requirements and benefits of the plan.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
4. Written Materials 42 CFR § 438.10.d(3) PBMC A.8.b	The PBM makes its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, formulary, identification cards, appeal and grievance notices, denial and termination notices, and member educational material, available in the prevalent non-English languages in its particular service area. Written materials that are critical to obtaining services are also to be made available in alternative formats upon request of the potential member or member at no cost, include taglines in the prevalent non-English languages in the state, and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and include the toll-free and TTY/TDY telephone number of the PBM's entity's member/customer service unit. Auxiliary aids and services are also to be made available upon request of the potential member or member at no cost.	☐ Non-English languages ☐ Alternate formats at no cost ☐ Toll-free number of customer service unit ☐ How to request auxiliary aids and services at no cost	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Information Requirements					
5. Interpretation Services 42 CFR § 438.10(d)(4) PBMC A.8.b	The PBM makes interpretation services available to each potential member free of charge to each member. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. Oral interpretation requirements apply to all non-English languages, not just those that TennCare identifies as prevalent.	☐ Yes ☐ No	**1.00** 0.00	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
6. Communication Assistance 42 CFR § 438.10(d)(5) PBMC A.8.b	The PBM notifies potential members: 1) That oral interpretation is available for any language and written translation is available in prevalent languages; 2) That auxiliary aids and services are available upon request and at no cost for members with disabilities; and 3) How to access these services.	☐ Oral interpretation available ☐ Auxiliary aids available ☐ How to access services	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
7. Written Material Requirements 42 CFR § 438.10(d)(6) PBMC A.8.b	The PBM provides all written materials for potential members and members consistent with the following: 1) Use easily understood language and format, 2) Use a font size no smaller than 12 points, 3) Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or	☐ Easily understood language and format ☐ Font size no smaller than 12 points ☐ Available in alternative formats and through auxiliary aids	**0.33** **0.33** **0.34**	**1.00**	**0.00**

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Information Requirements					
	potential members with disabilities or limited English proficiency.				
Comments					
Strength					
AON					
Suggestion					
8. Provider Directory Information 42 CFR § 438.10(h)(1) PBMC A.49.d	Each PBM makes available in paper form upon request and electronic form, the following information about its network providers: 1) The provider's name; 2) NPI; 3) Street address(es); 4) Telephone number(s); 5) Fax numbers; 6) Email address; and 7) Hours of operation.	☐ Provider name ☐ NPI ☐ Street address ☐ Telephone number ☐ Fax number ☐ Hours of operation	**0.16** **0.16** **0.17** **0.17** **0.17** **0.17**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Information Requirements					
9. Provider Directory Updates 42 CFR § 438.10(h)(3) PBMC A.49.d	Information included in an electronic provider directory is updated weekly on the PBM's Web site in a machine-readable file and format.	☐ Yes ☐ No	1.00 0.00	1.00	0.00
Comments **Strength** **AON** **Suggestion**					
10. Formulary Information Requirements 42 CFR § 438.10(i)	The PBM makes available in electronic or paper form, the following information about its formulary: 1) Which medications are covered (both generic and name brand); and 2) Formulary drug lists are available on the PBM's Web site in a machine-readable file and format as specified by the Secretary.	☐ Covered medications ☐ Machine readable format	0.50 0.50	1.00	0.00
Comments **Strength** **AON** **Suggestion**					
		Information Requirements	**0.00%**	**10.00**	**0.00**

2023 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**
Findings **Strength** **AON** **Suggestion**					
2. Cultural Competency PBMC A.6.i	The PBM shows evidence that it participates in TennCare's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency (LEP), disabilities, and/or diverse cultural and ethnic backgrounds and regardless of sex.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Findings **Strength** **AON** **Suggestion**					
3. Written Materials PBMC A.6.a.8, A.8.b	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; and 3) PBM staff can demonstrate the capability to provide vital documents in alternative formats to members with impaired	☐ 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**

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element Value	Element Score
Non-Discrimination Compliance					
	sensory skills (e.g., visually impaired) who require communication assistance.				
Findings					
Strength					
AON					
Suggestion					
4. Complaint Resolution and Reporting PBMC A.6	The PBM reports discrimination complaints to TennCare within two business days of receipt, assists with initial investigations if requested, and completes any corrective action required by TennCare. 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.	☐ Reports complaints within two business days ☐ Assists with investigations if requested ☐ Completed corrective action required ☐ Quarterly Non-Discrimination report submitted	0.25 0.25 0.25 0.25	1.00	0.00
Findings					
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
Findings					
Strength					
AON					

2023 Annual Quality Survey—Quality Process Standards: <PBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Non-Discrimination Compliance					
Suggestion					
6. Staff Compliance Training PBMC A.6.a, A.6.b.2.	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**
Findings					
Strength					
AON					
Suggestion					
		Non-Discrimination Compliance Score	**0.00%**	**6.00**	**0.00**

PA File Review Tools

UM Denials File Review Tool																	
MCC:																	mm/dd/2023
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														0			
3														0			
4														0			
5														0			
6														0			
7														0			
8														0			
9														0			
10														0			
Compliant Answers			0		0			0		0						0	
Applicable Answers			0		0			0		0						0	
															Total Compliant	0	
															Total Applicable	0	
															Percent Compliant	%	

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

***Expedited or Standard*

Grievances File Review Tool

MCC:			Time Standard Calculation: Calendar Days										mm/dd/2023
1	2	3	4		5		6	7	8	9		10	
File #	Case ID*	Grievance Rcvd. Date	Grievance Documented		Investigation of Grievance		Date Resolved	Number of Days to Resolve	Time Standard	Timeliness Standard Met		Notification of Resolution	
			Y	N	Y	N				Y	N	Y	N
1								0					
2								0					
3								0					
4								0					
5								0					
6								0					
7								0					
8								0					
9								0					
10								0					
Compliant Answers			**0**		**0**					**0**		**0**	
Applicable Answers			**0**		**0**					**0**		**0**	
									Total Compliant:			**0**	
									Total Applicable:			**0**	
									Percent Compliant:				

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

Appeals File Review Tool																
MCC:																mm/dd/2023
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										0						
2										0						
3										0						
4										0						
5										0						
6										0						
7										0						
8										0						
9										0						
10										0						
Compliant Answers			0			0						0		0		
Applicable Answers			0			0						0		0		

Total Compliant:	0
Total Applicable:	0
Percent Compliant:	

*Case IDs have been used to protect member information.

** Accelerated/Expedited/Standard

EPSDT Information System Tracking File Review Tool											
MCC:			mm/dd/2023								
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			0		0		0			0	
Applicable Answers			0		0		0			0	
							Total Compliant			0	
							Total Applicable			0	
							Percent Compliant				

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

CHOICES Annual Level of Care Assessment File Review Tool									
MCC:									mm/dd/2023
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			0		0				0
Applicable Answers			0		0				0

Case IDs have been used to protect member information.

Total Compliant	0
Total Applicable	0
Percent Compliant	

Transition of CHOICES Members Between MCOs: Criteria for Receiving MCO File Review Tool													
MCC:													mm/dd/2023
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											0	0
		N												
		NA												
6	Transition of Care Data from Sending MCO Reviewed	Y											0	0
		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											0	0
		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											0	0
		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											0	0
		N												
		NA												
10	For Group 2 or 3 Members Rec. STN Facility Svcs. on Date of Enrollment, F-to-F Visit Occurred within 30 Days	Y											0	0
		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											0	0
		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											0	0
		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											0	0
		N												
		NA												
14	For Group 1 Members, F-to-F Visit Occurred within 30 Days of Enrollment and Needs Assess. Conducted as Necessary	Y											0	0
		N												
		NA												
												Totals	0	0
												Percent Compliant		

Case IDs have been used to protect member information.

CHOICES Credentialing and Recredentialing File Review Tools

CHOICES Credentialing

MCC:	Reviewer:									Date of Review:											# 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	#1				#8				#15				#22				#29				#36			
CRA A.2.11.10.4.1.2.1	#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.	#1				#8				#15				#22				#29				#36			
CRA A.2.11.10.4.1.2.2	#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.	#1				#8				#15				#22				#29				#36			
CRA A.2.11.10.4.1.2.3	#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.	#1				#8				#15				#22				#29				#36			
CRA A.2.11.10.4.1.2.3	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			

MCC:	Reviewer:								Date of Review:												# of Files:			
Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA
	#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. *CRA A.2.11.10.4.1.5*	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
FINAL SCORE	**YES**				**NO**								**SCORE**				**PERCENTAGE**							

CHOICES Recredentialing

MCC:	Reviewer:								Date of Review:												# 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			

MCC:	Reviewer:												Date of Review:								# of Files:			
Item Verified?		**Y**	**N**	**NA**		**Y**	**N**	**NA**		**Y**	**N**	**NA**		**Y**	**N**	**NA**		**Y**	**N**	**NA**		**Y**	**N**	**NA**
	#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. *CRA A.2.11.10.4.1.5*	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
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 providers are recredentialed annually. *CRA A.2.11.10.4.1.1.1* *CRA A.2.11.10.4.1.1.2*	#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							

FINAL SCORE	**YES**	**NO**	**SCORE**	**PERCENTAGE**

PMV Tool—MCOs

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

Table 1. 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. **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).		

Table 1. NCQA's Information System Standards		
Standards	**Audit Findings**	**Impact on Reporting**
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 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.		
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

2023 PIP Validation Tool—<MCC> *<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, and explicitly states this focus	☐	☐	☐
5	Aligns with priority areas identified by the Department of Health and Human Services (HHS) and/or CMS, and explicitly states this focus	☐	☐	☐

Step 1 Results:	**Total**	**Met**	**Not Met**	**NA**
Elements	**5**			

Comment:	<Type comment here>.
Strength:	<Type comment here>.
AON:	<Type comment here>.
Suggestion:	<Type comment here>.

2023 PIP Validation Tool—<MCC> *<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: <Type comment here>.

AON: <Type comment here>.

Suggestion: <Type comment here>.

2023 PIP Validation Tool—<MCC>

<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: <Type comment here>.

AON: <Type comment here>.

Suggestion: <Type comment here>.

2023 PIP Validation Tool—<MCC>
<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:	<Type comment here>.			
AON:	<Type comment here>.			
Suggestion:	<Type comment here>.			

2023 PIP Validation Tool—<MCC>
<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	☐	☐	☐

2023 PIP Validation Tool—<MCC> *<PIP Topic>*					
Step 5: Review the Selected PIP Variables and Performance Measures					
	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**			
Comment:	<Type comment here>.				
Strength:	<Type comment here>.				
AON:	<Type comment here>.				
Suggestion:	<Type comment here>.				

2023 PIP Validation Tool—<MCC> *<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:	<Type comment here>.				
AON:	<Type comment here>.				
Suggestion:	<Type comment here>.				

2023 PIP Validation Tool—<MCC>

<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:	<Type comment here>.				
AON:	<Type comment here>.				
Suggestion:	<Type comment here>.				

2023 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: <Type comment here>.

AON: <Type comment here>.

Suggestion: <Type comment here>.

2023 PIP Validation Tool—<MCC>

<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: <Type comment here>.

AON: <Type comment here>.

Suggestion: <Type comment here>.

APPENDIX C | 2023 PIP Summary Table

Improvement strategies are not applicable to PIPs that were in their baseline measurement year in 2022. 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]; Remeasurement 6 [R6]), classification as clinical (C) or non-clinical (NC), and the results of each Performance Measure (Performance Measure 1 [PM1]; Performance Measure 2 [PM2]; Performance Measure 3 [PM3]; and Performance Measure 4 [PM4]).

Table C1. 2023 Performance Improvement Projects

Year	C/NC	Topic	PIP Aim Statement	Improvement Strategies	Results
Amerigroup					
R2	C	*Improve Childhood Immunization Status (CIS) Combination 10 Rates Statewide*	*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 ♦ Whole Health Family Blitz – a provider incentive program to increase efforts of reconnecting families to their providers. The program is an outreach initiative to member families in an effort to close gaps-in-care through wellness exams and vaccinations for adults and their children.	**PM1:** B AGE: 33.58% AGM: 45.26% AGW: 24.09% R1 AGE: 36.98% AGM: 42.34% AGW: 23.11% R2 AGE: 27.98% AGM: 37.96% AGW: 15.57%
B	C	*Improve the Percentage of Adult Members Adherence to Antidepressant Medication Statewide*	*Will member outreach programs and provider specific reporting for proactive gap closure improve the percentage of members ages 18 years and older, who had a diagnosis of major depression and were treated with antidepressant medication, adherence to prescribed antidepressant medication over each measurement year statewide?*		**PM1:** B: 35.99%
B	NC	*Reducing ER Visits by Increasing the Number of Members with Completed SDOH Assessments and Closed Loop Referrals to Community Based Organization*	*Will provider incentives increase the number of members of all ages (seen by AGP Health Starts Program Provider Cohorts) who have completed SDOH Risk Assessments with closed-loop referrals, resulting in the reduction of the number of ER visits for this population over each measurement year?*		**PM1**: B: 3.92 **PM2**: B: 13.21

Table C1. 2023 Performance Improvement Projects

Year	C/NC	Topic	PIP Aim Statement	Improvement Strategies	Results
R2	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	**PM1:** B-AGE: 33.09% AGM: 40.15% AGW: 35.28% R1-AGE: 36.01% AGM: 41.12% AGW: 44.53% R2-AGE: 39.66% AGM: 43.55% AGW: 47.93%
R1	NC	*Increase Statewide the % of Members with Documented LTSS Reassessment and Care Plan Update*	*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?*	♦ Add system enhancements to the Healthy Innovations Platform (HIP) product to improve reporting capabilities for inter-rater reliability and monitoring of re-assessment and care planning update progress. ♦ Initiate reporting of inter-rater reliability components of the PCSP monitoring and quality review process and Manager remediation results.	**PM1:** B: 51.04% R1: 76.04%
R1	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?*	♦ Whole Health Family Blitz – a provider incentive program to increase efforts of reconnecting families to their providers. The program is an outreach initiative to member families in an effort to close gaps-in-care through wellness exams and vaccinations for adults and their children.	**PM1:** B, AGW: 44.27% R1, AGW: 44.19%
BlueCare					
B	C	*Decreasing Behavioral Health Readmissions*	*Will targeted member and/or provider interventions improve the number of BlueCare West adult members 18 years of age and older who are readmitted within 30 days after a behavioral health admission over each measurement period?*		**PM1:** B BCW: 22.81%
B	C	*Improving HbA1c Control (<8.0%) for Members with Diabetes*	*Does providing member and/or provider focused interventions and approaches improve Hemoglobin A1c Control for Patients 18 to 75 years of age with Diabetes (Types 1 and 2) for the BlueCare population over each measurement year?*		**PM1:** B E: 51.70% M: 45.14% W: 47.80%

Table C1. 2023 Performance Improvement Projects

Year	C/NC	Topic	PIP Aim Statement	Improvement Strategies	Results
PM 1, 2: R3 **PM 3, 4:** R1	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	**PM1** 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% R3, E: 28.52% M: 32.37% W: 18.83 **PM2** 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% W: 27.55% R3, E: 31.94% M: 32.20% W: 27.90% **PM3** B, E: 43.12% M: 47.71% W: 29.89% R1, E: 43.12% M: 47.71% W: 29.89% **PM4** B, E: 32.16% M: 33.25% W: 28.40% R1, E: 32.16% M: 33.25% W: 28.40%
R6	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.	**PM1:** B, E: 72% M: 69%. W: 70% R1, E: 76% M: 76%. W: 73% R2, E: 81%

Table C1. 2023 Performance Improvement Projects

Year	C/NC	Topic	PIP Aim Statement	Improvement Strategies	Results
				♦ Partnerships with THL providers in the past have been successful at engaging members. ♦ BlueCare conducted a quality provider analysis and identified several target provider groups across the state that had significant gaps for well-child screenings.	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% R6, E: 78% M: 72%, W: 69%
R1	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?*	♦ Timely notification of inpatient admissions and discharges to the Care Coordinators/Support Coordinators (CC/SC).	**PM1** B, E: 62.96% M: 42.11% W: 51.61% R1, E: 56.52% M: 60.71% W: 57.14% **PM2** B, E: 55.56% M: 42.11% W: 45.16% R1, E: 56.52% M: 60.71% W: 57.14%
B	NC	*Improving Postpartum Care Rates*	*Will targeted member and/or provider interventions improve postpartum care rates for the postpartum population over each measurement period?*		B E: 70.07% M: 65.62% W: 65.89%
TennCare*Select*					
B	NC	*Improving HbA1c Control (<8.0%) for Members with Diabetes*	*Does providing member and/or provider focused interventions and approaches improve Hemoglobin A1c Control for Patients 18 to 75 years of age with Diabetes (Types 1 and 2) for the TennCareSelect population over each measurement year?*		**PM1:** B: 44.17%
B	C	*Decreasing Behavioral Health Readmissions*	*Will targeted member and/or provider interventions improve the number of TennCareSelect child members 17 years of age and younger who are readmitted within 30 days after a behavioral health admission over each measurement period?*		**PM1:** B: 12.44%
R3	C	*Improving Childhood and*	*Will targeted provider interventions result in*	♦ Development of a Vaccination Hesitancy Educational	**PM1,** B: 20.33%

Table C1. 2023 Performance Improvement Projects					
Year	**C/NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**	**Results**
		Adolescents Immunization Rates (CIS/IMA)	*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?*	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.	R1: 25.73% R2: 33.10% R3: 34.79% **PM2,** B: 30.44% R1: 32.33% R2: 30.33% R3: 32.85% **PM3**, B: 54.56% R1: 51.82% R2: 47.93% R3: 56.93% **PM4,** B: 31.44% R1: 34.06% R2: 34.41% R3: 34.06%
R3	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 (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.	**PM1:** B: 54.86% R1: 75.78% R2: 60.00% R3: 63.79%
R6	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	**PM1:** B: 60.00% R1: 66.00% R2: 69.00% R3: 71.00% R4: 65.00% R5: 66.00% R6: 62.00%
B	NC	*Improving Postpartum Care Rates*	*Will targeted member and/or provider interventions improve postpartum care rates for the postpartum population over each*		**PM1:** B: 56.90%

Table C1. 2023 Performance Improvement Projects					
Year	**C/NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**	**Results**
			measurement period?		
UnitedHealthcare					
B	NC	*Digital Outreach Consent*	*Will targeted member interventions increase the percentage of members across the total TN Medicaid population consenting to receive either email or text messaging outreach from the health plan during each remeasurement year?*		**PM1**: B: 27.75% **PM2**: B: 3.81%
B	C	*Follow-Up After ED Visit for Mental Illness 7-Day*	*Will targeted provider and member interventions increase FUM-7-day adherence for members 6 years of age and older who were seen in the ED with a principal diagnosis of mental illness or intentional self-harm during the measurement year over each measurement period?*		**PM1:** B, E: 32.05%
R4	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.	**PM1:** 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% R4: E: 34.55% M: 35.04% W: 21.17%
B	NC	*Social Determinants of Health*	*Will targeted SDoH screening initiatives with both internal staff and external stakeholders increase the number of TN Medicaid members with a SDoH screening completed during each remeasurement year?*		**PM1:** B: 29.60%
R2	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.	**PM1:** B, E: 25.92% M: 26.72% W: 20.30% R1, E: 24.24% M: 24.22% W: 20.84%

Table C1. 2023 Performance Improvement Projects					
Year	**C/NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**	**Results**
					R2, E: 24.32% M: 23.25% W: 21.52%
R1	NC	*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*	*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?*	♦ NCQA Admissions and Readmissions Coordinator Score Card Reporting for Inpatient admissions and Recurring Admissions per diagnosis for MCC aligned Dual members and Medicaid only members. ♦ Development of a comprehensive report for hospitalizations and post inpatient stays for all aligned dual members and Medicaid only members to better inform Coordinators of episodes of care for follow up reassessment and care planning	**PM1**, B: 12.50% R1: 18.75% **PM2**, B: 11.46% R1: 8.33%
DentaQuest					
R5	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 ♦ Updated look and content of provider Silver Diamine Fluoride Tool Kit from Improvement Strategy 1 ♦ Issue amendment by notice to all participating network providers outlining TennCare's expectations that Silver Diamine Fluoride is used as part of standard practice in treating TennCare members (copy submitted with PIP)	**PM1:** B 0.20% of utilizers received SDF. R1 0.50% R2 0.89% R3 1.55% R4 2.22% R5: 2.43%
R5	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*	♦ 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.	**PM1:** B 4.77% R1 2.99%

Table C1. 2023 Performance Improvement Projects

Year	C/NC	Topic	PIP Aim Statement	Improvement Strategies	Results
			remeasurement year?	♦ DentaQuest identified Dental Providers that are outliers amongst their peers, in terms of percentage of TennCare patients receiving an opioid prescription. These providers were targeted with a letter sent via mail and email calling attention to their prescriptive behaviors as well as providing education and alternative strategies for pain management.	R2 2.96% R3 2.88% R4 2.66% R5: 2.57%
OptumRx					
B	C	*Schizophrenia Medication Compliance Improvement Plan*	*Will increasing the utilization of long-acting atypical antipsychotic injectables reduce psychotic breaks by 15% within 1 year and reduce the frequency and costs associated with psychotic breaks (e.g., inpatient psychiatric hospitalizations, including medical-pharmacy claims, and emergency room (ER) visits) in patients with schizophrenia who have been non-compliant on oral antipsychotics over each remeasurement year?*		**PM1** B: 55.40 days **PM2** B: $11,225.56
R2	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?*	♦ Increase consistency and frequency of distribution of 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 2023 and review compliance data semi-annually vs annually beginning 2023, both January and July.	**PM1:** B 6.06% R1 6.64% R2: 6.65%