Tennessee
External Quality Review Organization

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2019 Annual

EQRO Technical Report

TN Division of TennCare

Qsource

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Acknowledgments, Acronyms, and Initialisms[1]

A/C ..... All/Critical (Elements in PIP Validation)

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

AGE, AGM, AGW..... Amerigroup referenced by operational region: East (E), Middle (M), and West (W)

AHS..... Automated Health Systems

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

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

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

AOD ..... Alcohol and Other Drug

AON ..... Area of Noncompliance

APP ..... Mobile Application

AQS..... Annual Quality Survey

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

B..... Baseline Year (PIP Study)

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

BCE, BCM, BCW ..... BlueCare Tennessee referenced by operational region: East (E), Middle (M), and West (W)

BH..... Behavioral Health

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

C/NC ..... Clinical/Non-Clinical

CAHPS® ..... Consumer Assessment of Healthcare Providers and Systems is a registered trademark of the Agency for Healthcare Research and Quality

CAP ..... Corrective Action Plan

CEU ..... Continuing Education Credits

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

CHCA..... Certified HEDIS Compliance Auditor

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

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

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

CIS Combo 10 ... HEDIS measure, percentage of two-year-olds who have received the No.10 combination of vaccines by their second birthday

CLS ..... Community Living Supports

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

COE..... Center of Excellence

CRA..... Contractor Risk Agreement

CY ..... Calendar Year

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

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

DQ ..... DentaQuest of Tennessee, LLC

ECF ..... Employment and Community First

EDI ..... Electronic Data Interchange

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

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

GDP..... General Dental Practitioner

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

HD ..... HEDIS Determination

[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.*

HEDIS® ..... Healthcare Effectiveness Data and Information Set, a registered trademark of the NCQA
HEDIS Compliance Audit™ ..... a trademark of NCQA
HPA ..... Health Plan Administrator
HRA ..... Health Risk Assessment
HSAG ..... Health Services Advisory Group, Inc.
ID ..... Identification
IET ..... Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (HEDIS measure)
IS ..... Information System(s)
LTSS ..... Long-Term Services and Supports
Magellan ..... Magellan Rx Management℠, a division and service mark of Magellan Health, Inc.
MAT ..... Medication-Assisted Treatment
MCC/MCO ..... Managed Care Contractor/Organization
MD ..... Doctor of Medicine
MRR ..... Medical Record Review
NA ..... Not Applicable/Not Assessed
NCQA ..... National Committee for Quality Assurance
NEMT ..... Non-Emergency Medical Transportation
NICU ..... Neonatal Intensive Care Unit
OB/GYN ..... Obstetrician/Gynecologist
P&P ..... Policy and Procedure
PA ..... Performance Activity
PBM ..... Pharmacy Benefits Manager
PCP ..... Primary Care Provider
PDV ..... Provider Data Validation
PERS ..... Personal Emergency Response System
PHPD ..... Population Health Program Description
PIHP ..... Prepaid Inpatient Health Plan
PIP ..... Performance Improvement Project
PMV ..... Performance Measure Validation
PPC ..... Prenatal and Postpartum Care (HEDIS Measure)
PSS ..... Provider Satisfaction Survey
QI/QIP ..... Quality Improvement/QI Program
QM/QMP ..... Quality Monitoring/QM Program
QP ..... Quality Process
Qsource® ..... a registered trademark
R ..... Reportable
R1–4 ..... Remeasurement Year 1–4 (PIP Study)
Roadmap ..... NCQA HEDIS Record of Administration, Data Management and Processes
SCP ..... Specialty Care Provider
SDF ..... Silver Diamine Fluoride
SF-12® ..... 12-Item Short Form Survey, a registered Trademark of Medical Outcomes Trust
SOP ..... Standard Operating Procedures
SPMI ..... Severe and Persistent Mental Illness
TCA ..... Tennessee Code Annotated
TCS ..... TennCare*Select*, administered by BlueCare Tennessee
TDCI ..... Tennessee Department of Commerce and Insurance
TennCare ..... Tennessee Division of TennCare
UHC ..... UnitedHealthcare Community Plan
UHCE, UHCM, UHCW ..... UHC referenced by operational region: East (E), Middle (M), and West (W)
UnitedHealthcare® ..... a registered mark of UnitedHealth Group, Inc.
UM ..... Utilization Management
UOP ..... Use of Opioids from Multiple Providers (HEDIS measure)
W34 ..... Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (HEDIS Measure)

Executive Summary

Overview

Qsource produced this *2019 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 compliance with federal and state standards through the Annual Provider Network Adequacy and Benefit Delivery (ANA) Review and the Annual Quality Survey (AQS)
- Validating performance measures (PMV)
- Validating performance improvement projects (PIPs)

During the period under review (Calendar Year [CY] 2018), TennCare's MCCs included managed care organizations (MCOs) operating in Tennessee's East, Middle, and West Grand Regions; a statewide MCO available to certain TennCare members under age 21 years enrolled by the State; a statewide dental benefits manager (DBM); and a statewide pharmacy benefits manager (PBM). While TennCare also contracts with a health plan administrator (HPA) and DBM for the CoverKids Children's Health Insurance Program (CHIP), and with nine Dual-Eligible Special Needs Plans (D-SNPs) for Medicare cost-sharing, EQRO reporting for both populations is separate from the TennCare-only population and, therefore, not included in this report.

TennCare annually identifies goals and objectives in a State *Quality Assessment and Performance Improvement Strategy* (Quality Strategy), to provide guidance for the Medicaid program. Qsource meets all the qualifications and standards of independence for EQROs set forth in Title 42 *Code of Federal Regulations* (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
- Assessment Background, Technical Method of Data Collection and Analysis, Description of Data Obtained, Comparative Findings, and Conclusions for the ANA Review, AQS, PMV, and PIP Validation
- Conclusions and Recommendations

Assessment

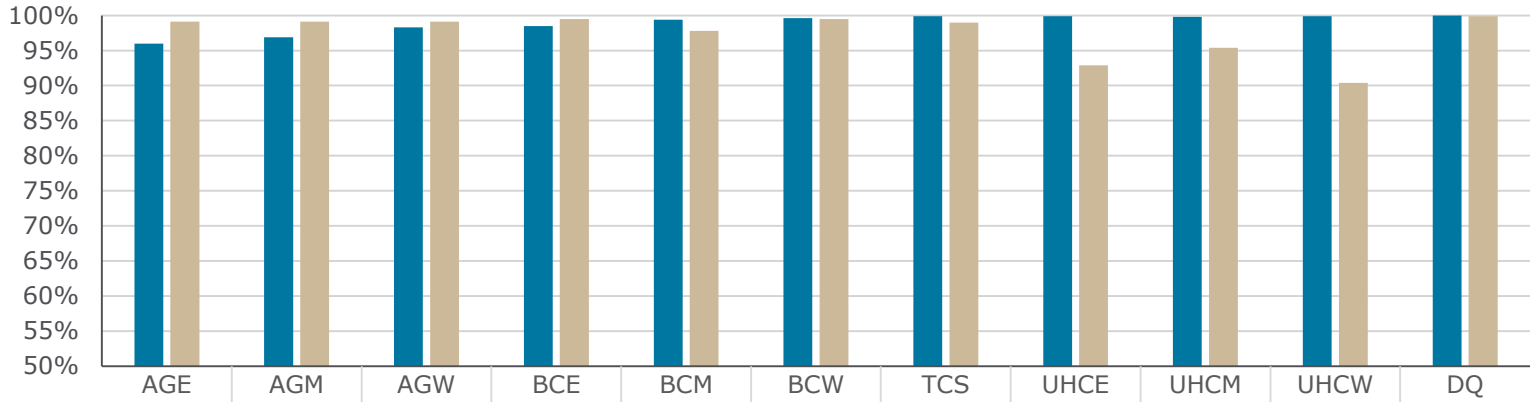
Results from Qsource's 2019 EQR activities show that TennCare's MCCs continue to exhibit a strong dedication to delivering timely, accessible, and high-quality care to members. Findings for each activity are summarized in this section.

In 2019, the MCCs were: Amerigroup (**AG**), referenced by operational Grand Region as **AGE** (East), **AGM** (Middle), and **AGW** (West); BlueCare (**BC**) by region as **BCE**, **BCM**, and **BCW**, and as administrator of the statewide TennCare*Select* (**TCS**); UnitedHealthcare (**UHC**) by region as **UHCE**, **UHCM**, and **UHCW**; DentaQuest (**DQ**), the statewide DBM; and **Magellan**, the statewide PBM. (For CY2018, the PBM was only required to undergo PIP validation.)

Access, Timeliness, and Quality: ANA

Figure 1 shows each MCO and DBM's 2019 ANA evaluation 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. Most MCC Network Adequacy scores were 99.4% or better, with only four receiving lower scores, which were still quite high: 96.0% for **AGE**, 96.9% for **AGM**, 98.3% for **AGW**, and 98.5% for **BCE**. For Benefit Delivery, all but four MCCs achieved scores of 99.0% or higher, the remaining being **BCM** at 97.8%, **UHCE** at 92.9%, **UHCM** at 95.4%, and **UHCW** at 90.4%.

Figure 1. 2019 MCC Scores for Network Adequacy and Benefit Delivery



	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW	DQ
Network Adequacy	96.00%	96.90%	98.30%	98.50%	99.40%	99.60%	99.90%	99.90%	99.80%	99.90%	100%
Benefit Delivery	99.10%	99.10%	99.10%	99.50%	97.80%	99.50%	99.00%	92.90%	95.40%	90.40%	99.90%

Individual MCC results and available trending are presented in the ANA Review section of this report and in Appendix A; sample assessment tools can be found in Appendix B.

Access, Timeliness, and Quality: AQS

For the AQS, MCCs were assessed for compliance with statewide quality process (QP) standards and operational performance activities (PAs) based on contractual, regulatory, legislative, and judicial requirements. If the contract risk agreement (CRA) requirements were the same or less stringent than the National Committee for Quality Assurance (NCQA) standards for MCO accreditation, they were not included in the AQS to avoid duplication. The DBM, which is not subject to NCQA accreditation, was evaluated on a distinct set of criteria derived from its contract with TennCare. All MCCs' credentialing and recredentialing policies and procedures (P&Ps) were assessed during the 2019 ANA. Those results, as well as results for the credentialing and recredentialing file reviews, were included in detail in the *2019 AQS Technical Papers* and *2019 AQS Summary Report*.

As shown in **Table 1,** 2019 AQS compliance scores were high overall. QP standards are reported as a single statewide score for each MCO. **AG**, **BC**, and **TCS** achieved a compliance score of 100% for all applicable QP standards. **UHC** achieved 100% compliance scores for all QP standards but Network: Contracting, Availability, Access, and Documentation, for which it received 88.9%. For CHOICES Credentialing and Quantity and Quality rates, a statewide-reported file review, MCCs received 100% except which **AG** and **BC** on Quantity, which received 83.3% and 88.9%, respectively (the standard isn't applicable to **TCS**). For CHOICES Recredentialing Quantity and Quality rates, all MCOs received 100% except **UHC**, which received 89.5% Quantity and 92.7% Quality. PA file review scores are reported by Tennessee Grand Region. During the 2019 AQS, all MCO operational regions achieved 100% compliance on all applicable PA file reviews except **AGM**, which earned 97.5% for UM Denials.

DQ achieved 100% compliance on all QP standards and in two of three applicable file reviews. The DBM score was still high for the remaining PA with 97.5% on Appeals.

Table 1. 2019 Summary AQS Results

MCC	Individual QP Standards Range	Individual File Review Range
MCOs	83.3%–100%	97.5%–100%
DBM	100%	97.5%–100%

Individual MCC results and available trending are presented in the AQS section of this report and in Appendix A; sample assessment tools can be found in Appendix B.

Quality Care: PMV

All TennCare MCOs report a full set of Healthcare Effectiveness Data and Information Set (HEDIS) measures as part of the required NCQA accreditation. To verify MCO reporting accuracy and compliance with reporting standards, TennCare annually selects two measures for the EQRO to validate. The DBM and PBM are not required to report performance measures, so are not included in this EQRO activity.

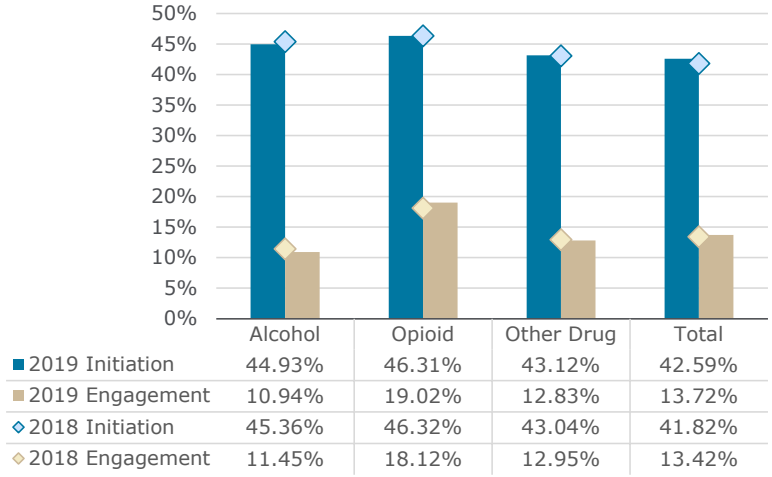
For the 2019 validations, each MCO passed the audit, was determined to be in full compliance with all standards, and received a Reportable (*R*) designation for the two audited measures: Use of Opioids from Multiple Providers (UOP) and Initiation and Engagement of Alcohol Other Drug Abuse or Dependence Treatment (IET). PMV scores are statewide and not reported by operational region. **TCS**, administered by **BC**, was evaluated as one rate with the statewide **BC** reporting. **Table 2** shows the ranges for reported UOP rates, and **Figure 2** shows trending for IET Total rates.

Table 2. 2019 PMV Statewide Reported Rates Where a Lower Rate Indicated Better Performance

Performance Measure	MCO Rate Ranges
Use of Opioids From Multiple Providers (UOP):	
Multiple Prescribers	21.80%–25.61%
Multiple Pharmacies	3.90%–5.80%
Multiple Prescribers and Pharmacies	1.58%–2.36%

Note: First year reporting, trending not possible

Figure 2. 2018 to 2019 MCO Rates for IET: Total



Note: The Total rate includes both age cohorts, 13–17 years and 18+ years, and all substance cohorts, alcohol, opioid, and other drug; due to specification changes, a break in trending occurred in 2018

Individual MCO results and available trending are presented in the PMV section of this report; sample assessment tools can be found in Appendix B.

Quality Care: PIP Validation

Devised by MCCs and approved by TennCare, PIP studies measure the effectiveness of quality improvement (QI) interventions in improving processes, healthcare provided, 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.

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 MCC 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 region must be submitted with region-specific data and information, including improvement strategies. Since 2015, TennCare has elected to have Qsource validate all PIPs submitted by MCCs that were underway during the 12 months preceding review. All CRA specifications were met this year in the 64 studies conducted by TennCare's MCCs and submitted for 2019 PIP validation.

This year's 64 PIPs covered 25 study topics (with several shared by more than one MCO), and were at different stages of progress during the review year, from Baseline (initial year) to Remeasurement Year 4. Of the 64 PIPs, 59 earned a validation status of Met (**Table 3**) and 55 of those also earned overall element validation 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 experience.

Table 3. 2019 PIP Validation Status

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

Individual MCC results and available trending of PIPs conducted a minimum of three remeasurement years are presented in the PIP Validation section of this report and in Appendix A; sample assessment tools are in Appendix B.

Conclusions and Recommendations

Most TennCare MCCs continue to achieve high compliance in all EQRO-related activities. Systems, processes, and networks are routinely evaluated and improved across all aspects of health plan operations. The MCCs remain focused on conducting thorough data analyses and documentation of processes. Overall, TennCare's MCCs demonstrated a continued dedication to providing high-quality services to TennCare members.

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 2019.

Background

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

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

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

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

Since enacting reform measures in early 2005, the TennCare program has stabilized, allowing for a return to the full-risk model under which MCOs are paid a per-member, per-month capitation rate for delivering care. In August 2006, two nationally recognized MCOs with experience in Medicaid managed care were awarded bids under this model, which was also marked by

a reintegration of physical and behavioral health services and an enhanced focus on disease management. These MCOs began serving members in the Middle Grand Region on April 1, 2007. West Grand Region MCOs returned to the full-risk, integrated model effective November 1, 2008. East Grand Region MCOs also returned to this model on January 1, 2009, marking integration by all MCOs and eliminating the need for behavioral health organizations to continue serving TennCare members.

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

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

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

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

State Quality Strategy Goals

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

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

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

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

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

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

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

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

Measures from the HEDIS audit, PIPs, AQS, and ANA are the primary mechanisms for assessing TennCare's primary goals, specifically as applied to the integrated physical and behavioral health services delivered by TennCare's MCOs. For select performance measures, TennCare offers incentives to MCOs

that demonstrate significant improvement from the previous reporting period as determined by established NCQA methodology.

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

The integration of LTSS with physical and behavioral care and the required NCQA accreditation form a strong foundation upon which future Quality Strategy objectives and success will be built. TennCare's continued focus on QI outcomes and health information technology supports these efforts.

EQR Activity Descriptions and Objectives

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 2019.

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 MCCs:

- Monitoring compliance with federal and state standards through ANA and AQS
- PMV
- PIP validation

Qsource is responsible for the creation and production of this *2019 Annual EQRO Technical Report*, which compiles the results of these EQR activities. Qsource's efforts are a primary means of assessing the quality, timeliness, and accessibility of services provided by TennCare's MCCs. Health Services Advisory Group, Inc. (HSAG), Qsource's subcontractor, assisted in the completion of the ANA.

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

- A brief description of the data collection, aggregation, and analyses for each of the EQR compliance activities

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

The mandated EQR activity audit periods for TennCare MCCs are summarized in **Table 4** for review period from January–December 2017. Applicable trending results are presented in the activity sections of this report.

Table 4. 2019 Audit Periods for EQR Activities

Activity	Audit Period
ANA	February–March 2019
AQS	February–May 2019
PMV	March–April 2019
PIP Validation	July–September 2019

The following MCC-specific reports were generated for each of the reviews:

- 2019 ANA Reports
- 2019 AQS Technical Papers
- 2019 AQS Summary Report
- 2019 Annual PMV Reports
- 2019 Annual PIP Validation Technical Papers
- 2019 Annual PIP Validation Summary Report

This *2019 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 MCCs must ensure

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

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

AQS

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

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

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

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

PMV

To evaluate performance levels, TennCare selected a process for an objective, comparative review of quality-of-care outcomes and performance measures. Its primary aims were to evaluate the accuracy of MCO-reported measures and to determine whether those measures were calculated according to required technical specifications. To satisfy CMS protocol for MCOs and to meet the requirements set forth in 42 CFR §438.240(b)(2), TennCare identified for validation the following two HEDIS measures, defined by the NCQA and validated through an NCQA HEDIS Compliance Audit: UOP within the Effectiveness of Care Measures domain and Overuse/ Appropriateness category where lower rates indicate better performance; and IET within the Access/Availability of Care Measures domain. 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 §438.240(b)(1). 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.

PIPs are further defined in 42 CFR §438.240(b)(1) to include all of the following:

- Performance measurement using objective quality indicators
- System interventions implementation for QI
- Evaluation of intervention effectiveness
- Planning and initiation of activities to increase or sustain improvement

The 2019 PIP validation process evaluated 64 PIPs spread across 10 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 study design and approach, an evaluation of each PIP's compliance with the analysis plan, and an assessment of the effectiveness of MCC interventions. The results of the validation process can be found in the PIP section.

EQR Optional Activities

In addition to EQR mandatory activities, 42 CFR §438.358 outlines five optional activities:

- Validating encounter data reported by an MCO or prepaid inpatient health plan (PIHP)
- Administering or validating consumer or provider surveys of quality of care
- Calculating performance measures in addition to those reported by an MCO or PIHP and validated by an EQRO
- Conducting PIPs in addition to those conducted by an MCO or PIHP and validated by an EQRO
- Conducting studies on quality that focus on a particular aspect of clinical or non-clinical services at a point in time

Qsource does not perform these optional activities under its current contract with TennCare. It does, however, provide TennCare and MCCs with technical assistance—an EQR-related activity also defined by 42 CFR §438.358. In this capacity, Qsource maintains ongoing, collaborative communication with TennCare and supports the MCCs and benefit managers in their EQR activities. Further examples of Qsource technical assistance include the following areas of expertise: (a) Medicaid legislation, (b) MCC accreditation standards and guidelines as outlined by NCQA, and (c) continuous QI. Qsource also participates in MCC collaborative

workgroups, conducts PIP training for MCC staff and assists the TennCare Quality Oversight with its strategic planning sessions and Quality Strategy development.

Additional Contractual Activities

In addition to those mentioned, Qsource performs other activities as part of its EQRO contract with TennCare. These include the following 2019 deliverables, required annually unless otherwise noted:

- Abortion, Sterilization, and Hysterectomy (ASH) Audit Report
- Annual Child Focus Study
- CHOICES Report: Group Enrollment Trend
- EPSDT Summary Report
- HEDIS/CAHPS Report: Comparative Analysis of Audited Results from TennCare Managed Care Organizations
- Annual HEDIS D-SNPs Report
- Impact Analysis Report
- Medication-Assisted Treatment (MAT) Provider Network Survey
- Provider Data Validation (PDV) Report (Quarterly)

Qsource also conducts meetings three times a year that are attended by TennCare and representatives of the MCCs. The three 2019 meetings featured seminars about sickle cell disease, alternative pain management, addiction medicine program, school-based and infant mental health, blood pressure programs, a child health fitness program, the impact of dieticians in reducing costs and improving outcomes, using technology to improve care for pregnant women and newborns, community-based population health teams and integrating patient and family caregivers into care teams, aligning Medicare and Medicaid benefits in the state, and EQRO improvements to the PIP Summary Form used by MCCs to submit information for validation. For follow-up to the onsite meetings, Qsource posts highlights online within a month of each, which were February 5, June 25, and September 11.

Technical Report Guidelines

To assist both EQROs and state agencies, CMS supplemented the requirements of 42 CFR §438.364 and provided guidelines for this *2019 Annual EQRO Technical Report*, which—in addition to the Executive Summary and this Overview—includes the following sections:

- ANA
- AQS
- PMV
- PIP Validation
- Conclusions and Recommendations with MCC Best and Emerging Practices

State Utilization of the EQRO Technical Report

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

State Quality Initiatives

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

TennCare has implemented several initiatives to support both QI among its contractors and the goals of its 2018 Quality Strategy. These include the implementation of the Care Coordination Tool, which will perform a number of tasks, including produce risk scores, prioritize patients and activities based on those scores, track gaps in care, and allow members to view prescription fill information. The implementation of a Clinical Knowledge Module will standardize the clinical information loaded from the admission, discharge information, and transfer information feeds. As use of this module increases, it will allow for the development of a clinical database that will address gaps in care and help reduce hospital admissions.

Through its Quality Apps project, the state will be able to collect clinical quality data that cannot be acquired from medical claims and use that to provide all payers with the necessary information to reimburse providers and promote high-quality health outcomes.

TennCare also sought to support the five principles for achieving better health, drawn from the policy statement set forth in TCA §68-11-1625 and outlined in the *2014 Update to the State Health Plan*. These principles include the following:

- Healthy Lives—Improve the health of people in Tennessee.
- Access—People in Tennessee should have access to healthcare and the conditions to achieve optimal health.

- Economic Efficiencies—Health resources in Tennessee, including healthcare, should be developed to address the health of people in Tennessee while encouraging value and economic efficiencies.
- Quality of Care—People in Tennessee should have confidence that the quality of care is continually monitored and standards are adhered to by providers.
- Workforce—The state should support the development, recruitment and retention of a sufficient and quality health workforce.

TennCare's 2016 Quality Strategy helped determine the parameters of state Medicaid initiatives, of which Population Health, Satisfaction Surveys, Pay-for-Performance, and PIP Validation were chosen for inclusion in this report due to the programs' relevance to EQR activities. These do not represent all of TennCare's efforts.

Population Health

By July 1, 2013, TennCare required each MCC to replace the disease/health management model with operationalized population health programs. By 2014, all MCCs had transitioned from disease management to population health and all TennCare members had been stratified into three population health levels. The 2016 evaluation data showed positive results for emergency department visits, readmissions, neonatal intensive care unit (NICU) babies, and end-stage renal disease.

Unlike disease management, which addresses only those members with existing health conditions, population health is a more comprehensive approach that requires intensive care management for high-risk members and more personalized health management for those at lower risk levels.

Population health programs are designed to help members self-manage their conditions and risk factors. TennCare emphasizes improving members' self-management of two specific conditions, which are pregnancy and diabetes. Statewide collaborative working groups have been established with each MCC.

To support those efforts, TennCare requires MCCs to offer the following population health programs:

- Wellness
- Low- to Moderate-Risk Maternity
- "Opt Out" Health Risk Management
- Care Coordination
- "Opt In" Chronic Care Management
- "Opt In" High-Risk Maternity
- "Opt In" Complex Case Management

As part of the evaluation process, all MCOs were required to conduct rapid cycle improvement projects. Some of the successful projects included changing or improving member behavior, decreasing the rate of failed contact attempts with

members, and improving the health of members by successful weight management.

Pay-for-Performance

The required reporting of HEDIS measures has allowed TennCare to establish performance incentives for those MCOs that meet defined benchmarks. Pay-for-performance quality incentive payments are offered to MCOs that demonstrate significant improvement from the previous reporting period for specified measures. The pay-for-performance initiative has been in place since 2006. Previously, these incentives were identical for each MCO rather than MCO-specific, but they will transition to MCO-specific during the next three years.

MCO-specific measures selected for measurement year 2018 validation included IET with Initiation and Engagement rates broken down by age and substance cohorts, as well as UOP broken down by provider type.

PIP Validation

This year, TennCare required the validation of a total of 64 PIPs conducted by its 12 MCCs, which include 10 MCOs, one DBM, and one PBM. Qsource validated these studies according to CMS's *EQR Protocol 3: Validating Performance Improvement Projects (PIPs), A Mandatory Protocol for External Quality Reviews (EQR)* (Version 2.0, September 2012).

To comply with their CRAs with TennCare, MCOs must conduct at least two clinical and three non-clinical PIPs. The DBM and PBM must conduct at least one clinical and one non-clinical PIP. For the MCOs, the two clinical PIPs must include one in the area of behavioral health that is relevant to one of the population health programs for bipolar disorder, major depression, or schizophrenia. The other must be in the area of either child health or perinatal (prenatal/postpartum) health. Furthermore, one of the three non-clinical PIPs is required to be in the area of LTSS. Beginning in 2017, a PIP in the area of EPSDT was also required. All of these specifications were met per CRA requirements.

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 MCC 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 from February 12 through March 13, 2019.

Technical Methods of Data Collection and Analysis

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

For Network Adequacy, quantitative analyses were conducted of provider files supplied by the MCCs 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, 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 MCCs and the TDCI were analyzed to determine a ratio per total members, and CHOICES Home and Community-Based Services (HCBS) and ECF were reviewed by county.

Benefits delivery evaluation was based on several desk review items and analyses. All credentialing/recredentialing findings and results were incorporated by Qsource into AQS reports at TennCare's request. Details on the ANA review process and results are in each MCC's *2019 Annual Network Adequacy Report*.

Description of Data Obtained

The 2019 ANA evaluation period was January 1 to December 31, 2018, focused on the following data sources:

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

Comparative Findings

All MCCs received 90.4% or greater compliance scores for both overall Network Adequacy and overall Benefit Delivery for the 2019 ANA, as shown in Figure 1 and **Table 5**. Compliance scores for each MCC are also provided for 2017 and 2018, although trend with caution due to minor contract updates. The MCCs' overall compliance scores for Network Adequacy declined (0.3 to 2.8 percentage points) from 2018 to 2019, with the exception of **TCS** and **DQ**, which maintained >99.9% and 100%, respectively, and **UHC**, which showed a slight improvement (0.5 to 0.7 percentage points) in all three regions (Figure 3). For Benefit Delivery, overall MCC compliance scores declined (0.4 to 9.5 percentage points), except for **DQ** (Figure 4). For the 2019 ANA, the MCCs were determined to be compliant with seven achieving 99.4% or higher for Overall Network Adequacy and 99.1% or higher for Overall Benefit Delivery.

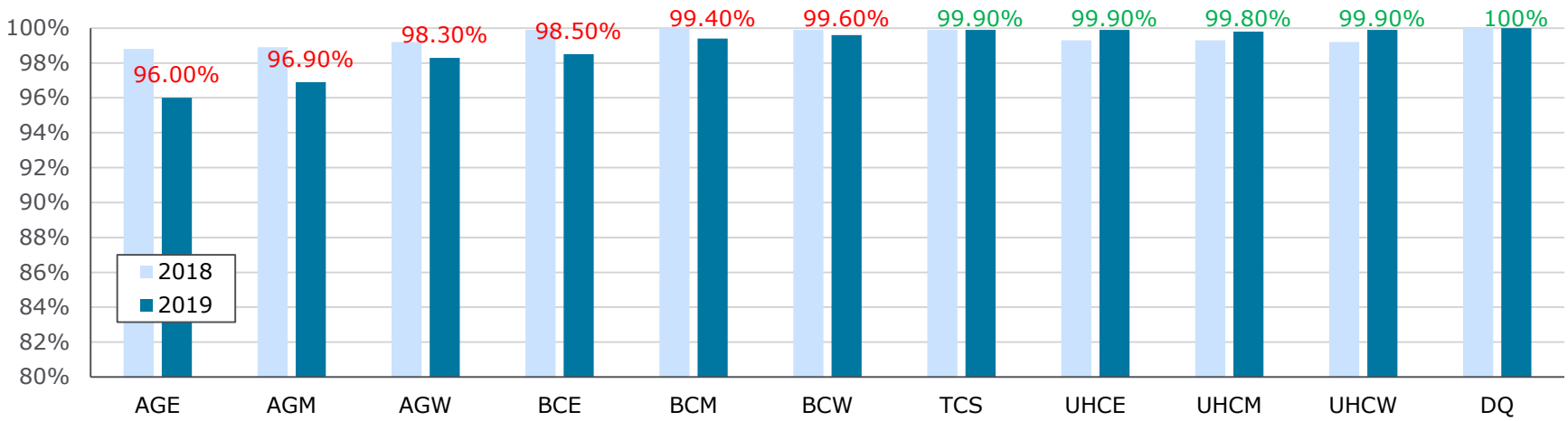
Table 5. 2017–2019 ANA Review Overall Compliance by MCC

MCC	2017		2018		2019	
	Network Adequacy	Benefit Delivery	Network Adequacy	Benefit Delivery	Network Adequacy	Benefit Delivery
AGE	98.8%	100%	98.8%	>99.9%	96.0%	99.1%
AGM	97.7%	>99.9%	98.9%	>99.9%	96.9%	99.1%
AGW	97.7%	100%	99.2%	>99.9%	98.3%	99.1%
BCE	99.0%	>99.9%	>99.9%	>99.9%	98.5%	99.5%
BCM	99.3%	>99.9%	100%	>99.9%	99.4%	97.8%
BCW	99.9%	100%	>99.9%	>99.9%	99.6%	99.5%
TCS	>99.9%	>99.9%	>99.9%	>99.9%	>99.9%	99.0%
UHCE	>99.9%	>99.9%	99.3%	>99.9%	99.9%	92.9%
UHCM	>99.9%	>99.9%	99.3%	98.3%	99.8%	95.4%
UHCW	>99.9%	>99.9%	99.2%	>99.9%	>99.9%	90.4%
DQ	100%	>99.9%	100%	>99.9%	100%	>99.9%

MCC Network Adequacy

For the 2019 evaluation, all three regions achieved high compliance for overall Network Adequacy, with no MCC earning less than a 96.0% score. The detailed scores for analyses performed on provider and member data are provided in Appendix A.

Figure 3. 2018 to 2019 MCC Overall Network Adequacy Scores



Data labels show 2019 Network Adequacy scores and are red if a decline, green if increased or maintained compared to 2018.

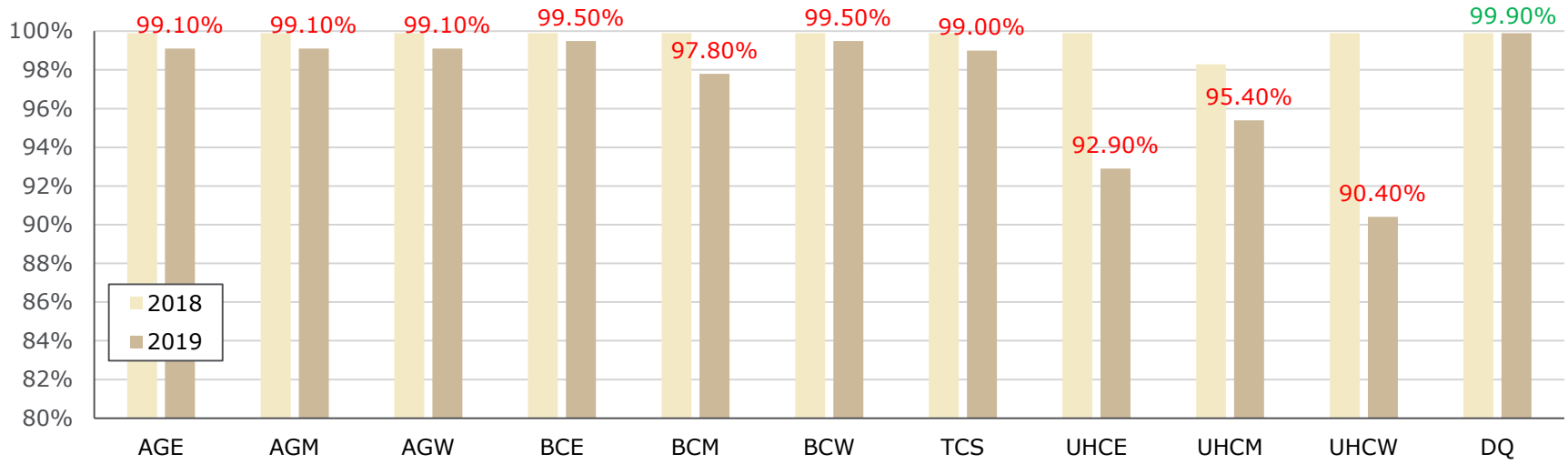
The lowest measure contributing to overall Network Adequacy scores were for adequacy of ECF CHOICES Providers with average scores of 87.2% for **AGE**, 89.7% for **AGM**, 96.0% for **AGW**; 98.2% for **BCM**; and 98.3% for **DQ**. **BCE**'s (97.0%) and **BCW**'s (99.1%) lowest scoring component was specialty care providers (SCPs). The lowest for **UHCW** (99.7%) was for CHOICES Providers. The remaining MCO's lowest component scores were for Opioid Use Disorder Treatment Providers: **TCS**—99.2%, **UHCE**—97.5%, and **UHCM**—96.5%).

In 2019, scores declined the most for **AG**: 2.8 percentage points for **AGE**, 2.0 for **AGM**, and 0.9 for **AGW**. Scores also declined for **BC** in all operational regions: 1.4 percentage points for **BCE**, 0.6 for **BCM**, and 0.3 for **BCW**. **UHC**'s scores increased slightly overall: 0.6 in the East, 0.5 in the Middle, and 0.7 in the West. **TCS** and **DQ** maintained the similar scores to the 2018 ANA. **TCS** maintained its statewide overall Network Adequacy score of >99.9% for the fifth year in a row. **DQ** achieved 100% compliance in overall Network Adequacy in 2019, maintaining that score since 2015.

MCC Benefit Delivery

For 2019, all MCCs received high compliance scores for overall Benefit Delivery, the lowest was 90.4% (**UHCW**) and the highest was >99.9% for **DQ**, the only MCC to maintain the same score achieved in 2018. All other MCCs declined from 0.4 to 9.5 percentage points. **UHCW** declined the most, from 99.9% in 2018 to 90.4% in 2019; followed by **UHCE**, which declined 7 percentage points, then **UHCM**, which declined 2.9 points. **UHC** had the lowest individual measure score, 81.6% on Appointment Availability in P&Ps for all regions.

Figure 4. 2018 to 2019 MCC Overall Benefit Delivery Scores



Data labels show 2019 Network Adequacy scores and are red if a decline, green if increased or maintained compared to 2018.

CHOICES credentialing and recredentialing file review results from the 2019 ANA were reported in the MCC individual AQS technical papers and summary report and are thus detailed in the AQS section of this report.

Conclusions Drawn

Recommendations, Areas for Improvement

East Grand Region

AGE should address the shortage of

- Obstetrician/Gynecologist (OB/GYN) providers in Morgan County;
- optometry providers in Johnson County;

- contracted hospitals in Polk County;
- opioid use disorder treatment providers for children and adults in Blount, Bradley, Campbell, Carter, Claiborne, Cocke, Greene, Hamilton, Hancock, Hawkins, Johnson, Marion, Morgan, Scott, Sequatchie, Sevier, Sullivan, Unicoi, and Union counties;
- CHOICES adult day care providers in Blount, Campbell, Claiborne, Cocke, Hamilton, Hawkins, Knox, Rhea, Sevier, and Sullivan counties;
- CHOICES pest control providers in Anderson, Bledsoe, Campbell, Franklin, Grundy, McMinn, Meigs, Monroe, Morgan, Polk, Rhea, Scott, and Sequatchie counties;
- CHOICES community support development, organization, and navigation in all counties;
- CHOICES peer-to-peer person-centered planning, self-direction, employment, and community support and navigation in Bledsoe, Campbell, Claiborne, Cocke, Franklin, Grainger, Grundy, Hamblen, Hancock, Johnson, McMinn, Meigs, Monroe, Morgan, Polk, Roane, Scott, Sequatchie, and Union counties; and
- CHOICES specialized consultation and training providers in Bledsoe, Blount, Bradley, Carter, Cocke, Franklin, Grainger, Grundy, Hamblen, Hancock, Hawkins, Jefferson, Johnson, Marion, McMinn, Meigs, Polk, Rhea, Sequatchie, Sevier, Sullivan, Unicoi, and Union counties.

BCE should address the shortage of

- opioid use disorder treatment providers in Bledsoe, Blount, Bradley, Campbell, Carter, Claiborne, Cocke, Greene, Hamilton, Hancock, Hawkins, Johnson, Morgan, Scott, Sevier, Sullivan, Unicoi, and Union counties;
- CHOICES adult day care providers in Blount, Campbell, Claiborne, Cocke, Loudon, McMinn, Rhea, Roane, Sevier, and Sullivan counties; and
- CHOICES specialized consultation and training providers in Campbell, Carter, Franklin, Grundy, Hancock, Marion, McMinn, Meigs, Polk, Roane, Sequatchie, and Union counties.

UHCE should ensure every provider has a signed and dated contract with a correct TennCare provider number prior to furnishing members services. It should also address the shortage of

- OB/GYN providers in Morgan County;
- opioid use disorder treatment providers in Bledsoe, Bradley, Carter, Claiborne, Cocke, Franklin, Greene, Grundy, Johnson, Loudon, Marion, McMinn, Meigs, Monroe, Morgan, Polk, Rhea, Roane, Sequatchie, Sevier, Sullivan, and Union counties; and
- CHOICES adult day care providers in Campbell, Claiborne, Cocke, Greene, Hamilton, Hawkins, Knox, McMinn, Rhea, Roane, Sevier, and Sullivan counties.

Middle Grand Region

AGM should address the shortage of

- OB/GYN providers in Hickman, Houston, Humphreys, Lewis, Pickett, Stewart, and Wayne counties;
- optometry providers in Giles and Lincoln counties; and
- opioid use disorder treatment providers for children and adults in Cannon, Dickson, Fentress, Giles, Houston,

Humphreys, Lawrence, Lincoln, Macon, Pickett, Rutherford, Stewart, and Warren counties;

- CHOICES adult day care providers in Bedford, Cheatham, Cumberland, Davidson, Dickson, Giles, Lawrence, Lincoln, Maury, Montgomery, Perry, Robertson, Rutherford, Stewart, Sumner, Wayne, and Wilson counties;
- CHOICES pest control providers in Bedford, Coffee, Giles, Hickman, Lawrence, Lewis, Lincoln, Marshall, and Moore counties;
- CHOICES community support development, organization, and navigation in all counties; and
- CHOICES peer-to-peer person-centered planning, self-direction, employment, and community support and navigation in Bedford, Cannon, Clay, Coffee, Cumberland, Dickson, Fentress, Houston, Humphreys, Jackson, Lincoln, Macon, Marshall, Montgomery, Moore, Overton, Pickett, Putnam, Stewart, Van Buren, Warren, and White counties.

BCM should ensure every provider has a signed and dated contract prior to furnishing members services. It should also address the shortage of

- opioid use disorder providers in Cumberland, Fentress, Giles, Lawrence, Lewis, Lincoln, Marshall, Maury, Montgomery, Perry, Pickett, Stewart, Wayne, and Williamson counties;
- CHOICES adult day care providers in Bedford, Cumberland, Davidson, Dickson, Maury, Robertson, Sumner, and Warren counties; and
- CHOICES specialized consultation and training providers in Cannon, Clay, Cumberland, Dekalb, Fentress, Jackson, Lincoln, Macon, Maury, Montgomery, Overton, Pickett, Putnam, Smith, Stewart, Van Buren, Warren, and White

UHCM should address the shortage of

- OB/GYN providers in Hickman, Houston, Humphreys, Lewis, Perry, Stewart, and Wayne counties;
- opioid use disorder treatment providers in Bedford, Cannon, Clay, Coffee, Cumberland, DeKalb, Dickson, Fentress, Giles, Houston, Humphreys, Jackson, Lawrence, Lincoln, Macon, Montgomery, Moore, Overton, Pickett, Putnam, Stewart, Van Buren, Warren, and White counties; and
- CHOICES adult day care providers in Cheatham, Cumberland, Davidson, Dickson, Maury, Robertson, Rutherford, Sumner, Warren, Williamson, and Wilson counties.

West Grand Region

AGW should address the shortage of

- optometry providers in Fayette and Hardeman counties;
- contracted hospitals in McNairy County;
- opioid use disorder treatment providers for children and adults in Chester, Fayette, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madison, McNairy, Shelby, and Tipton counties; and
- CHOICES adult day care providers in Benton, Carroll, Chester, Crockett, Decatur, Dyer, Gibson, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madison, McNairy, Obion, Tipton, and Weakley

BCW should address the shortage of

- opioid use disorder providers in Benton, Crockett, Decatur, Dyer, Fayette, Hardeman, Haywood, Henry, Lake, Lauderdale, Obion, and Tipton counties;
- CHOICES adult day care providers in Chester, Dyer, Gibson, Haywood, Lake, Lauderdale, Madison, Obion, Shelby, and Tipton counties; and
- CHOICES specialized consultation and training providers in McNairy County.

UHCW should ensure every provider has a signed and dated contract prior to furnishing members services. It should also address the shortage of

- OB/GYN providers in Benton, Decatur, and Henderson counties;
- contracted hospitals in Lake and McNairy counties;
- substance abuse outpatient treatment services providers in Hardeman, Hardin, and McNairy counties; and
- CHOICES adult day care providers in Dyer, Gibson, Lake, Lauderdale, and Obion counties.

Statewide

Across all three Grand Regions, **AG** had no identified providers for CHOICES **community** transportation.

TCS should ensure Member Handbooks and plan documents contain complete information about reconstructive breast surgery and about tissue transplants for members age 21 years and older as covered by Medicare and for members younger than 21 years as medically necessary. The MCO should also address the shortage of opioid use disorder providers in Bledsoe, Blount, Bradley, Campbell, Carter, Claiborne, Cocke, Greene, Hamilton, Hancock, Hawkins, Johnson, Morgan, Scott, Sevier, Sullivan, and Union counties.

UHC should address evidencing members' being informed of plan benefits in plan documents, including rehabilitation hospital services for members 21 years and older, coverage for surgery to establish symmetry of a non-diseased breast after breast surgery, standard information and compliant age requirements for mammography screenings, residential substance abuse benefits, and nursing facility stay limitations and alternative, community-based residential benefits for CHOCIES Groups 2 and 3. The MCO also needs to make improvements in documentation to meet availability and accessibility requirements, including information to access Tennessee Health Link; correct information for geographic access and travel time to psychiatric inpatient hospital services, outpatient and intensive outpatient non-MD (non-Doctor-of-Medicine) behavioral health services, inpatient and outpatient substance abuse services, and opioid use disorder treatment.

DQ needs to address the shortage of dental providers in Claiborne, Crockett, Dyer, Gibson, Haywood, Macon, Sumner, Wayne, and Weakley counties.

MCO Strengths and Best Practices

Several best practices were identified from review year 2018 for each MCC. **AG** embarked on a process in late 2017 that resulted in migration to a new member web portal in early 2018. The previous portal was not mobile friendly (identified as a member need) and did not support needed customization. In addition, through a series of member feedback sessions, the MCO realized that more than two-thirds of its members were aware of additional services offered, such as smoking cessation, weight loss, and reward programs. The new member portal provided a more effective way to communicate, was easier for members to navigate and locate important information, and offered new features that included secure messaging and enhanced ease in accessing information about care, coverage, and customer service.

Throughout 2018, BlueCare Tennessee used a new texting platform to encourage members to complete preventive screenings. Monthly, **BC** and **TCS** sent text messages to newly identified members with gaps in care for breast cancer screenings, cervical cancer screenings, diabetic retinal eye exams, or well-child visits. The overall percentage of claims received as a result of the text messages was 13.59%. Many members have expressed a preference to communicate via text message, and the MCOs are providing an improved member experience as well as closing gaps in care and improving the health of members with those messages.

UHC created a page on its website with age-appropriate preventive care information, including a list of services offered during EPSDT exams, screenings available, immunizations, and counseling for injury prevention, diet and exercise, substance use, sexual behavior, and drug therapy. The MCO also provided members a mobile application (app) whereby they can instantly access personal health information, check claims, find a provider/urgent and emergency care, view plan details, and generate a plan identification (ID) card 24 hours a day, 7 days a week. Further, **UHC**'s *Talk to Me* tool allowed members to request a call from a service representative to answer coverage and benefits questions.

DQ implemented three initiatives to engage providers and increase attendance to provider education/training sessions:

1. Continuing education credits (CEUs) were offered for the 2018 TennCare statewide provider sessions.
2. Break-out case workgroups were used during the sessions to engage with and furnish educational information to providers while reviewing cases based on priority topics.
3. During the statewide provider sessions, separate orthodontic discussions were held to furnish orthodontists with an opportunity for deeper discussion with and feedback from **DQ** representatives.

Annual Quality Survey (AQS)

Assessment Background

Qsource conducted the AQS pursuant to nationally recognized guidelines: (1) *NCQA 2018 Health Plan Accreditation Standards and Guidelines for Credentialing*; (2) CMS's *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs), Final Protocol* (Version 2.0, February 2012); and (3) additional state and federal regulations. The AQS was conducted from February through May 2019. Throughout the AQS, Qsource provided technical assistance to TennCare and its MCCs, and maintained ongoing, collaborative communication.

Technical Method of Data Collection and Analysis

The AQS included a pre-onsite documentation review, an onsite survey, and post-onsite compliance analyses for each MCC. The 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 contracts with the MCCs:

- *Statewide Contract with Amendment 8—July 1, 2018*
- *An Agreement for the Administration of TennCareSelect between the State of Tennessee, d.b.a. TennCare and Volunteer State Health Plan, Inc.* (Amendments 1–43)
- *Contract #36736 Between the State of Tennessee, Department of Finance and Administration and DentaQuest USA Insurance Company, Inc.*

TennCare contributed in developing assessment tools and evaluating MCC planned improvements, and each MCC had representatives participate in the onsite. AQS tools assess QP standards for MCC P&Ps, and PA file reviews for documentation in member files. Tool criteria, elements, or standards are updated annually—reworded/reordered, added, and/or consolidated—with TennCare approval to reflect changes in contract references, align with the State Quality Strategy, and ensure data collection. Qsource provided the tools to the MCCs prior to onsite reviews, giving each the opportunity to ask questions, submit requested desk-review documentation and prepare for the onsite.

The surveyor team documented preliminary desktop review findings in the survey tools prior to onsite visits. They completed the tools during the visit, conducting interviews with MCC staff and obtaining additional documentation to determine compliance with contractual requirements, explore issues not fully addressed in pre-assessment review, and increase overall understanding of MCC performance. Surveyors closed the onsite by summarizing initial findings and recommendations with the MCCs.

Post-onsite, Qsource compiled and analyzed compliance scores and reported results, identified MCC strengths, suggestions, and areas of noncompliance (AONs), as well as 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 PAs have the same possible overall value.

Individual *2019 AQS Technical Papers* for each MCC were submitted as drafts within 30 days of each onsite completion and finalized, following TennCare and MCC feedback, within 60 days of the onsite. As completed, ANA review tools and findings for credentialing and recredentialing P&Ps and file reviews were incorporated in AQS findings. Beginning this year, only CHOICES (LTSS) providers' credentialing and recredentialing records were required to be reviewed for compliance, and were not conducted for **TCS** or the DBM due to small CHOICES populations.

Onsite participants, documents requested before the onsite visit, and completed AQS tools (with surveyor comments and notes) were in the individual MCC reports as a comprehensive record of assessment activity. Additional details are available in those individual reports as well as the compiled findings in the *2019 AQS Summary Report*. Detailed scores are in Appendix A.

Description of Data Obtained

Qsource requested the following documentation from the review year (2018) for desk review:

- MCOs and DBM
  - Member Handbooks in English and Spanish
  - Provider Manual
  - Quality Improvement Program (QIP) Description
  - Provider and Member Newsletters
  - Quarterly EPSDT reports
  - Utilization Management (UM) Program Description
  - UM Program Evaluation of 2017 Activities
  - QIP Evaluation of 2017 Activities
  - Policies that define the MCC's time standards for handling all denials, complaints, and appeals
  - 2018 corrective action plans and related documentation, if applicable
  - All additional policies, procedures, and other documentation needed to answer survey tool elements
  - Resumes of UM staff
- MCOs only
  - Current Population Health Program Descriptions
  - 2018 Population Health Satisfaction Surveys
  - Provider and Member Satisfaction Surveys
- DBM only
  - 2018 TennCare Kids Outreach Plan
  - 2018 QIP Work Plan
  - UM P&Ps
  - Dental Service P&Ps

Additional documentation reviewed onsite included committee meeting minutes, quality studies, reports, medical and provider records/files as needed to assess MCC compliance with QP standards and PAs. Because NCQA accreditation is not mandated for the DBM and its service provisions are unique, the QP standards differed from the MCOs. The following is a list of the QP Standards and PAs for the MCOs and the DBM:

- MCO QP Standards
  - Network: Contracting, Availability, Access, and Documentation
  - QI Activities
  - Clinical Criteria for UM Decisions
  - Member Rights and Responsibilities
  - EPSDT
  - TennCare Medical Services Grievance and Appeal Process
  - Non-Discrimination Compliance
  - Credentialing/Recredentialing P&Ps
- MCO File Reviews
  - UM Denials (ages 20 years and younger)
  - Appeals
  - EPSDT Information System Tracking
  - CHOICES Annual Level of Care Assessment
  - Transition of CHOICES Members Between MCOs
  - CHOICES Credentialing (Quantity and Quality)*
  - CHOICES Recredentialing (Quantity and Quality)*
- DBM QP Standards
  - Written Quality Monitoring (QM) Program (QMP) Description
  - Systematic Process of Quality Assessment and Improvement
  - Accountability to the Governing Body
  - Active Quality Monitoring Program Committee
  - Quality Monitoring Supervision
  - Adequate Resources
  - Provider Participation in the QMP
  - Member Rights and Responsibilities
  - Standards for Facilities
  - Dental Records
  - Utilization Review
  - Coordination of QM Activity with Other Management Activity
  - EPSDT
  - Non-Discrimination Compliance
  - Credentialing/Recredentialing P&Ps
- DBM File Reviews
  - Appeals
  - Complaints
  - UM Denials (ages 20 years and younger)

* Provider credentialing and recredentialing file reviews with quantity ratings reflect the percentage of files available for review; quality ratings measure the files' accuracy and completeness.

Comparative Findings

MCO Scoring

Results for QP standards are reported as one statewide score for each MCO. This year, only one standard fell short of 100% compliance—Network: Contracting, Availability, Access, and Documentation, for which **UHC** achieved 88.9%. Credentialing and recredentialing file reviews are also reported as one statewide score for each MCO. For CHOICES credentialing files, **UHC** earned 100% compliance for both quantity and quality ratings. **AG** and **BC** earned 83.3% and 88.9%, respectively, for the CHOICES credentialing quantity rating, and 100% each for the quality rating. For CHOICES recredentialing files, **AG** and **BC** each achieved 100% for both quantity and quality ratings. **UHC** earned 89.5% for quantity and 92.7% for quality.

PA file review scores are reported separately by operational region. During the 2019 AQS, all MCO regions achieved 100% compliance on all applicable PAs except **AGM**, which earned 97.5% for UM Denials. The Transition of CHOICES Members Between MCOs file review was not conducted for **AGW** because a sufficient number of files was not available for review. None of CHOICES file reviews were conducted for **TCS** due to its low number of members in that program.

Trended Scoring

Some trending is possible, though some changes were made to survey tools for the 2019 AQS in consultation with TennCare to reflect updated contracts/NCQA requirements and facilitate evaluation. The MCOs maintained 100% overall compliance for five QP standards assessed since the 2016 AQS review: QI Activities, Clinical Criteria for UM Decisions, Member Rights and Responsibilities, TennCare Medical Services Grievance and Appeal Process (previously *Grier Revised Consent Decree*), and Non-Discrimination Compliance.

Overall, 2019 AQS scores were remarkably similar to the 2018 excellent results. Once again, **BC** and **TCS** achieved 100% compliance with all eight QP standards. **AG** raised its score for Credentialing/Recredentialing P&Ps from 93.9% to 100%, also earning 100% with all other QP standards, while **UHC**'s score for Network: Contracting, Availability, Access, and Documentation declined from 100% in 2018 to 88.9% this year. Also, 2019 DBM results were very similar to 2018; **DQ** earned 100% compliance with all but one evaluation category. Though the DBM raised its score in the Complaints PA from 95.0% to 100% this year, its Appeals score declined from 100% to 97.5%.

CHOICES credentialing and recredentialing file reviews were the one performance category with noticeably different results from last year. While all three applicable MCOs achieved 100% compliance in 2018 for all quantity and quality ratings for CHOICES credentialing and recredentialing records, each MCO saw a decline in one or more ratings in 2019. **AG**'s and

BC's 100% CHOICES credentialing quantity ratings fell to 83.3% and 88.9%, respectively, while UHC maintained 100% for both credentialing ratings. For CHOICES recredentialing, AG and BC maintained 100% for both ratings, while UHC's quantity and quality ratings declined from 100% to 89.5% and 92.7%, respectively. Among PAs, BC's three regions, TCS, and UHC's three regions matched last year's achievement of 100% compliance with all applicable file reviews. Although AGE raised its UM Denials score from 97.6% to 100%, AGM's score in the same PA declined from 100% to 97.5%.

Conclusions Drawn

MCC scoring for each evaluated QP standard and file review reflect its degree of compliance with applicable contractual, State, and federal requirements. Qsource identifies suggestions and AONs to denote areas in which an MCC could improve, or must improve to achieve compliance, and strengths to highlight areas in which each MCC excels (**Table 6**).

Recommendations, Areas for Improvement

Qsource offers suggestions to help MCCs maximize quality efforts, even for measures in which an MCC achieves 100% compliance. AONs are identified when an MCC achieves less than 100% compliance on any given QP standard element or file review. AONs may be accompanied by recommendations for policy, procedure, or process changes.

While suggestions are not required for full compliance, Qsource made numerous suggestions that could help MCCs improve performance in the future. This year, most suggestions involved including explicit statements about requirements in P&Ps and the Population Health Program Description (PHPD), or developing new policies that include such explicit statements. AONs were identified in one QP standard and four file reviews.

MCO Strengths and Best Practices

Strengths indicate that an MCC has demonstrated particular proficiency on a given QP standard element or file review and may be identified regardless of compliance scores. The lack of an identified strength should not be interpreted as a shortcoming on the part of an MCC.

Table 6. 2019 AQS Strengths, Suggestions, and Areas of Noncompliance (AONs)	
QP Standards—MCO	
EPSDT	
Element #18: Family Involvement and Accessible Services	**Strength:** (AG) Two behavioral health specialty case managers went above and beyond to ensure that members were cared for post-discharge, which resulted in a strong bond between the case managers and each member's family.

Table 6. 2019 AQS Strengths, Suggestions, and Areas of Noncompliance (AONs)	
Network: Contracting, Availability, Access, and Documentation	
Element #1, Specialist Termination	**AON:** The MCO (**UHC**) should ensure that timely notifications are sent to members after a specialist and/or specialty group terminates participation with the MCO.
Element #2, Notice of Provider Termination	**AON:** The MCO (**UHC**) should ensure that timely notifications are sent to members after a PCP terminates participation with the MCO.
Element #4, Subcontractor Audits	**Suggestion:** The MCO (**AG**) could ensure that the stricter subcontractor audit requirement between the CRA and CFR is always followed.
Element #5, Marketing Activities	**Suggestion:** The MCO (**BC**, **TCS**) could develop a policy that states the MCO is not involved in marketing activities.
QI Activities	
Element #11–14 for CHOICES and ECF CHOICES Members; #15, Keeping Care/ Support Coordinator Informed, and #16, Care/Support Coordinator Review	**Suggestions:** The TennCare-approved PHPD did not include the criteria in these elements, so the MCO (**AG**) could ensure that the updated PHPD either includes these criteria or explicitly references the P&P that does.
Element #9, Enrollment of CHOICES and ECF CHOICES Members in Population Health Programs	**Suggestion:** The MCO's (**UHC**) P&Ps could explicitly state that dual-eligible ECF CHOICES members are included in the set of eligible members.
Element #15, Keeping Care/ Support Coordinator Informed	**Suggestion:** (**BC**, **TCS**) The PHPD could explicitly state how the care/support coordinator receives member information and participation notifications.
Element #19, Nursing Facility-to-Community Transition	**Suggestion:** The MCO (**AG**) could create a P&P detailing support coordinator responsibilities pertaining to transitions of ECF CHOICES members from a nursing facility to a community.
Element #20, Transition of CHOICES and ECF CHOICES Members from Nursing Facilities	**Suggestion:** The MCO (**AG**) could create a P&P detailing support coordinator responsibilities pertaining to transitions of ECF CHOICES member from a nursing facility to a community-based residential alternative.
Element #24, Member Advisory Committee	**Strength:** The MCO (**BC**) showed a strong commitment to the CHOICES programs and their members by creating separate Member Advisory Committees for CHOICES and ECF CHOICES in each Grand Region. **Strength:** The MCO (**UHC**) showed a special commitment to the CHOICES programs and their members by creating separate advisory committees for CHOICES HCBS and ECF CHOICES.

Table 6. 2019 AQS Strengths, Suggestions, and Areas of Noncompliance (AONs)	
Member Rights and Responsibilities	
Element #1, Member Handbook Development and Distribution	**Suggestion:** The MCO (**AG**) could develop a P&P outlining the process for ensuring potential members have access to the Member Handbook upon request.
TennCare Medical Services Grievance and Appeal Process	
Element #2, Appeals Procedures	**Suggestion:** The MCO (**AG**) could ensure the Desktop Process: Standard Appeal and Accelerated Appeal Process includes consistent timeframes throughout the document.
Non-Discrimination Compliance	
Element #1, Non-Discrimination Compliance Questionnaire	**Suggestion:** The MCO (**AG**) could submit the completed Non- Discrimination Compliance Questionnaire to TennCare within 60 calendar days of receipt from TennCare.
Element #4, Complaint Resolution and Reporting	**Suggestion:** The MCO (**AG**, **UHC**) could create and maintain a log specifically for employee discrimination complaints.
QP Standards—DBM	
Systematic Process of Quality Assessment and Improvement	
Element #1, Population Served	**Suggestion:** The DBM should include the ECF CHOICES population in its QMP guidelines for conducting PIPs.
Element #10, Marketing Activities	**Suggestion:** The DBM could document compliance with its TennCare contract in P&Ps by incorporating a statement regarding the criteria of this element, noting it does not engage in marketing without prior TennCare approval or seek to influence enrollment with offering private insurance.
Member Rights and Responsibilities	
Element #6, Member Handbook Inclusions	**Suggestions:** In addition to inclusion in the question-and-answer format in its Member Handbook, the DBM could state, in plain language, that members will be referred to a provider outside of its network when not available in network and that member copays would be the same for that referral. The DBM should state, in plain language in its Member Handbook, that failure to notify it about an address change could result in the member's not receiving important eligibility and/or benefit information.
Non-Discrimination Compliance	
Element #9, Provider and Subcontractor Compliance Education	**Suggestion:** The DBM's provider training document could explicitly mention Title IX of the Education Amendments of 1972.

Table 6. 2019 AQS Strengths, Suggestions, and Areas of Noncompliance (AONs)	
PA File Reviews	
Appeals	**AON:** The DBM should ensure it meets the time standard in resolving appeals; this issue was noted in one file.
UM Denials	**AON:** The MCO (**AGM**) should ensure that timely member notifications are sent to members after UM denial decisions are made; this issue was noted in one file.
EPSDT IS Tracking	**Suggestion:** The MCO (**BCM**) could provide education to providers on EPSDT codes and billing services.
CHOICES Credentialing (Quantity)	**AON:** The MCO should ensure that all files in the credentialing file sample are initial credentialing records rather than recredentialing records; this issue was noted in two **AG** files, and one **BC** file.
CHOICES Recredentialing File Review (Quantity and Quality)	**AON:** For the quantity rating, the MCO (**UHC**) should ensure that all files included in the recredentialing sample are recredentialing records rather than initial credentialing records; this issue was noted in two files. For the quality rating, the MCO should ensure that ongoing CHOICES providers are recredentialed at least annually, and that all other CHOICES providers are recredentialed at least every three years; this issue was noted in three files.

Improvements Since the 2018 AQS

Corrective action plans (CAPs) are designed to improve performance and give MCCs the opportunity to receive help with QI. TennCare may request CAPs at its discretion, but MCCs must submit a CAP for any QP standard element or file review scored less than 100% compliance, regardless of overall performance on the standard or activity. Qsource provided technical assistance to the MCCs completing CAPs, submitted CAP evaluations to TennCare for follow-up, and encouraged MCCs to monitor CAP activities throughout 2019 to ensure fully meeting stated goals and to close compliance gaps within documented timelines.

All CAPs submitted by MCCs after last year's AQS met objectives. **BC**, **TCS** was not required to submit a CAP last year. Qsource identified the following improvements on past AONs:

AG

The MCO's actions subsequent to the 2018 AQS satisfied its three CAPs assigned during that review. To improve the Credentialing and Recredentialing elements on CHOICES Providers and Ongoing CHOICES providers, **AG** revised the TN State Specific Credentialing Policy Addendum to include the frequency of recredentialing for ECF CHOICES providers by provider type, and the annual recredentialing requirements for ongoing ECF CHOICES providers. To improve handling of UM Denials, **AG** requested its external vendor send a daily denial log and defined a new process whereby Appeals staff reviewed the logs to ensure timely processing of letters within applicable request type turnaround times.

DQ

The DBM's actions subsequent to the 2018 AQS satisfied its CAP for failing to notify members of complaint resolutions within required timeframes. DQ's complaints and grievances staff established guidelines to help ensure resolution letters were generated and attached to the appropriate member file within 24 hours. Failure to do so for specified number of files and/or over specified terms, and the associated staff member could undergo monthly review and face the potential for warnings and termination if issues recurred. Tracking received dates and resolution dates in weekly reports evidenced follow-through of the QI implementation.

UHC

The MCO's actions subsequent to the 2018 AQS satisfied its two CAPs assigned during that review. To improve in credentialing files' meeting requirements to be reviewed within 30 days, **UHC** held training sessions with staff to ensure that they understood the requirement to process credentialing files within 30 days of receiving a completed file from practitioners. The MCO also revised P&Ps/standard operating procedures (SOPs) to better monitor meeting the requirement, and established weekly staff meetings to review credentialing inventory reports.

UHC also needed to improve in meeting the 36-month maximum time to complete recredentialing. To accomplish this, the MCO initiated a partnership with staff members who could notify the credentialing team about an anticipated increase in the volume of files that would be moving through recredentialing. **UHC** also monitored recredentialing in the scheduled weekly inventory meetings and designated an information system as the source for validating Medicaid identification numbers. Finally, the MCO also authorized overtime for credentialing teams to ensure meeting timelines.

State Best Practices

Though only federally required to be completed every three years, TennCare has helped ensure quality care for Medicaid members by requiring a full AQS be completed annually and reduces the burden of this requirement by mandating MCCs attain NCQA certification, eliminating 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)

Assessment Background

Qsource's PMV team consisted of both Certified HEDIS Compliance Auditors (CHCAs) and non-certified individuals selected for specified skills, including statistics, analysis, managed care operations, clinical expertise, performance measure reporting, IS assessments, and computer programming. Intended to measure achievement of TennCare's Quality and Performance goals and objectives and meet CMS requirements of EQR Protocol 2, 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.

Technical Methods of Data Collection and Analysis

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

1. Pre-Onsite Activities: In addition to scheduling the onsite 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 support documentation.

2. 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
   - How all data sources were combined and the method used to produce the analytical file for reporting

3. Validation Results: Based on all validation activities, results were determined for each performance measure following NCQA's HEDIS Compliance Audit protocol and a report of preliminary findings was prepared for each MCO. Following the MCOs' completion of audit follow-up requests and any applicable corrective actions, final rates submitted by the MCOs were approved by the auditor. A final report for each MCO was concluded with HEDIS Compliance Audit measure designations that includes *Reportable (R)*, which

indicates a reportable rate was submitted for the measure, and *Not Applicable (NA)*, which indicates the denominator was too small (less than 30) to report a valid rate. A complete list of designations was included in each 2019 PMV 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 onsite 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 the 2018 measurement year, TennCare MCOs were required to report a full set of HEDIS measures for NCQA-accreditation purposes, two of which were validated by Qsource in 2019—Use of Opioids from Multiple Providers (UOP), and Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET). Because TennCare only allowed reporting via administrative methodology, medical record review (MRR) was not applicable to the scope of the audit.

According to NCQA's *HEDIS 2019, Volume 2, Technical Specifications for Health Plans*, UOP measures the proportion of members aged 18 years and older who received prescription opioids for ≥ 15 days from four or more different prescribers and/or pharmacies during the measurement year. Three UOP rates are reported for which a lower rate indicates better performance: Multiple Prescribers, Multiple Pharmacies, and Multiple Prescribers and Multiple Pharmacies.

IET is the percentage of adolescent and adult members aged 13 years and older who demonstrated a new episode of AOD abuse or dependence and received the following:

- *Initiation of AOD Treatment*—Initial treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis
- *Engagement of AOD Treatment*—Two or more services with an AOD diagnosis within 34 days of the initiation visit in addition to initiating treatment

MCOs report a total rate and two age stratifications (13–17 years and ≥ 18 years) for each, along with a diagnosis total rate and three AOD diagnosis cohorts: Alcohol, Opioid, and Other Drug.

Comparative Findings

AG, **BC**, and **UHC** were compliant with the HEDIS Information Systems Standards and HEDIS Determination Standards, and continue to use NCQA-certified software vendors for HEDIS measure production. The MCOs calculated results for CY2018 and reported them to TennCare as statewide rates for the PMV rather than rates by operational rate as reported for HEDIS auditing. The DBM and PBM do not report performance measures, so were not included in validation. MCO-specific results appear in **Table 7**.

Table 7. 2019 PMV Results

Measure	Amerigroup	BlueCare	UnitedHealthcare
HEDIS Effectiveness of Care Measures Where Lower Rates Indicate Better Performance—Overuse/Appropriateness			
Use of Opioids From Multiple Providers (UOP)*:			
Multiple Prescribers	25.61%	24.97%	21.80%
Multiple Pharmacies	5.80%	3.90%	4.60%
Multiple Prescribers and Pharmacies	2.36%	1.58%	2.03%
HEDIS Access/Availability of Care Measures			
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET):			
IET: Initiation of AOD Treatment:			
13-17 Years: Alcohol	32.94%	38.52%	33.80%
Opioid	54.55%	45.95%	66.67%
Other drug	50.66%	46.56%	41.42%
Total	45.77%	45.33%	40.33%

Table 7. 2019 PMV Results			
Measure	**Amerigroup**	**BlueCare**	**UnitedHealthcare**
18+ Years: Alcohol	47.23%	46.39%	42.82%
Opioid	58.91%	47.10%	38.66%
Other drug	46.85%	41.79%	40.85%
Total	47.95%	42.30%	38.88%
Initiation Total: Alcohol	**46.76%**	**46.01%**	**42.63%**
Opioid	**58.89%**	**47.09%**	**38.70%**
Other drug	**47.13%**	**42.31%**	**40.89%**
Total	**47.84%**	**42.52%**	**38.93%**
IET: Engagement of AOD Treatment:			
13-17 Years: Alcohol	14.12%	15.56%	9.86%
Opioid	18.18%	18.92%	33.33%
Other drug	26.65%	25.57%	19.26%
Total	23.80%	24.26%	18.38%
18+ Years: Alcohol	12.37%	11.37%	9.25%
Opioid	29.34%	18.88%	13.51%
Other drug	14.05%	11.70%	10.12%
Total	16.83%	13.23%	10.68%
Engagement Total: Alcohol	**12.42%**	**11.57%**	**9.27%**
Opioid	**29.29%**	**18.88%**	**13.54%**
Other drug	**14.99%**	**13.22%**	**10.66%**
Total	**17.18%**	**14.02%**	**10.95%**

** NCQA indicated a break in trending due to the measure results' being revised to display as a percentage in 2019.*
Note: For the PMV, reporting was statewide by MCO and not by Tennessee Grand Region/operational regions; BlueCare includes all three operational regions as well as its statewide TennCareSelect

Figures 5–10 compare statewide weighted rates for IET for 2018 and 2019 by age and cohort as NCQA indicated to break trending in 2018 when the diagnosis cohorts were added. Because UOP was a first-year measure, trending is not possible.

Figure 5. Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)—Initiation: 13–17 Years Statewide weighted rates for HEDIS 2018–2019

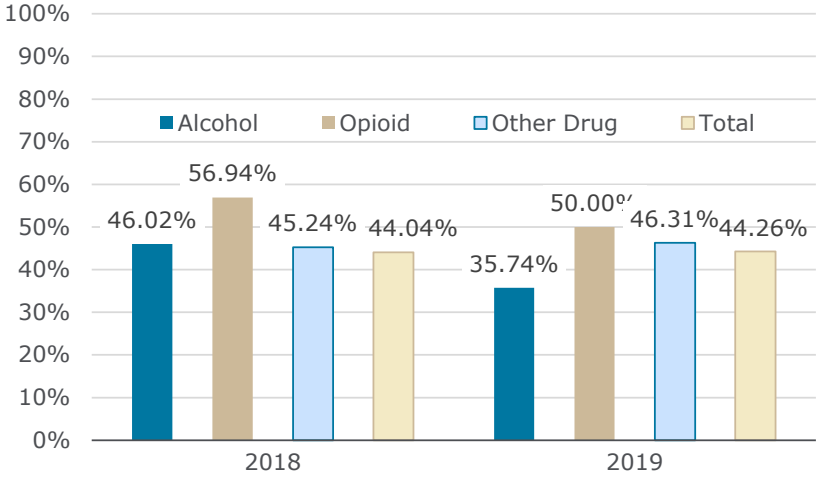


Figure 7. IET—Initiation: Total (Age) Statewide weighted rates for HEDIS 2018–2019

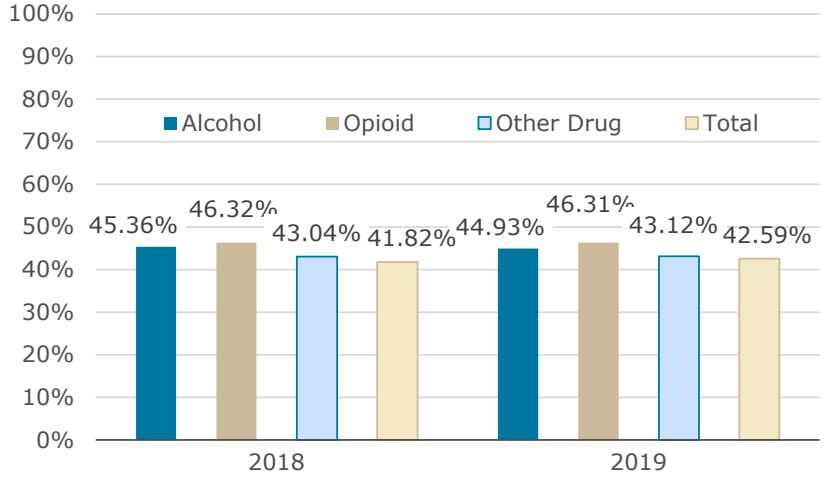


Figure 6. IET—Initiation: 18+ Years Statewide weighted rates for HEDIS 2018–2019

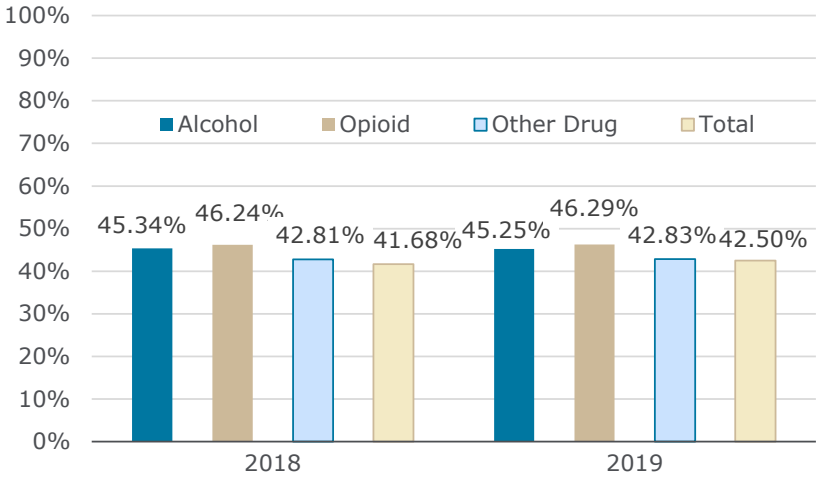


Figure 8. IET—Engagement: 13–17 Years Statewide weighted rates for HEDIS 2018–2019

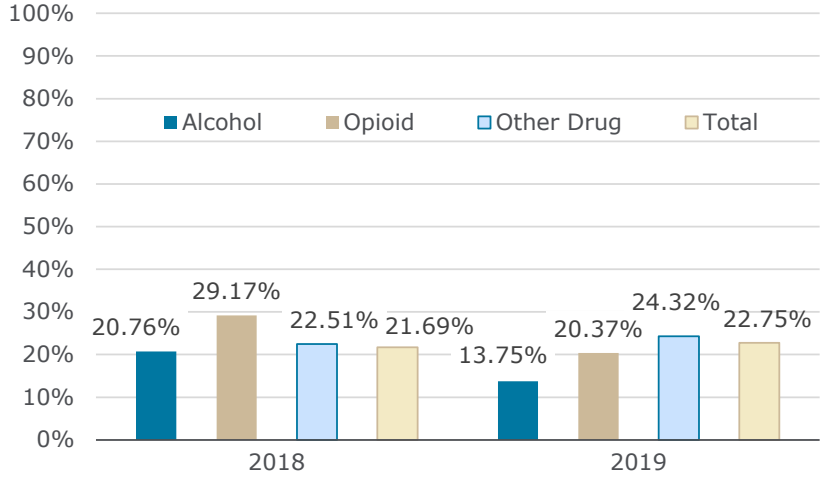


Figure 9. IET—Engagement: 18+ Years Statewide weighted rates for HEDIS 2018–2019

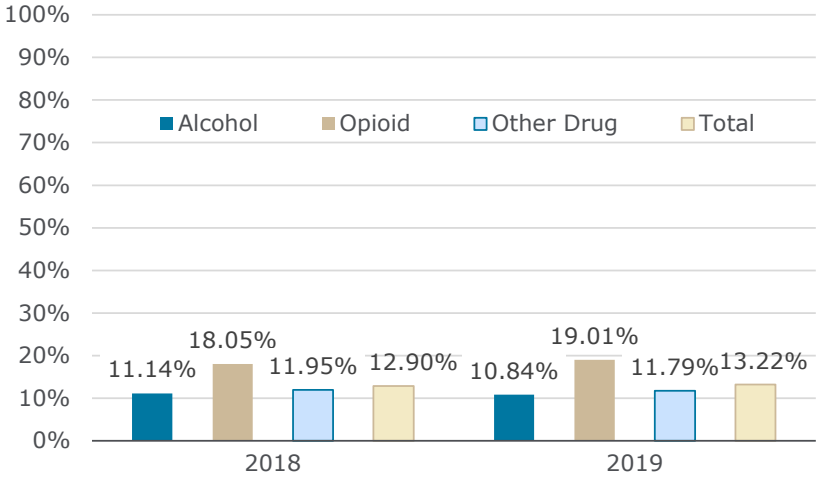
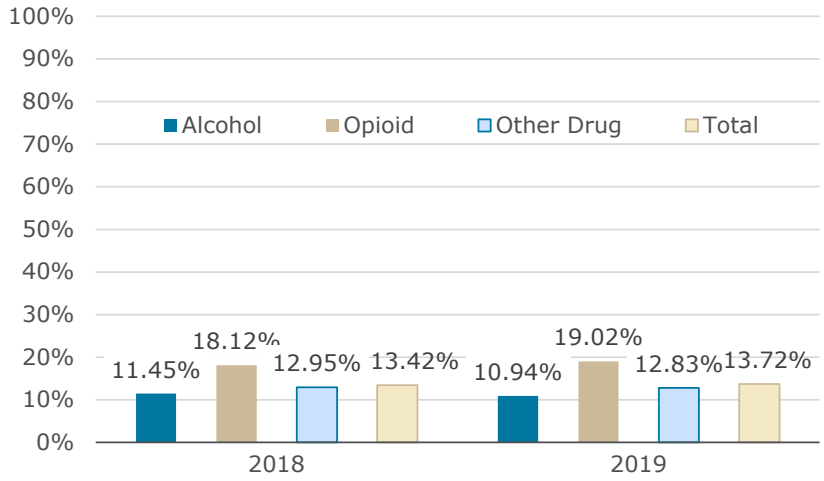


Figure 10. IET—Engagement: Total Statewide weighted rates for HEDIS 2018–2019



Conclusions Drawn

All the MCOs evaluated passed the 2019 annual PMV audit, were determined to be in full compliance with all HEDIS standards (IS and HD), and received an *R* designation for all audited measures. **AG**, **BC**, and **UHC** continue to use NCQA-certified software vendors for HEDIS measure production. All submitted measures were prepared according to the HEDIS Technical Specifications and presented fairly, in all material, the MCOs' performances with respect to these specifications.

All supplemental databases used by MCOs were approved for HEDIS 2019 reporting. All providers followed the fee-for-service payment model, so data completeness was not an issue. Also, none of the MCOs had a backlog in processing enrollment data during the measurement year.

Recommendations, Areas for Improvement

The plans were fully compliant with all standards and no suggestions or areas needing improvement were identified.

MCO Strengths and Best Practices

For **AG** (**AGE**, **AGM**, and **AGW**), Qsource identified an improvement, a strength, and a best practice. For future HEDIS reporting years, **AG** is looking to contract with a single electronic data interchange (EDI) vendor, which will add efficiencies and reduce administrative burden as their 2018 process involved four sources. Enrollment data error reports

were generated and worked daily with a 24-hour turnaround time frame and reconciled at 100 percent. Onsite, **AG** demonstrated an excellent trending process, which included variance calculations in its spreadsheet to systematically identify data aberrations over time.

For **BC** (**BCE**, **BCM**, **BCW**, and **TCS**), Qsource identified an improvement and a strength. In October 2018, receipt of enrollment files smoothly shifted from Automated Health Systems (AHS) to the Bureau with collaboration between the two and consultation with the MCO, and all issues were resolved to ensure accurate HEDIS reporting. Claims accuracy exceeded 99 percent during the measurement year.

For **UHC** (**UHCE**, **UHCM**, and **UHCW**), Qsource did not identify a specific improvement, strength, or best practice.

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 § 438.240(b)(1), including:

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

To evaluate PIPs, Qsource assembled a validation team of experienced technical writers, clinical QI specialists, and a biostatistician with expertise in statistics, and study design and evaluation. For the 2019 PIP validation, 64 PIPs (25 unique topics) were spread across 12 MCCs (Table 10).

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 in compliance with and aligned to the 10 activities of CMS's *EQR Protocol 3: Validating Performance Improvement Projects (PIPs)*, Version 2.0, September 2012. Each MCC submitted multiple PIP studies and supplemental information using the PIP Summary Form in July–September 2019.

Each PIP validation assessed MCC performance on the 10 activities from the CMS protocol and in the PIP Summary Form, and each activity consisted of multiple elements essential to the successful completion of a valid PIP. The actual number of activities validated for each PIP varied depending on how far the MCC had progressed with an individual study or whether the activity was applicable to the study's methodology. For example, Activity V was not validated when a study did not use sampling, used an administrative-only data collection methodology, or used HEDIS Technical Specifications for sampling.

The elements of each activity were scored as Met, Not Met, or Not Assessed. To ensure a valid and reliable review, 13 elements across eight activities were designated as "critical"— i.e., necessary to be Met, if applicable, for the MCC to assure accurate and reliable PIP results. Given the importance of the critical elements to this scoring methodology, any applicable critical element that received a Not Met status resulted in an overall validation rating of Not Met and required future revisions of the PIP.

Validation scores are calculated by dividing the number of evaluation elements Met by the number assessed, inclusive of critical elements for an overall validation percentage. Critical elements are similarly calculated separately so that each MCC is given two scores based on which a validation status is determined that indicates confidence in study results. More specific information on validation methodology is available in the individual, topic-and MCC-specific *2019 PIP Validation Technical Papers* as well as the *2019 PIP Validation Summary Report*.

Description of Data Obtained

Submitted PIPs should include the necessary documentation detailing data collection methods, data analysis plans, and an interpretation of all results. MCCs should also address threats to validity regarding data analysis and include an interpretation of study results.

Table 8 lists the 10 mandated PIP activities and the 13 critical elements identified as necessary to be Met for study assurance.

Table 8. PIP Activities and Critical Elements

PIP Activity	Critical Element
I. Choose the Study Topic(s)	The study topic… ♦ Has the potential to affect member health, functional status or satisfaction
II. Define the Study Question(s)	The study question… ♦ States the problem to be studied in simple terms ♦ Is answerable
III. Use a Representative and Generalizable Study Population*	The study population… ♦ Is accurately and completely defined ♦ Captures all members to whom the study question applies
IV. Select the Study Indicators*	The study indicators… ♦ Are well-defined, objective, and measurable ♦ Allow for the study questions to be answered ♦ Have available data that can be collected on each indicator
V. Use Sound Sampling Methods	Sampling methods… ♦ Ensure a representative sample of the eligible population
VI. Use Valid and Reliable Data Collection Procedures	Data collection procedures include… ♦ A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications

Table 8. PIP Activities and Critical Elements	
PIP Activity	**Critical Element**
VII. Analyze Data and Interpret Study Results*	Study results… ♦ Are conducted according to the data analysis plan in the study design ♦ Allow for generalization of results to the study population if a sample was selected
VIII. Include Improvement Strategies*	Improvement strategies are… ♦ Related to causes/barriers identified through data analysis and QI processes
IX. Assess for Real Improvement	♦ No critical elements
X. Assess for Sustained Improvement	♦ No critical elements

** Beginning this year, Qsource adjusted the order of Activities III, IV, VII, and VIII to align with current EQR Protocol.*

Comparative Findings

2019 PIP Scores

MCCs achieved a 100% critical element score and a Met validation status for the vast majority of PIPs submitted in 2019. Of the 64 PIPs validated, 59 earned a Met validation status and 55 also earned overall element scores of 100% (**Table 9**). For **AGE**, **AGM**, and **AGW**, each region achieved a Met status and overall scores of 100% for all six submitted PIPs. For **BCE**, **BCM**, and **BCW**, each region achieved a Met status for all six submitted PIPs, and overall scores of 100% for five PIPs. **TCS** achieved a Met status and overall scores of 100% for all six submitted PIPs. **UHCW** achieved a Met status for five of six submitted PIPs, while **UHCE** and **UHCM** achieved a Met status for four of six PIPs. **DQ** and **Magellan** achieved a Met status and overall scores of 100% for both submitted PIPs.

Table 9. 2019 PIP Validation Statuses

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

A summary of scores for both overall and critical elements, as well as validation status, is presented in **Table 10** by MCC and PIP topic with measurement year of the study identified, as well as classification as either clinical (C) or non-clinical (NC).

Table 10. Overall 2019 PIP Validation Scores

PIP Study Topic	Study Year	C/NC	Elements Met		Validation Status*
			Overall	Critical	
AGE					
Improve EPSDT Screening Rates in the 18–20-Year-Old Age Group	B	C	100%	100%	**Met**
Increase Percentage of Members with Documented In-Home Assessment of Nine Core Elements within 90 Days	B	NC	100%	100%	**Met**
Increasing Member Participation in the EPSDT Healthy Rewards Incentive Program	R1	NC	100%	100%	**Met**
Increasing the Percentage of Complex Case Management and High-Risk OB Members that Complete the 2nd Quality of Life Survey (SF-12)	R2	NC	100%	100%	**Met**
Reducing Transportation (NEMT) Member Complaints	R3	NC	100%	100%	**Met**
Antidepressant Medication Management	R3	C	100%	100%	**Met**
AGM					
Improve EPSDT Screening Rates in the 18–20-Year-Old Age Group	B	C	100%	100%	**Met**
Increase Percentage of Members with Documented In-Home Assessment of Nine Core Elements within 90 Days	B	NC	100%	100%	**Met**
Increasing Member Participation in the EPSDT Healthy Rewards Incentive Program	R1	NC	100%	100%	**Met**
Increasing the Percentage of Complex Case Management and High-Risk OB Members that Complete the 2nd Quality of Life Survey (SF-12)	R2	NC	100%	100%	**Met**
Reducing Transportation (NEMT) Member Complaints	R3	NC	100%	100%	**Met**
Antidepressant Medication Management	R4	C	100%	100%	**Met**
AGW					
Improve EPSDT Screening Rates in the 18–20-Year-Old Age Group	B	C	100%	100%	**Met**
Increase Percentage of Members with Documented In-Home Assessment of Nine Core Elements within 90 Days	B	NC	100%	100%	**Met**
Increasing Member Participation in the EPSDT Healthy Rewards Incentive Program	R1	NC	100%	100%	**Met**

Table 10. Overall 2019 PIP Validation Scores

PIP Study Topic	Study Year	C/NC	Elements Met		Validation Status*
			Overall	Critical	
Increasing the Percentage of Complex Case Management and High-Risk OB Members that Complete the 2nd Quality of Life Survey (SF-12)	R2	NC	100%	100%	**Met**
Reducing Transportation (NEMT) Member Complaints	R3	NC	100%	100%	**Met**
Antidepressant Medication Management	R3	C	100%	100%	**Met**
BCE					
Critical Incident in CHOICES Members	B	NC	95.5%	100%	**Met**
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	R2	NC	100%	100%	**Met**
Antidepressant Medication Management (AMM)	R3	C	100%	100%	**Met**
Maternal Health: Improving Prenatal and Postpartum Care Rates	R3	C	100%	100%	**Met**
Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (IET)	R3	NC	100%	100%	**Met**
Improving Provider Satisfaction Survey Response Rates	R3	NC	100%	100%	**Met**
BCM					
Critical Incident in CHOICES Members	B	NC	95.5%	100%	**Met**
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	R2	NC	100%	100%	**Met**
Antidepressant Medication Management (AMM)	R3	C	100%	100%	**Met**
Maternal Health: Improving Prenatal and Postpartum Care Rates	R3	C	100%	100%	**Met**
Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (IET)	R3	NC	100%	100%	**Met**
Improving Provider Satisfaction Survey Response Rates	R3	NC	100%	100%	**Met**
BCW					
Critical Incident in CHOICES Members	B	NC	95.5%	100%	**Met**
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	R2	NC	100%	100%	**Met**
Antidepressant Medication Management (AMM)	R3	C	100%	100%	**Met**
Maternal Health: Improving Prenatal and Postpartum Care Rates	R3	C	100%	100%	**Met**
Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (IET)	R3	NC	100%	100%	**Met**
Improving Provider Satisfaction Survey Response Rates	R3	NC	100%	100%	**Met**

Table 10. Overall 2019 PIP Validation Scores

PIP Study Topic	Study Year	C/NC	Elements Met		Validation Status*
			Overall	Critical	
TCS					
Follow-Up After Hospitalization for Mental Illness	B	C	100%	100%	**Met**
Social Determinants of Health Data Collection Process	B	NC	100%	100%	**Met**
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	R2	NC	100%	100%	**Met**
Maternal Health: Improving Prenatal and Postpartum Care Rates	R3	C	100%	100%	**Met**
Improving Provider Satisfaction Survey Response Rates	R3	NC	100%	100%	**Met**
Improving the Rate of Well-Child Visits in 3rd, 4th, 5th and 6th Years	R3	NC	100%	100%	**Met**
UHCE					
Perception of Care Coordination	B	NC	87.9%	90.0%	**Not Met**
Impact of Member and Provider Outreach on Immunization Rates for CIS Combo 10	B	C	100%	100%	**Met**
Transitions of CHOICES Individuals	B	NC	87.0%	75.0%	**Not Met**
Impact of Provider Incentives on Screening Rates for Adolescents	R1	C	100%	100%	**Met**
Increasing Health Risk Assessment (HRA) Annual Completion Rates	R3	NC	100%	100%	**Met**
Improving Medication Adherence for Major Depressive Disorder	R3	C	100%	100%	**Met**
UHCM					
Perception of Care Coordination	B	NC	87.9%	90.0%	**Not Met**
Impact of Member and Provider Outreach on Immunization Rates for CIS Combo 10	B	C	100%	100%	**Met**
Transitions of CHOICES Individuals	B	NC	87.0%	75.0%	**Not Met**
Impact of Provider Incentives on Screening Rates for Adolescents	R1	C	100%	100%	**Met**
Increasing Health Risk Assessment (HRA) Annual Completion Rates	R3	NC	100%	100%	**Met**
Improving Medication Adherence for Major Depressive Disorder	R3	C	100%	100%	**Met**
UHCW					
Perception of Care Coordination	B	NC	100%	100%	**Met**
Impact of Member and Provider Outreach on Immunization Rates for CIS Combo 10	B	C	100%	100%	**Met**

Table 10. Overall 2019 PIP Validation Scores

PIP Study Topic	Study Year	C/NC	Elements Met		Validation Status*
			Overall	Critical	
Transitions of CHOICES Individuals	B	NC	87.0%	75.0%	**Not Met**
Impact of Provider Incentives on Screening Rates for Adolescents	R1	C	100%	100%	**Met**
Increasing Health Risk Assessment (HRA) Annual Completion Rates	R3	NC	100%	100%	**Met**
Improving Medication Adherence for Major Depressive Disorder	R3	C	100%	100%	**Met**
DQ					
Increasing Provider Use of Silver Diamine Fluoride (SDF) as a Preventive Measure	R1	C	100%	100%	**Met**
Decreasing TennCare Enrollees Receiving Opioid Prescriptions	R1	NC	100%	100%	**Met**
Magellan					
Acute Use of Opioids	R1	C	97.2%	100%	**Met**
Decreasing Call Center Volume Related to Attestations	R1	NC	100%	100%	**Met**

**Met indicates that the PIP was valid; Not Met indicates that reported PIP results were not credible.*

Trended PIP Results

Tables 11a (**AGE**, **AGM**, **AGW**)–**11d** (**UHCE**, **UHCM**, **UHCW**) present a summary of the PIPs conducted for a minimum of three remeasurement years by MCC. Each includes the PIP's title, summary of performance, interventions, validation results, discussion points, study indicators, populations affected, and any decrease or increase in measurement results. This information is useful for determining whether to continue or retire a specific PIP. Italicized text was taken directly from MCC materials unedited by Qsource, though references to attachments were removed.

PIP topics trended include improving the HEDIS rate for Antidepressant Medication Management (AMM), which was in Remeasurement Year 3 (RM3) for AGE, AGW, BC all regions, and UHC all regions, and in RM4 for **AGM**. Also in RM3 was **AG**'s Reducing Transportation (NEMT) Member Grievances (Complaints); **BC**'s improving the HEDIS rates for IET, **BC** all regions and **TCS** for improving the HEDIS rates for Prenatal and Postpartum Care (PPC) and the MCOs' response rates for its provider satisfaction survey; **TCS**'s improving rates for the HEDIS measure Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34),

which is also part of the Core Set of Children's Health Care Quality Measures; and **UHC**'s Increasing Health Risk Assessment (HRA) Annual Completion Rates.

Table 11a. Performance Summary for 2019 PIPs ≥ Three Years: AGE, AGM, AGW	
Antidepressant Medication Management (AMM)	
Validation Status	Met
Study Population	
Using the HEDIS® 2019 technical specifications for the measure Follow-Up Care for Anti-Depressant Medication Management, the eligible population will meet the following criteria: *Amerigroup Community Care-TN Medicaid members who are over 18 years of age as of as of April 30, 2018 with a diagnosis of major depression who were newly treated with an antidepressant medication and remained on antidepressant medication treatment. Two timelines are required:* ■ *Effective Acute Phase Treatment: Patients newly diagnosed and treated who remained on an antidepressant medication for at least 84 days (12 weeks).* ■ *Effective Continuation Phase Treatment: Patients newly diagnosed and treated who remained on an antidepressant medication for at least 180 days (6 months).* *Amerigroup (AGP) utilizes 2019 HEDIS ® Technical Specifications, for administrative data collection. Members identified through these specifications are then matched to members who have been prescribed antidepressant medication as pulled from the Magellan filed claims for prescriptions filled. Members with special care needs were not excluded.* *The HEDIS Antidepressant Medication Management measures focus on compliance with medication regimens as the key to improved care for eligible members (patients 18 years of age and older diagnosed with depression as of April 30 of the measurement year).* *The Acute Phase is defined as at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD. The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, there may be no more than 30 gap days.* *Effective continuation phase treatment is defined that had at least 180 days (6 months) of continuous treatment with antidepressant medication) during the 231-day period following the IPSD. Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, there may be no more than 51 gap days.* *Continuous Enrollment: 105 days prior to the IPSD through 231 days after the IPSD.* *Exclusions: Members who did not have a diagnosis of major depression in an inpatient, outpatient, emergency department, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Members with special healthcare needs are not excluded.*	

Table 11a. Performance Summary for 2019 PIPs ≥ Three Years: AGE, AGM, AGW
Interventions and Improvement Strategies
Baseline to Remeasurement 1: 1/1/2015- 12/31/2015 Middle Region
Member Newsletter Ameritip: A member educational flyer to be distributed by clinical liaisons to providers for member distribution wellness coordinators to members directly via community outreach events.
Provider BH PowerPoint Presentation: Provider education presentation to be used at Lunch and Learns by various plan staff to educate providers regarding the 2016 BH tech specs and codes. All BH HEDIS measures and member population age groups included.)
Member Mailings: Monthly mailings sent to member's (18 years and older) to remind them of the need for compliance with medications after prescription fills (acute and continuation phases included). Continuation Phase letters included a Pharmacy Tips Flyer that is sent alongside the letter. 14,641 Acute Phase Letters were sent out to AMM members in the Acute Phase in MY 2015. 19,081 Continuation Phase letters were sent out to AMM members in the Continuation Phase in MY 2015.
Outreach calls by Case Management Staff: Outreach calls made by HCMS case managers to members who are prescribed antidepressants and engaged in case management. Outreach includes assistance with transportation, medication fill issues, provider follow-ups, comorbidities, and community resources available to assist member's socioeconomic situation. Case management staff reaches out to 366 Acute Phase members and 240 Continuation Phase members.
HEDIS AMM Lunch and Learns: Provided on-site education to Providers regarding the importance of the AMM HEDIS measures. 27 Lunch and Learns were held in 2015.
Amerigroup is aware of the significance of provider and member outreach efforts through educational information. Interventions are available through population based health fairs, material distribution, reminder mailings and provider alerts. Participation in local provider efforts is key. Our approach is prospective and retrospective.
Further analysis of the baseline findings will be done in relation to subsequent Re-measurement year findings.
Baseline:
Middle – N/A
East/ West – N/A
Baseline to Re-measurement 1 (Middle):
Based on data analysis and the resulting fishbone diagram, the plan's Quality Management team, Medical Advisory Committee, and the Medical Director reviewed the results to determine barriers and opportunities. Interventions were developed to address member, plan systems, and provider barriers.
Interventions implemented in 2015 continue and remain designed to change member behavior through education. Provider interventions are designed to assist the provider in management of the AMM patient through provision of patient tools and education.
2015 intervention to review data mapping of Behavioral Health providers to include community mental health centers was completed and centers are now included in numerator statistics.
Research and development of an additional provider interactive initiative in 2016: AMM Provider Scheduler Incentive - A provider incentive pilot to engage members ages 18 and over to be compliant with antidepressant medication treatment for at least 12 weeks after prescription fill. The plan will target the top 40 prescribing providers to offer tiered gift cards and a possible lunch for office staff based on percentage of

Table 11a. Performance Summary for 2019 PIPs ≥ Three Years: AGE, AGM, AGW

member compliance for at least 12 weeks of prescription fill. Plan is to implement by July 2016 in Re-measurement year. This should show dramatic improvement for Re-measurement year 2.

Baseline to Re-measurement 1 East : 1/1/2016- 12/31/2016

Implemented in 2016 was provider shared savings for AMM. Six Shared Savings Groups have AMM measures in their cost shared savings agreements. Six Clinics in Tennessee (2 in East Region) have the AMM Acute Phase HEDIS measure as one of their HEDIS Measures in the shared savings contract. These clinics must reach certain HEDIS measure goals to earn their financial incentive. These large practices focus strongly on these measures and AGP TN health plan assists these practices with interventions. Clinical leads from the health plan audit charts at these practices, look for HEDIS gaps in care, and assist clinic staff in setting up clinic days to close gaps. They also assist them in monitoring AMM measures to reach their goal rates.

Provider education presentations (3) to educate providers regarding the importance of the AMM HEDIS measures were implemented.

Member Mailings: Monthly mailings sent to member's (18 years and older) to remind them of the need for compliance with medications after prescription fills (acute and continuation phases included). Continuation Phase letters included a Pharmacy Tips Flyer that is sent alongside the letter.

Outreach calls by Case Management Staff: Outreach calls made by HCMS case managers to members who are prescribed antidepressants and engaged in case management. Outreach includes assistance with transportation, medication fill issues, provider follow-ups, comorbidities, and community resources available to assist member's socioeconomic situation. Case Management staff completed outreach from January through April, 2016 when outreached ceased due to a reporting issue. Outreach resumed again in November, 2016.

The following two provider interventions that were planned for 2016 did not implement due to other provider initiatives for late 2016/ early 2017:

The AMM Provider Intervention: Letter along with a list of noncompliant AMM Patients sent out with Provider Pharm Tips – TNPEC-0777-14 Provider Pharm Tips-FINAL.PDF to the Provider.

The AMM Provider Scheduler Incentive - A provider incentive pilot to engage members ages 18 and over to be compliant with antidepressant medication treatment for at least 12 weeks after prescription fill by targeting the top 40 prescribing providers to offer tiered gift cards and a possible lunch for office staff based on percentage of member compliance for at least 12 weeks of prescription fill.

TN Healthlink implemented in December 2016. PCMH is planned for January2017. These are TennCare mandated programs for all MCO's and their effect on AMM rates will be measured in 2017. Components of both programs address provider performance measurement, quality improvement, closing gaps in care for AMM members, and payments based on efficacy/quality of care. It is anticipated that these programs will reduce care gaps and improve outcomes for members.

Baseline to Re-measurement 1 West: 1/1/2016- 12/31/2016

Implemented in 2016 was provider shared savings for AMM. Six Shared Savings Groups have AMM measures in their cost shared savings agreements. Six Clinics in Tennessee (3 in West Region) have the AMM Acute Phase HEDIS measure as one of their HEDIS Measures in the shared savings contract. One Clinic (in the West Grand Region) has the AMM Continuation Phase HEDIS measure as one of their HEDIS Measures in the shared savings contract. These clinics must reach certain HEDIS measure goals to earn their financial incentive. These large practices focus strongly on these measures and AGP TN health plan assists these practices with interventions. They also assist them in monitoring AMM measures to reach their goal rates.

Provider education presentations (16) to educate providers regarding the importance of the AMM HEDIS measures were also implemented.

Table 11a. Performance Summary for 2019 PIPs ≥ Three Years: AGE, AGM, AGW

Member Mailings: Monthly mailings sent to member's (18 years and older) to remind them of the need for compliance with medications after prescription fills (acute and continuation phases included). Continuation Phase letters included a Pharmacy Tips Flyer that is sent alongside the letter.

Outreach calls by Case Management Staff: Outreach calls made by HCMS case managers to members who are prescribed antidepressants and engaged in case management. Outreach includes assistance with transportation, medication fill issues, provider follow-ups, comorbidities, and community resources available to assist member's socioeconomic situation. Case Management staff completed outreach from January through April, 2016 when outreached ceased due to a reporting issue. Outreach resumed again in November, 2016.

The following two provider interventions that were planned for 2016 did not implement due to other provider initiatives for late 2016/ early 2017:

The AMM Provider Intervention: Letter along with a list of noncompliant AMM Patients sent out with Provider Pharm Tips – TNPEC-0777-14 Provider Pharm Tips-FINAL.PDF to the Provider.

The AMM Provider Scheduler Incentive - A provider incentive pilot to engage members ages 18 and over to be compliant with antidepressant medication treatment for at least 12 weeks after prescription fill by targeting the top 40 prescribing providers to offer tiered gift cards and a possible lunch for office staff based on percentage of member compliance for at least 12 weeks of prescription fill.

TN Healthlink implemented in December 2016. PCMH is planned for January 2017. These are TennCare mandated programs for all MCO's and their effect on AMM rates will be measured in 2017. Components of both programs address provider performance measurement, quality improvement, closing gaps in care for AMM members, and payments based on efficacy/quality of care. It is anticipated that these programs will reduce care gaps and improve outcomes for members.

Remeasurement 1 to Remeasurement 2:

Middle 1/1/2016- 12/31/2016

Implemented in 2016 was provider shared savings for AMM. Six Shared Savings Groups have AMM measures in their cost shared savings agreements. Clinics in Tennessee (1 in Middle Region) have the AMM Acute Phase HEDIS measure as one of their HEDIS Measures in the shared savings contract. These clinics must reach certain HEDIS measure goals to earn their financial incentive. These large practices focus strongly on these measures and AGP TN health plan assists these practices with interventions. They also assist them in monitoring AMM measures to reach their goal rates.

Provider education presentations (3) to educate providers regarding the importance of the AMM HEDIS measures were continued in the Middle Region.

Member Mailings: Monthly mailings sent to member's (18 years and older) to remind them of the need for compliance with medications after prescription fills (acute and continuation phases included). Continuation Phase letters included a Pharmacy Tips Flyer that is sent alongside the letter.

Outreach calls by Case Management Staff: Outreach calls made by HCMS case managers to members who are prescribed antidepressants and engaged in case management. Outreach includes assistance with transportation, medication fill issues, provider follow-ups, comorbidities, and community resources available to assist member's socioeconomic situation. Case Management staff completed outreach from January through April, 2016 when outreached ceased due to a reporting issue. Outreach resumed again in November, 2016.

The following two provider interventions that were planned for 2016 did not implement due to other provider initiatives for late 2016/ early 2017:

Table 11a. Performance Summary for 2019 PIPs ≥ Three Years: AGE, AGM, AGW

The AMM Provider Intervention: Letter along with a list of noncompliant AMM Patients sent out with Provider Pharm Tips – TNPEC-0777-14 Provider Pharm Tips-FINAL.PDF to the Provider.

The AMM Provider Scheduler Incentive - A provider incentive pilot to engage members ages 18 and over to be compliant with antidepressant medication treatment for at least 12 weeks after prescription fill by targeting the top 40 prescribing providers to offer tiered gift cards and a possible lunch for office staff based on percentage of member compliance for at least 12 weeks of prescription fill.

TN Healthlink implemented in December 2016. PCMH is planned for January 2017. These are TennCare mandated programs for all MCO's and their effect on AMM rates will be measured in 2017. Components of both programs address provider performance measurement, quality improvement, closing gaps in care for AMM members, and payments based on efficacy/quality of care. It is anticipated that these programs will reduce care gaps and improve outcomes for members.

Remeasurement 1 to Remeasurement 2: East and West- 1/1/2017- 12/31/2017

Implemented in January 2017 was Patient Centered Medical Home (PCMH). This program addressed provider performance measurement, quality improvement, closing gaps in care for AMM members, and payments based on efficacy/ quality of care. Also implemented December 2016 was Tennessee Healthlink (THL). THL integrates 15 quality and efficiency measures that determine the provider's performance and outcome payments. Performance outcomes and outcome payments are measured and paid out on an annual basis. HealthCrowd implemented in November 2017. This communications outreach program contacts members via interactive voice recognition calls (IVR) to remind members to consistently take their prescribed medications and to contact the health plan if they need assistance in obtaining medications or making an appointment with their provider. A provider letter was also implemented in November of 2017, which notifies the provider of members that they have prescribed antidepressants for, and outlines care standards for Antidepressant Medication Management (AMM) HEDIS measure. The letter also encourages the provider to follow-up with member to ensure meds are being filled and subsequent appointments are being scheduled with member. Providers are given a link to clinical guidelines for AMM, as well as information regarding the availability and referral process for case management if it is needed for the member. The provider letter will be mailed monthly starting in 2018.

Provider Shared Savings continued in 2017, which have AMM measures in their contract with AGP-TN. These providers must reach specific HEDIS measure goals to earn their financial incentive. These are primarily large practices, in which the health plan assists with monitoring AMM measures to meet their goals, as well as assistance with intervention implementation.

Provider education sessions to educate providers on AMM HEDIS measures were done. Member mailings with members 18 years old and older were done to remind them of the need to stay compliant with medications after prescriptions fills (acute and continuous phases). There was a period of time when mailings were halted due to outdated tag lines from July- October 2017, but mailings resumed November 2017 for one final mailing and then discontinued due to implementation of the provider letter. Outreach calls to members that were prescribed antidepressants and engaged in case management were completed by case management staff with the exception of first quarter 2017. The outreach calls focused on member assistance with medication fill issues, transportation, provider follow-ups and community resource information.

Remeasurement 2 to Remeasurement 3:

Middle- 1/1/2017- 12/31/2017

Implemented in January 2017 was Patient Centered Medical Home (PCMH). This program addressed provider performance measurement, quality improvement, closing gaps in care for AMM members, and payments based on efficacy/ quality of care. Also implemented December 2016 was Tennessee Healthlink (THL). THL integrates 15 quality and efficiency measures that determine the provider's performance and outcome payments. Performance outcomes and outcome payments are measured and paid out on an annual basis. HealthCrowd implemented in November 2017. This communications outreach program contacts members via interactive voice recognition calls (IVR) to remind members to consistently take their prescribed medications and to contact the health plan if they need assistance in obtaining medications or making an

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appointment with their provider. A provider letter was also implemented in November of 2017, which notifies the provider of members that they have prescribed antidepressants for, and outlines care standards for Antidepressant Medication Management (AMM) HEDIS measure. The letter also encourages the provider to follow-up with member to ensure meds are being filled and subsequent appointments are being scheduled with member. Providers are given a link to clinical guidelines for AMM, as well as information regarding the availability and referral process for case management if it is needed for the member. The provider letter will be mailed monthly starting in 2018.

Provider Shared Savings continued in 2017, which have AMM measures in their contract with AGP-TN. These providers must reach specific HEDIS measure goals to earn their financial incentive. These are primarily large practices, in which the health plan assists with monitoring AMM measures to meet their goals, as well as assistance with intervention implementation.

Provider education sessions to educate providers on AMM HEDIS measures were done. Member mailings with members 18 years old and older were done to remind them of the need to stay compliant with medications after prescriptions fills (acute and continuous phases). There was a period of time when mailings were halted due to outdated tag lines from July- October 2017, but mailings resumed November 2017 for one final mailing and then discontinued due to implementation of the provider letter. Outreach calls to members that were prescribed antidepressants and engaged in case management were completed by case management staff with the exception of first quarter 2017. The outreach calls focused on member assistance with medication fill issues, transportation, provider follow-ups and community resource information.

East & West- 1/1/2018- 12/31/2018

The Plan continued to monitor the impact of the HealthCrowd Interactive Voice Recorded (IVR) calls and the AMM Provider Letters, which implemented in November 2017. Provider letters were mailed quarterly in 2018 instead of monthly to avoid provider abrasion. A member mailing was completed in October of 2018 that reminds members about the importance of filling their medications and adhering to taking it. In addition, AGP-TN implemented the HealthCrowd Texting Program in October of 2018 to educate the member on AMM measures and promote medication adherence. HealthCrowd indicated that 85% of our members have cell phones and 13% have landlines, so this intervention was developed as a result to improve AMM rates for members that prefer texting instead of phone calls. This intervention was applied statewide as the barrier with members that do prefer texts spans all three grand regions. The PCMH and THL Programs continue, with the majority of Shared Saving providers converting to the PCMH program in 2018. Health Plan staff continue to follow-up with PCMH and THL providers to educate them regarding their performance with HEDIS measures. Provider education sessions on HEDIS AMM measures also continued with non PCMH/THL providers by Quality Management staff in order to improve AMM HEDIS scores. Finally, case management outreach calls to members that were prescribed anti-depressants continued in 2018 to improve member compliance with medication.

Remeasurement 3 to Remeasurement 4:

Middle- 1/1/2018- 12/31/2018

The Plan continued to monitor the impact of the HealthCrowd Interactive Voice Recorded (IVR) calls and the AMM Provider Letters, which implemented in November 2017. Provider letters were mailed quarterly in 2018 instead of monthly to avoid provider abrasion. A member mailing was completed in October of 2018 that reminds members about the importance of filling their medications and adhering to taking it. In addition, AGP-TN implemented the HealthCrowd Texting Program in October of 2018 to educate the member on AMM measures and promote medication adherence. HealthCrowd indicated that 85% of our members have cell phones and 13% have landlines, so this intervention was developed as a result to improve AMM rates for members that prefer texting instead of phone calls. This intervention was applied statewide as the barrier with members that do prefer texts spans all three grand regions. The PCMH and THL Programs continue, with the majority of Shared Saving providers converting to the PCMH program in 2018. Health Plan staff continue to follow-up with PCMH and THL providers to educate them regarding their performance with HEDIS measures. Provider education sessions on HEDIS AMM measures

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also continued with non PCMH/THL providers by Quality Management staff in order to improve AMM HEDIS scores. Finally, case management outreach calls to members that were prescribed anti-depressants continued in 2018 to improve member compliance with medication.

Summary of Performance

East Grand Region- Remeasurement year 1 (1/1/16- 12/31/16) *Acute and Continuation Phase AMM rates declined from baseline year 2015. Acute AMM rate decreased from 60.00% in 2015 to 52.15 % in 2016 (7.85 percentage points). The decrease in Acute AMM rate is a significant difference @95th percentile with Z score of 2.477445, and P Value of 0.0132. Continuation Phase AMM rate decreased from 37.05% in 2015 to 36.80 % in 2016 (0.25 percentage points). The decrease in Continuous Phase AMM rate is not a significant difference at the 95th percentile with a Z score of 0.050655 and a P value of 0.9596. Amerigroup expanded into the East Region in 2015, which accounted for a population shift in 2016, and lapse of case management outreach to members from May 2016- Oct 2016 may have impacted rates from the previous year. AGP has several initiatives, designed to improve AMM rates that will implement in 2017. AGP will continue to measure effects of new interventions on AMM rates.*

West Grand Region- Remeasurement year 1 (1/1/16- 12/31/16). *Acute and Continuation Phase AMM rates declined from baseline year 2015. Acute AMM rate decreased from 50.43% in 2015 to 44.99% in 2016 (5.44 percentage points). The decrease in Acute AMM rate is not a significant difference at 95th percentile with Z score of 1.117325 and a P value of 0.2639. Continuation Phase AMM rate decreased from 38.36% in 2015 to 29.55 % in 2016 (8.81 percentage points). The decrease in Continuous Phase AMM rate is not a significant difference at the 95th percentile with a Z score of 1.599063 and a P value of 0.1098. Amerigroup expanded into the West Region in 2015, which accounted for a population shift in 2016, and lapse of case management outreach to members from May 2016- Oct 2016 may have impacted rates from the previous year. AGP has several initiatives, designed to improve AMM rates that will implement in 2017. AGP will continue to measure effects of new interventions on AMM rates.*

Middle Grand Region- Remeasurement year 2 (1/1/16- 12/31/16) *Acute and Continuation Phase AMM rates have continued to decline from baseline year 2014 through remeasurement year 2. Acute AMM rate decreased from 52.90% in 2015 to 50.28% in 2016 (2.62 percentage points). The decrease in Acute AMM rate is not a significant difference at 95th percentile with Z score of 1.50849 and a P value of 0.1314. Continuation Phase AMM rate decreased from 37.89% in 2015 to 36.13 % in 2016 (1.76 percentage points). The decrease in Continuous Phase AMM rate is not a significant difference at the 95th percentile with a Z score of 0.833029 and a P value of 0.4048. However there was a significant decline from baseline year 2014 to remeasurement year 2 in Acute rate (Z score of 3.288535 with P value of 0.001) but not a significant decline in Continuous Phase rate (Z score of 1.048663 and P value of 0.2943) from baseline year 2014 to remeasurement year 2. There were no specific factors to account for overall statistical decline in the Acute rate. The declines in both Acute and Continuous measures indicates that the member and provider interventions did not have an influence on statistically improving rates from baseline to remeasurement year 2.*

AGP has several initiatives, designed to improve AMM rates that will implement in 2017. AGP will continue to measure effects of new interventions on AMM rates.

East Grand Region- Remeasurement year 2 (1/1/17- 12/31/17)

Acute AMM rates have declined from baseline 2015 at 60% to 52.15% (remeasurement year 1) in 2016. The rate in 2017 was 52.54%. Significant decline was noted from baseline to remeasurement year 1 per Z test documented above. There was not a significant decline from remeasurement year 1 to remeasurement year 2 per Z test, but also no improvement noted either. There was significant decline noted from baseline 2015 (60%) to remeasurement year 2- 2017 (52.54%) per Z test at the 95th percentile-2 tail with a Z score of 3.061334 and a P value of 0.0022. Rate is below the baseline by 7.46 percentage points. This indicates that interventions implemented to improve Acute AMM rates did not influence any improvement in rates over the course of the performance improvement project. Several new initiatives-

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HealthCrowd IVR calls and the AMM Provider Letter, which was initiated late in the year is designed to improve AMM rates and will show impact in 2018. AGP-TN will continue to measure the effects of these new interventions.

Continuation Phase AMM rates also have declined from baseline 2015 at 37.05% to 36.80% (remeasurement year 1) in 2016. The rate in 2017 was 36.02%. The decline in rate from baseline to remeasurement year 1 was not significant per Z test documented above. The drop in rate from 2016 (remeasurement year 1) to 2017 (remeasurement year 2) was also not significant per Z test documented above. There is not a significant decline from baseline 2015 (37.05%) to remeasurement year 2- 2017(36.02%) per Z score at the 95th percentile- 2-tail with a Z score of 0.430323 and a P value of 0.667, however the 2017 rate is below the baseline by 1.03 percentage points. This indicates that interventions implemented to improve Continuation Phase AMM rates did not influence any improvement in rates over the course of the performance improvement project. Several new initiatives- HealthCrowd IVR calls and the AMM Provider Letter, which was initiated late in the year is designed to improve AMM rates and will show impact in 2018. AGP-TN will continue to measure the effects of these new interventions.

West Grand Region- Remeasurement year 2 (1/1/17- 12/31/17)

Acute AMM rates have declined from baseline 2015 at 50.43% to 44.99% (remeasurement year 1) in 2016. The rate in 2017 (remeasurement year 2) was 45.73%. There was not a significant decline from baseline to remeasurement year 1 per Z test documented above. There was also no significant decline from 2016 (remeasurement year 1) to 2017 (remeasurement year 2) per Z test documented above. The rate decline from baseline 2015 to remeasurement year 2- 2017 is not significant per Z test at 95th percentile, 2-tail with a Z score of 1.351613 and a P value of 0.1765. Rate is below the baseline by 4.7 percentage points. This indicates that interventions implemented to improve Acute Phase AMM rates did not influence any improvement in rates over the course of the performance improvement project. Several new initiatives- HealthCrowd IVR calls and the AMM Provider Letter, which was initiated late in the year is designed to improve AMM rates and will show impact in 2018. AGP-TN will continue to measure the effects of these new interventions.

Continuation Phase AMM rates have also declined from baseline 2015 at 38.36% to 29.55% (remeasurement year 1) in 2016. The rate in 2017 was 30.69%. There was not a significant decline from baseline year 2015 to 2016 (remeasurement year 1) per Z test documented above. There was a slight increase from 2016 (measurement year 1) to 2017 (measurement year 2) that was not a significant improvement per Z test documented above. The rate drop from baseline 2015 to 2017 (remeasurement year 2) is a significant decline per Z test at the 95th percentile, 2-tail with a Z score of 2.27921 and a P value of 0.0227. Rate is below the baseline by 7.67 percentage points. This indicates that interventions implemented to improve Continuation Phase AMM rates did not influence any improvement in rates over the course of the performance improvement project. Several new initiatives- HealthCrowd IVR calls and the AMM Provider Letter, which was initiated late in the year is designed to improve AMM rates and will show impact in 2018. AGP-TN will continue to measure the effects of these new interventions.

Middle Grand Region- Remeasurement year 3 (1/1/17- 12/31/17)

Acute AMM rates have declined from baseline 2014 at 55.99% to 52.90% in 2015 (remeasurement year 1). The rate declined again to 50.28% in 2016 (remeasurement year 2). The rate slightly improved in 2017(remeasurement year 3) at 50.30%. The rate decreases or increases were not significant per the Z tests documented above from year to year. There is a significant decline, however from baseline 2014 to 2017(remeasurement year 3) per Z test at 95th percentile, 2-tail with a Z score of 4.575986 and a P value of 0. The 2017 rate is below the baseline by 5.69 percentage points. This indicates that interventions implemented to improve Acute Phase AMM rates did not influence any improvement in rates over the course of the performance improvement project. Several new initiatives- HealthCrowd IVR calls and the AMM Provider Letter, which was initiated late in the year is designed to improve AMM rates and will show impact in 2018. AGP-TN will continue to measure the effects of these new interventions

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Continuation Phase AMM rates also declined from baseline 2014 at 38.25% to 37.89% in 2015(remeasurement year 1). The rate continued to drop to 36.13% in 2016 (remeasurement year 2) and in 2017 (remeasurement year 3) at 34.35%. The rate declines were not significant per the Z tests documented above from year to year. There is a significant decline, however from baseline 2014 to 2017 (remeasurement year 3) per Z test at 95th percentile, 2-tail with a Z score of 3.255191 and a P value of 0.0011. The 2017 rate is below the baseline by 3.9 percentage points. This indicates that interventions implemented to improve Continuation Phase AMM rates did not influence any improvement in rates over the course of the performance improvement project. Several new initiatives- HealthCrowd IVR calls and the AMM Provider Letter, which was initiated late in the year is designed to improve AMM rates and will show impact in 2018. AGP-TN will continue to measure the effects of these new interventions.

East Grand Region- Remeasurement year 3 (1/1/18- 12/31/18)-FINAL YEAR

Acute AMM rates declined from a baseline rate of 60% to 52.15 in remeasurement year 1. Rates improved in remeasurement year 2 to 52.54% but was not a statistically significant improvement. Rates declined in remeasurement year 3 to 52.38% and was not a statistically significant decrease. We are 7.62 percentage points below our baseline rate of 60.0%. This is a significant drop per Z test at the 95th percentile, 2-tail with a Z score of 3.090428 and a P value of 0.002. This indicates that interventions implemented to improve Acute AMM rates did not influence any improvement in rates over the course of the performance improvement project.

Continuation AMM rates declined from a baseline rate of 37.05% to 36.80% in remeasurement year 1 and was not a statistically significant drop. Rates again declined to 36.02% in remeasurement year 2, which was not a significantly significant drop. The rate in remeasurement year 3 was 36.58%, which was not a significantly statistical improvement. We are 0.47 percentage points below our baseline rate of 37.05%. This is not a significant decrease per Z test at the 95th percentile, 2-tail with a Z score of 0.195086 and a P value of 0.8453, indicating that interventions implemented to improve Continuation AMM rates did not influence any improvement in rates over the course of the performance improvement project.

West Grand Region- Remeasurement year 3 (1/1/18- 12/31/18)-FINAL YEAR

Acute AMM rates declined from a baseline rate of 50.43% to 44.99% in remeasurement year 1, but was not a statistically significant drop. The rates improved to 45.73% in remeasurement year 2 but this was also not statistically significant. The rate declined again in remeasurement year 3 to 42.55%, also not statistically significant. We are 7.88 percentage points below our baseline rate of 50.43%. This decline from baseline to current represents a significant decline at 95th percentile, 2-tail with a Z score of 2.256233 and a P value of 0.0241. This indicates that interventions implemented to improve Acute AMM rates did not influence any improvement in rates over the course of the performance improvement project.

Continuation AMM rates declined from a baseline rate of 38.36% to 29.55% in remeasurement year 1, but was not a statistically significant drop. The rates improved to 30.69% in remeasurement year 2, also not a significant difference. The rates declined in remeasurement year 3 to 27.44%, which was a significant decrease per Z test. We are 10.92 percentage points below the baseline rate of 38.36%. The decline from baseline to current represents a significant decline at 95th percentile, 2-tail with a Z score of 3.24304 and a P value of 0.0012. This indicates that interventions implemented to improve Continuation AMM rates did not influence any improvement in rates over the course of the performance improvement project.

Middle Grand Region- Remeasurement year 4 (1/1/18- 12/31/18)-FINAL YEAR

Acute AMM rates declined from a baseline rate of 55.99% to 52.90% in remeasurement year 1, but was not a statistically significant drop. Rates declined again in remeasurement year 2 to 50.28%, also not a significant decline. The rate in remeasurement year 3 was 50.30%, not a significant difference from year 2, and ended at 49.43% in remeasurement year 4, also not a significant decline from year 3. We are 6.56 percentage points below our baseline rate of 55.99% by 6.56 percentage points. This represents a significant decline from baseline to current

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at the 95th percentile, 2-tail with a Z score of 5.217349 and a P value of 0. This indicates that interventions implemented to improve Acute AMM rates did not influence any improvement in rates over the course of the performance improvement project. *Continuation rates declined from a baseline rate of 38.25% to 37.89% in remeasurement year 1, which was not a statistically significant drop. Rates declined again in remeasurement year 2 to 36.13%, also not statistically significant. Rates declined again in remeasurement year 3 to 34.35%, which was not significant. We ended remeasurement year 4 at 34.48%, which was not a significant change. We are 3.41 percentage points below our baseline rate of 38.25%. This represents a statistically significant decline from baseline to current year at the 95th percentile, 2-tail, with a Z score of 3.115012 and a P value of 0.0018. This indicates that interventions implemented to improve Continuation AMM rates did not influence any improvement in rates over the course of the performance improvement project.*	
EQRO Discussion	The MCO reported the rates, differences in rates between measurement years, statistical results, and level of significance for consecutive year comparisons and between Baseline and final remeasurement years for both study indicators. For Study Indicator 1, the MCO observed a significant decline between Baseline and Remeasurement 1. All other statistical tests of comparisons between consecutive years of measurement revealed no significant changes in rates for both study indicators. The final rate for Study Indicator 1 was significantly below the baseline rate, and the final rate for Study Indicator 2 was not significantly different from the baseline rate. The MCO concluded that the interventions did not influence the rates over the course of the study. The MCO could discuss the barriers to intervention effectiveness and the implications for the study's results.
Reducing Transportation (NEMT) Member Grievances (Complaints)	
Validation Status	Met
Study Population	
The entire eligible population of Medicaid members who utilized NEMT services for the reporting period was included in the total number of scheduled NEMT trips. Members with special care needs were not excluded from this study. The baseline measurement year for this study is 2015 (1/1/15 – 12/31/15) member grievance data and scheduled NEMT trips for all three grand regions- East, Middle, and West, and Statewide.	
Interventions and Improvement Strategies	
Baseline to Remeasurement 1: 1/1/2016- 12/31/2016 Interventions listed below apply to all three Grand Regions and Statewide *The Plan recognized the significance of member and provider outreach efforts through case management and care coordination and implemented interventions to improve member experience with transportation. A Member Education Flyer outlining transportation services and how to schedule transportation was created. This flyer was used by Healthcare Case Management (HCM) with complex case management members during face to face visits and mailed to members as needed by case managers. Flyers were also distributed during Community Outreach, Clinic days, and new member expos. HCM educated members that shared transportation was acceptable and necessary, thereby providing members with reasonable expectations regarding transportation services. HCM revised their process for securing transportation for members that need medical care on same or next day with TN Carriers by creating a consistent process and shared email box for urgent TN Carrier referrals, and creation of a contact list for addressing transportation concerns. HCM staff was trained on the new process to develop consistency within the case management department in scheduling same day transportation and escalation of issues with priority*	

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transportation. Weekly and quarterly meetings between multi-disciplinary Amerigroup staff and TN Carrier were conducted to discuss/resolve various concerns in real time. Ad-hoc meetings between the member, health plan, and TN Carrier were also conducted when an individual situation trigged extensive collaboration to resolve issues.

Remeasurement 1 to Remeasurement 2: 1/1/2017- 12/31/2017 Interventions listed below apply to all three Grand Regions and Statewide

The Plan continued their efforts to reduce member grievances with transportation in 2017. Development of a new NEMT transportation brochure for members was implemented in December of 2017. This brochure educates members about transportation services offered and is provided in new member packets, and annual member mailings. The brochures are also available at community events, and given to members who file agrievance about transportation services. There was also an opportunity to improve communication between TCI and their vendors. Transportation vendors did not always confirm scheduled trips with members, resulting in missed services, and vendors did not consistently receive trip manifests from TCI. As a result, development of a provider process between TCI and their vendors was implemented in December 2017. The process outlined the need to confirm trip manifests and scheduled trips with members. This communication process was disbursed by Tennessee Carriers. TCI also notified their transportation vendors in December 2017 that liquidated damages will be passed to them according to their contracts with TCI. Healthcare Management (HCM) continued with their outreach efforts by assisting members with transportation services, following a developed process for scheduling urgent transportation and escalating issues as needed with TCI. Finally, regular meetings between TCI and AGP-TN continued throughout 2017 to identify issues and work together for resolution.

Remeasurement 2 to Remeasurement 3: 1/1/2018- 12/31/2018 Interventions listed below apply to all three Grand Regions and Statewide

The Plan continued to develop interventions to further reduce transportation grievances in 2018. The interventions were implemented statewide as the issues with transportation in each region were similar and required the same interventions to further reduce grievances. The Healthcare Management (HCM) department updated their materials for training case managers on the urgent care transportation project, which continues. AGP-TN informed Tennessee Carriers (TCI) in April 2018 that the plan was going to begin assessing liquidated damages per our contract for missed services. The liquidated damages would be assessed quarterly in an effort to enforce accountability with TCI to improve transportation services. The new member brochure is in use and educates members about NEMT services offered. It is disbursed via new member packets, quarterly and annual member mailings, available at community events, and sent to members who file a grievance about transportation services. HCM also utilizes the brochure to educate case managed members regarding transportation services. HCM staff still continue to follow a consistent process for scheduling same day or next day transportation services with case managed members, and how to escalate with TCI as needed when scheduling problems are encountered. Regular meetings between TCI and AGP-TN also continued throughout 2018 to discuss transportation issues in real time and continue the problem solving process.

Summary of Performance

<u>Sustained improvement: Statewide TN</u>

Baseline to Remeasurement 1: 1/1/2016- 12/31/2016

The member grievances per 1000 NEMT trips rate decreased in 2016 (0.31) from baseline year (0.43) by 0.12 percentage points. The rate decrease in measurement year 1 from baseline year represents a significant difference at the 95th percentile based on the Z-test score of 3.18578 and P value of 0.0014, but the rate remains above the health plan goal (0.28) by 0.03 percentage points. There was a 17% reduction in the total number of NEMT scheduled trips from 2015 (991,332) to 2016 (819,019) during the remeasurement year, but the variance does not impact the transportation grievances for the remeasurement year. The health plan will continue to identify opportunities to reduce NEMT

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transportation grievances by developing and implementing targeted NEMT education materials and multi-disciplinary interventions to address barriers.

Remeasurement 1 to Remeasurement 2: 1/1/2017- 12/31/2017

Total transportation grievances per 1000 Total NEMT Scheduled Trips is 0.26. The transportation grievances per 1000 scheduled member NEMT trips decreased in 2017 from 0.31 to 0.26 (0.05 percentage points), and is below the health plan goal of 0.28 by 0.02 percentage points. The decrease in grievance rate represents a significant reduction at the 95% confidence level 2 tail with a Z score of 2.079604 and a P value of 0.0376. Statewide is now below the health plan goal by 0.02 percentage points and has met the goal. This suggests that targeted interventions did influence the reduction of grievances.

Transportation grievances also decreased from Baseline year 2015 (0.43) to 2017-remeasurement year 2 (0.26) by 0.17 percentage points. This represents a significant reduction in grievances at the 95% confidence level 2 tail with a Z score of 6.348336 and a P value of 0. This suggests that targeted interventions did influence the reduction in grievances from baseline year 2015 to 2017-remeasurement year 2. The decreasing Statewide grievance rate of 0.43 in 2015, 0.31 in 2016, and 0.26 in 2017 demonstrates sustained improvement. Statewide is now below the health plan goal by 0.02 percentage points. Additional interventions planned in 2018 will continue to further decrease transportation grievances.

Remeasurement 2 to Remeasurement 3: 1/1/2018- 12/31/2018

Total transportation grievances per 1000 Total NEMT Scheduled Trips is 0.32. The transportation grievances per 1000 scheduled member NEMT trips increased year over year (YOY) from 0.26 to 0.32 (0.06 percentage points), and is above the health plan threshold of 0.28 by 0.04 percentage points. The increase in grievance rate represents a significant increase at the 95% confidence level 2 tail with a Z score of 2.414644 and a P value of 0.0158. Although we are over the threshold in 2018 mainly because of an increase in grievances in the East and Middle regions, there was still a significant decline in the grievance rate from baseline 2015 rate of 0.43 to 2018 rate of 0.32 at the 95th confidence level, 2 tail with a Z score of 3.740915 and a P value of 0.0002. This indicates that targeted interventions did reduce the grievance rate from the start of this project except in 2018, when grievances spiked upward again.

Sustained improvement: East Grand Region

Baseline to Remeasurement 1: 1/1/2016- 12/31/2016

The member grievances per 1000 NEMT trips rate decreased in 2016 (0.17) from baseline year (0.35) by 0.18 percentage points. The rate decrease in measurement year 1 from baseline year represents a significant difference at the 95th percentile based on the Z-test score of 3.18578 and P value of 0.0014, but the rate remains above the health plan goal (0.28) by 0.11 percentage points. There was a 32.88% reduction in the total number of NEMT scheduled trips from 2015 (258,235) to 2016 (173,309) during the remeasurement year, but the variance does not impact the transportation grievances for the remeasurement year. The health plan will continue to identify opportunities to reduce NEMT transportation grievances by developing and implementing targeted NEMT education materials and multi-disciplinary interventions to address barriers.

Remeasurement 1 to Remeasurement 2: 1/1/2017- 12/31/2017

Total transportation grievances per 1000 Total NEMT Scheduled Trips is 0.19. The transportation grievances per 1000 scheduled member NEMT trips increased in 2017 from 0.17 to 0.19 (0.02 percentage points), and is below the health plan goal of 0.28 by 0.09 percentage points. The increase in the grievance rate is not significant at the 95% confidence level 2 tail with a Z score of 0.447637 and a P value of 0.6544. East Region is below the health plan goal by 0.09 percentage points. This indicates that the targeted interventions did not further

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reduce transportation grievances in 2017 over 2016. However, the East Region continues to be below the health plan goal which suggests that the interventions already implemented continued to be effective and sustained in 2017.

Transportation grievances decreased from Baseline year 2015 (0.35) to 2017-remeasurement year 2 (0.19) by 0.16 percentage points. This represents a significant reduction in grievances at the 95% confidence level 2 tail with a Z score of 3.176755 and a P value of 0.0015. This suggests that targeted interventions did influence the reduction in grievances from baseline year 2015 to 2017-remeasurement year 2. Decreasing grievance rates of 0.35 in 2015, 0.17 in 2016, and 0.19 in 2017 demonstrates sustained improvement. East Region is below the health plan goal by 0.09 percentage points. Additional interventions planned in 2018 will continue to further decrease transportation grievances.

Remeasurement 2 to Remeasurement 3: 1/1/2018- 12/31/2018

Total transportation grievances per 1000 Total NEMT Scheduled Trips is 0.36. The transportation grievances per 1000 scheduled member NEMT trips increased YOY from 0.19 to 0.36 (0.17 percentage points), and is above the health plan threshold of 0.28 by 0.08 percentage points. The increase in grievance rate represents a significant increase at the 95% confidence level 2 tail with a Z score of 2.95609 and a P value of 0.0031. The 2016 grievance rate declined from baseline 2015 by 0.18 percentage points. There was not a statistical change in 2017, however grievances increased in 2018 to 0.36. We are now over our threshold by 0.08 percentage points. From baseline (2015) to 2018, there was an increase in the grievance rate by 0.01 percentage points but this is not a statistical increase at the 95% confidence level, 2 tail with a Z score of 0.183479 and a P value of 0.8544. This indicates that targeted interventions did reduce grievances from the start of this project, except in 2018 when grievances spiked upward again.

Sustained improvement: Middle Grand Region

Baseline to Remeasurement 1: 1/1/2016- 12/31/2016

The member grievances per 1000 NEMT trips rate decreased in 2016 (0.31) from baseline year (0.48) by 0.17 percentage points. The rate decrease in measurement year 1 from baseline year represents a significant difference at the 95th percentile based on the Z-test score of 3.11883 and a P value of 0.0018, but the rate remains above the health plan goal (0.28) by 0.03 percentage points. There was a 13.26% reduction in the total number of NEMT scheduled trips from 2015 (444,183) to 2016 (385,278) during the remeasurement year, but the variance does not impact the transportation grievances for the remeasurement year. The health plan will continue to identify opportunities to reduce NEMT transportation grievances by developing and implementing targeted NEMT education materials and multi-disciplinary interventions to address barriers.

Remeasurement 1 to Remeasurement 2: 1/1/2017- 12/31/2017

Total transportation grievances per 1000 Total NEMT Scheduled Trips is 0.25. The transportation grievances per 1000 scheduled member NEMT trips decreased in 2017 from 0.31 to 0.25 (0.06 percentage points), and is below the health plan goal of 0.28 by 0.03 percentage points. The decrease is not a significant difference @95% confidence level 2 tail with a Z score of 1.673556 and a P value of 0.0942. Middle Region is now below the health plan goal by 0.03 percentage points. The Z score test indicates that the targeted interventions that were implemented did not influence the reduction of transportation grievances in 2017 as it did in 2016. However the grievance rate decreased from 0.31 in 2016 to 0.25 in 2017, which is below the health plan goal. This suggests that the interventions implemented did influence the reduction of grievances.

Transportation grievances decreased from Baseline year 2015 (0.48) to 2017-remeasurement year 2 (0.25) by 0.23 percentage points. This represents a significant reduction in grievances at the 95% confidence level 2 tail with a Z score of 5.421031 and a P value of 0. This suggests that targeted interventions did influence reduction of grievances from Baseline 2015 to 2017-remeasurement year 2. Decreasing grievance

Table 11a. Performance Summary for 2019 PIPs ≥ Three Years: AGE, AGM, AGW

rates of 0.48 in 2015, 0.31 in 2016, and 0.25 in 2017 demonstrates sustained improvement. The Middle Region is now below the health plan goal by 0.03 percentage points. Additional interventions planned in 2018 will continue to further decrease transportation grievances.

Remeasurement 2 to Remeasurement 3: 1/1/2018- 12/31/2018

Total transportation grievances per 1000 Total NEMT Scheduled Trips is 0.34. The transportation grievances per 1000 scheduled member NEMT trips increased YOY from 0.25 to 0.34 (0.09 percentage points), and is above the health plan threshold of 0.28 by 0.06 percentage points. The increase in grievance rate represents a significant increase at the 95% confidence level 2 tail with a Z score of 2.191696 and a P value of 0.0284. The grievance rate showed a significant reduction in 2016 over baseline 2015 by 0.17 percentage points, and further reduced to 0.25 in 2017, although that change was not statistically significant. Although we are over the threshold in 2018, there was still a significant reduction in complaints from 0.48 (baseline) to 0.34 in 2018 at the 95% confidence level, 2 tail with a Z score of 3.094704 and a P value of 0.002. This indicates that targeted interventions did reduce grievances from the start of this project, except in 2018 when grievances spiked upward again.

Sustained improvement: West Grand Region

Baseline to Remeasurement 1: 1/1/2016- 12/31/2016

The member grievances per 1000 NEMT trips rate decreased in 2016 (0.40) from baseline year (0.43) by 0.03 percentage points. The slight rate decrease in measurement year 1 from baseline year does NOT represent a significant difference at the 95th percentile based on the Z-test score of 3.45713 and P value of 0.6476 and the rate remains above the health plan goal (0.28) by 0.12 percentage points. There was a 9.85% reduction in the total number of NEMT scheduled trips from 2015 (288,914) to 2016 (260,442) during the remeasurement year, but the variance does not impact the transportation grievances for the remeasurement year. The health plan will continue to identify opportunities to reduce NEMT transportation grievances by developing and implementing targeted NEMT education materials and multi-disciplinary interventions to address barriers.

Remeasurement 1 to Remeasurement 2: 1/1/2017- 12/31/2017

Total transportation grievances per 1000 Total NEMT Scheduled Trips is 0.31. The transportation grievances per 1000 scheduled member NEMT trips decreased in 2017 from 0.40 to 0.31 (0.09 percentage points), but remains above the health plan goal of 0.28 by 0.03 percentage points. The decrease in the grievance rate is not significant at the 95th confidence level 2 tail with a Z score of 1.682684 and a P value of 0.0924. Although the grievance rate continues to decrease in the West Region, we are still above our goal and have not met our goal. The Z score test indicates that the targeted interventions implemented did not influence the reduction of transportation grievances in 2017. However the grievance rate dropped from 0.43 at baseline, decreased to 0.40 in re-measurement year 1, and further decreased to 0.31 in 2017, suggesting that the interventions implemented did influence the reduction of grievances.

Transportation grievances decreased from Baseline 2015 (0.43) to 2017-remeasurement year 2 (0.31) by 0.12 percentage points. This represents a significant reduction in grievances at the 95% confidence level 2 tail with a Z score of 2.337086 and a P value of 0.0194. This suggests that targeted interventions did influence the reduction in transportation grievances from baseline 2015 to 2017-remeasurement year 2. Although the grievance rate continues to decrease in the West Region, we still exceed our goal by 0.03 percentage points. Additional interventions planned in 2018 will continue to decrease transportation grievances to meet our goal of 0.28/1000 or less.

Remeasurement 2 to Remeasurement 3: 1/1/2018- 12/31/2018

Total transportation grievances per 1000 Total NEMT Scheduled Trips is 0.27. The transportation grievances per 1000 scheduled member NEMT trips decreased YOY from 0.31 to 0.27 (0.04 percentage points), and is now below the health plan threshold by 0.01 percentage points. The reduction in the grievance rate is not a significant reduction at the 95% confidence level 2 tail with a Z score of 0.793817 and a P value of 0.4273. Although the Z scores indicate no statistical change YOY from the start of this project in 2015, the grievance rates did decline

Table 11a. Performance Summary for 2019 PIPs ≥ Three Years: AGE, AGM, AGW	
from 0.43 in 2015, to 0.40 in 2016, to 0.31 in 2017 to 0.27 in 2018. We are now below our threshold of 0.28. There was a reduction in complaints from baseline to year 3 by 0.16 percentage points, and indicates a significant reduction at the 95% confidence level, 2 tail with a Z score of 3.131488 and a P value of 0.0017. This indicates that targeted interventions did reduce grievances from the start of this project.	
EQRO Discussion	Statewide, statistically significant decreases in the complaint rate occurred from Baseline to Remeasurements 1 and 2, but a significant increase occurred from Remeasurement 2 to Remeasurement 3. The MCO concluded that the interventions had an overall effect of reducing the complaint rate from Baseline. Regionally, a significant decrease occurred from Baseline to Remeasurement 1, no statistically significant change occurred from Remeasurement 1 to Remeasurement 2, and a significant increase occurred from Remeasurement 2 to Remeasurement 3. From Baseline, significant reductions were observed at Remeasurements 1 and 2, but no changes occurred from Baseline to Remeasurement 3. The MCO concluded that initial improvement was evidenced by the reduced complaint rates from Baseline, except in 2018, when a spike occurred, and no significant changes from Baseline were observed, indicating no sustained improvement.

Table 11b. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW	
Antidepressant Medication Management (AMM)	
Validation Status	Met
Study Population	
The population for this study is determined by the specific guidelines for the Antidepressant Medication Management (AMM) measures, which includes clear definitions for inclusion, exclusion, diagnosis criteria, and enrollment criteria as described in the NCQA Volume 2 HEDIS Technical Specifications. Study population includes the entire BlueCare Tennessee member population who met the AMM measure criteria based on HEDIS specifications. Study population includes the entire BlueCare East, BlueCare Middle, and BlueCare West member populations who met the AMM measure criteria based on HEDIS specifications. Specifically, BlueCare East, BlueCare Middle, and BlueCare West members who have a new antidepressant prescription from May 1st of the year prior to the measurement year through April 30th of the measurement year and are enrolled with the health plan at least 105 days prior to the prescription dispensing event through 231 days post the prescription dispensing event will be included in this study. All members meeting these criteria will be included in the study.	
Interventions and Improvement Strategies	
1. AMM Workgroup • *A multi-disciplinary workgroup was organized and met regularly to review data, plan interventions, identify barriers and monitor progress towards improvement.* • *This workgroup continued to meet on a regular basis to monitor progress towards improvement and address any additional barriers as they were identified.* • *The workgroup met throughout 2016 to review data and evaluations. The group continued to address barriers and monitor progress to improvement.*	

Table 11b. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW

- *The workgroup met throughout 2017-2018 to discuss trends in data, barriers and progress toward the goal. A fishbone diagram was completed to document barriers associated with non-compliance with this measure.*

2. *Intro and Non-compliant Letters/Educational Letter to Members*
   - *A process was put in place to send initial introduction letters to members when they had a diagnosis of Major Depression and Anti-Depressant Medication was prescribed.*
   - *Introduction letters were sent within one week of members receiving a new antidepressant medication and non-compliant letters were sent once members had at least a 15 day gap in their medication adherence.*
   - *The initial Intro letter to members includes the following:*
     - *See your doctor at least three times during the first three months you are taking this medicine.*
     - *Talk to your doctor about any side effects you're having.*
     - *Do not stop taking this medicine without talking to your doctor first.*
     - *Stopping this medicine suddenly can cause serious side effects.*
   - *Due to the timeliness of this measure, a weekly claims-based member list was developed. The logic for this list mimics the AMM criteria for the denominator and identifies members who were prescribed an antidepressant, had a diagnosis of major depression, and a negative medication history for antidepressants. Since continuous enrollment is not considered, not all members identified in the list may be in the final denominator.*
   - *An additional outreach letter was developed to address members trending towards non-compliance with their anti-depressant medication regime.*
   - *Outreach was initially implemented to reach members by mailing out initial contact letters to members with a diagnosis of Major Depression and newly prescribed anti-depressant medication.*
   - *Initially, we were mailing this letter at 30 days non-compliance. Performance monitoring did not show significant improvement, so we adjusted our logic to 15 days non-compliant.*

3. *Provider Outreach Letter*
   - *In 2015, the intervention was modified to identify members as soon as they had a 10 day gap in antidepressant medication adherence creating a call list for the pharmacy technician. If members continue to remain non-compliant for 20 days then the member and their prescriber will receive the non-compliant letter.*
   - *Provider outreach was developed to notify treating providers of members trending non-compliant with their anti-depressant medication regime.*
   - *The timing of this letter coincides with the second member letter above.*

4. *Pharmacy Specialist Outreach Calls*
   - *Certified pharmacy technicians were hired to perform phone calls to members trending as non-compliant in their anti-depressant medication regime.*
   - *This was to compliment the letter process already in place which created a two-tiered approach.*
   - *The specialist reached out to members to remind them that their medication needed to be refilled, provide education and answer questions if needed and assist member with physician appointment follow up if needed.*

Table 11b. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW

5. *Face to Face Education – THL Providers / Incentivized Measure*
   - *Behavioral Health Quality Management Specialist educated THL providers on an ongoing basis regarding AMM. Talking points were also developed to discuss with providers. The talking points included best practices to stay in close contact with members and ways to help make sure they have success using their medicine. Face to face visits with THL providers is an ongoing action.*
   - *THL providers AMM rates were incentivized for 2018. AMM continuation phase will be the incentivized portion of this measure for 2019.*

6. *Provider Education*
   - *BHAC meetings - Education provided on ways to ensure AMM gap closure.*
   - *Mental Health Symposium - Education provided on ways to ensure AMM gap closure.*
   - *Article in Quality Cares Newsletter - Information on accessing Behavioral Health resources for providers.*

Baseline:

1. *Pharmacy Specialist Outreach Calls*
   - *BlueCare did not see the movement in the measurement, it was decided to enhance the outreach to members by hiring a pharmacy outreach specialist, certified pharmacy technician, to conduct member outreach phone calls to the members trending non-compliant with anti-depressant medication regime. The specialist is able to reach out to members to give a reminder on their medication refill needed, provide education and answer questions if needed. The staff member is also able to assist member with physician appointment follow up if needed.*

2. *Outreach Letters*
   - *The timing of the letters was adjusted to compliment these phone calls. Members trending towards non-compliance will appear on the call list at 10 days non-compliance. Members will be mailed the second letter (non-compliant letter) at 20 days non-compliance. Members will appear again on the call list if they remain non-compliant 10 days after the non-compliant letter was mailed.*

Baseline to Remeasurement 1:

1. *Pharmacy Specialist Outreach Calls*
   - *Analysis of the Pharmacy Outreach Specialist calls to member indicated they were successful, but overall the closure of gaps did not demonstrate significant improvement. It is recommended that a deep dive analysis be implemented on the call process to identify the member's current state of compliance when phone calls are made, and capture outcomes of the pharmacy calls. Further review of the intervention indicates a need for expansion of the phone call process to address all barriers identified for members. Increasing the number of pharmacy outreach calls is recommended to include additional follow up phone calls to reach the members regarding barriers, education and resources.*

2. *Outreach* Letters
   - *The Outreach Letters are not demonstrating a significant improvement for the measure. It is recommended that a modification of the initial letter process be implemented to include an adjustment of when the initial letter is mailed, inclusion of description of potential*

Table 11b. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW

barriers and medication information for the member be addressed and to incorporate a more interactive letter to the member in the initial phase of the medication treatment. Non-compliant letters should continue to the member and provider as implemented.

Remeasurement 1 to Remeasurement 2:

1. *Barrier Tracking Block*
   - *For the current remeasurement period, the strategy for improvement is to outreach to members, pharmacies, and providers to assist members in becoming compliant by refilling their prescriptions and/or coordinating appointments and transportation as needed as well as provide general education on the importance of medication adherence.*
   - *A new barrier tracking block was implemented in March 2017 to capture the barriers members stated during outreach calls in regards to filling medications.*
   - *Opportunities were found surrounding outreach for this measure. BlueCare is currently unable to track the member's refill rate percentages, and the denominator for this measure is large- not all members are receiving telephone outreach due to volume.*
   - *It is recommended that additional ways to outreach/educate members is explored (text messaging, newsletters, mailings, etc.).*
   - *A new report has been requested for a more real time evaluation showing refill rate percentages for members.*

Remeasurement 2 to Remeasurement 3:

7. *Face to Face Education – THL Providers*
   - *Behavioral Health Quality Management Specialist educated THL providers on an ongoing basis regarding AMM. Talking points were also developed to discuss with providers. The talking points included best practices to stay in close contact with members and ways to help make sure they have success using their medicine. Face to face visits with THL providers is an ongoing action. THL providers AMM rates were incentivized for 2018. AMM continuation phase will be the incentivized portion of this measure for 2019.*

8. *Provider Education – Mental Health Symposium*
   - *During the Mental Health Symposium providers in attendance were given AMM informational brochures. The brochures included information regarding AMM and the standard timeframes. Flyers "Your Dr. is your partner: How antidepressant medicine helps you" & "Understanding your Depression Medicine" were distributed at the Mental Health Association of East TN Symposium on Oct 18-19, 2018.*

9. *Provider Education – BCBST Quality Week*
   - *During the Mental Health Symposium providers in attendance were given AMM informational brochures. The brochures included information regarding AMM and the standard timeframes. Flyers "Your Dr. is your partner: How antidepressant medicine helps you" & "Understanding your Depression Medicine" were distributed at BCBST quality week from Oct 22-26, 2018.*

Summary of Performance

Remeasurement 1
Did show slight declines in values but those were not deemed statistically significant.

Remeasurement 2
Did show lack of improvement that indicated increases primarily resulting from changes to NDC rather than current interventions. It has been found that current interventions are not impacting a large enough percentage of the denominator to result in a notable increase in rates. New interventions have been implemented in 2018 in order to reach more members in the denominators of this measure. Remeasurement of this study will be completed in the next cycle to evaluate the effectiveness of the interventions.

Table 11b. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW
All study indicators for all regions experienced statistical significant increases in rate from baseline to current period. *Based on the current change to methodology and ongoing interventions, rates do appear sustainable over time.* ***Remeasurement 3*** *For all indicators for each line of business, BlueCare experienced declines in rates and all the declines were deemed statistically different having p-values <.05. Recent changes to identifying voided claims within pharmacy data may have impacted the measurement of these indicators.* *This PIP has not shown sustained improvement and there have been multiple factors that have impacted the measurement of the indicators.* *1. Remeasurement 1 - Picked up the BlueCare Middle region starting 1/1/2015. The growth of the middle region appears to be a major contributing factor to the overall results comparisons and threaten validity of the statistical comparisons of baseline to remeasurement 2.* *2. Remeasurement 1 to Remeasurement 2 - NCQA had some significant changes to the AMM measure including General Guideline 45, Using Claims to Identify Events in Conjunction with Diagnosis or Other Events. However, this would impact identifying the denominator and is estimated at having minimal impact on the rate.* *3. Remeasurement 1 to Remeasurement 2 - NCQA added 322 NDCs to the AMM medication list which may have some impact since the comparison will not be on the same exact study indicators.* *4. Remeasurement 3 - TennCare provided BlueCare with updated directions on how to process pharmacy claims, specifically as they pertain to processing voids. This change heavily impacted BlueCare's processing of claims which resulted in much fewer pharmacy claims available for HEDIS processing which led to much lower rates for adherence measures which included antidepressant medication management. Therefore, the data elements from year to year may be different and may not be a valid measurement of the effectiveness of outreach programs within the last year compared to previous years.* *The change in the processing of pharmacy claims impedes effective measurement of the impact of antidepressant medication interventions.* *BlueCare will retire this PIP and will continue to monitor this measure and the interventions that have been shown to have an impact on increasing compliance with antidepressant medications.*

EQRO Discussion	The MCO [**BC** all regions] concluded that statistically significant declines in rates were due to the changes to pharmacy claims and modifications to the HEDIS Technical Specifications medication list. The MCO included graphs for each study indicator that displayed the results over time.
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	
Validation Status	Met
Study Population	

The population for this study is determined by the specific guidelines for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) HEDIS measure, which includes clear definitions for inclusion, exclusion, diagnosis criteria, and enrollment criteria as described in the NCQA Volume 2 HEDIS Technical Specifications (2018). Study population includes the entire BlueCare East, BlueCare West, and BlueCare Middle member populations who meet the IET measure criteria based on HEDIS specifications. Specifically, BlueCare enrollees who are enrolled in a BlueCare plan during the measurement year and enrolled with the plan 60 days prior to the date of diagnosis through 48 days post diagnosis without a prior diagnosis of alcohol or other drug dependency within 60 days of the current diagnosis are eligible for this denominator. Included in the HEDIS 2018 study populations are BlueCross BlueShield Tennessee dual eligible members (those who have Medicare Advantage HMO/PPO/or DSNP and also have BlueCare Medicaid). Any member meeting these requirements will be included in this study.

Table 11b. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW

Interventions and Improvement Strategies

Information applies to all regions, except the Emergency Department Initiative. Emergency Department Initiative applies to the East Grand Region.

Baseline:

1. *IET Workgroup*
   - *A multi-disciplinary workgroup was organized and consisted of the Manager and Supervisor of Behavioral Health Quality Management, Behavioral Health Quality Management Specialist, Accreditation Research Consultant, Quality Assurance Manager and a Performance/Process Improvement Clinical Consultant. The workgroup met regularly to review data, plan interventions, and identify barriers. An analysis was completed and interventions were developed, additional BlueCare employees were consulted and/or added to the workgroup as needed.*
   - *The initial focus of this study was members who entered the denominator through the emergency department (ED). BlueCare began contract negotiations with Covenant Health Systems to engage with members in the ED; however through data analysis BlueCare identified the need for additional interventions outside the ED initiative.*
   - *BlueCare analyzed specialty provider compliance rates, including the volume of members placed into the denominator by pain management providers, to identify other opportunities to improve member engagement in substance abuse treatment. As a result of the analysis conducted in 2016, BlueCare implemented a multifaceted approach to improving IET rates in 2017.*
   - *Provider knowledge of IET and the steps to engage members in treatment within the HEDIS specified timeframe was also identified as a barrier. A BlueAlert newsletter educating providers on engaging members in substance abuse treatment within the HEDIS specifications was sent to address provider knowledge.*
   - *Ongoing Tennessee Health Link (THL) provider education was implemented to help providers continually monitor their rates and improve substance abuse treatment engagement.*
   - *The workgroup continued to meet monthly to identify opportunities for improvement, barriers, and to monitor progress.*

2. *Emergency Department Initiative*
   - *BlueCare has collaborated with Covenant Health Systems (Peninsula) to develop a process which places trained staff in the Emergency Department (ED) in the East Grand Region to engage with members coming in with an AOD diagnosis. The staff will encourage the members to initiate AOD treatment and follow up with members in an effort to keep the member engaged in treatment to meet the requirements for the IET measure. This process will be implemented in the seven (7) EDs operated by Covenant.*
   - *The contract was not executed in 2016 due to a management change at Covenant Health Systems. Education was provided to Covenant Health Systems' new management about the IET ED initiative, including the previously submitted contract. Therefore, contract negotiations were extended through CY2016.*
   - *Covenant Health Systems accepted the contract in CY2017 and the initiative was implemented on May 30, 2017.*

Table 11b. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW

Baseline to Remeasurement 1:

1. *Behavioral Health Provider Education*
   - *The interventions during CY2016 addressed the need for provider education and development of a multifaceted approach to IET. The nineteen behavioral health providers included in Tennessee Health Link (THL) were on-boarded September 2, 2016 and received education about IET, as well as other measures.*
   - *After onboarding, all THL providers received additional education about IET and other measures in December 2016, the same month the THL program launched. The THL program is a medical delivery system change which assists providers in standardizing their approach to IET engagement and rate monitoring.*
   - *THL provider education began quarterly in 2017 by Grand Region. Quarterly education is provided to assess/address knowledge of the measure. So that the providers can monitor their rates a report is reviewed with the providers that includes their IET rates. This intervention should lead to improved quality of care for our members. The success of the THL program and ongoing education will be evaluated in 2017. Both of these interventions are expected to induce permanent change.*
   - *A BlueAlert newsletter was developed and sent out to providers to educate them about engaging members in AOD treatment within the HEDIS specifications. The intent of the newsletter was to enhance the knowledge base of all provider types.*

2. *Data Analysis*
   - *Lack of a multifaceted approach to IET engagement was identified as a barrier. After data analysis, opportunities to improve IET rates were identified through specialty and pain management providers. The analysis revealed that physical health and pain management providers contribute to a significant number of members in the denominator; however, their compliance rates were low.*
   - *BlueCare utilized the data analysis to implement a multifaceted approach in 2017. Interventions will target all types of providers, not only the Emergency Department.*

3. *Emergency Department Initiative*
   - *The ED initiative was the original intervention.*
   - *Contract negotiations with Covenant Health Systems continued throughout 2016.*
   - *After extended contract negotiations, the contract was secured and implemented in 2017.*
   - *The effect of this intervention on IET rates will determine whether BlueCare will implement this initiative as a permanent system change.*

Remeasurement 1 to Remeasurement 2:

1. *Data Analysis*
   - *BlueCare continued to utilize the specialty provider data analysis to develop a multifaceted approach to improving the IET rate.*
   - *The analysis was utilized to target specific providers and develop interventions for all provider types.*
   - *The multidisciplinary workgroup completed a barrier analysis. The workgroup added additional staff that included the Chief Medical Officer, physical and behavioral health Medical Directors, coding and reimbursement staff and the Director of Quality Improvement as needed.*

2. *Pain Management Provider Coding Education*
   - *Pain Management Providers were identified as having a high-volume of members who never initiate, engage or receive follow-up treatment through data analysis.*
   - *Further analysis revealed that pain management providers were not billing and coding appropriately.*

Table 11b. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW

- *Follow-up revealed that some members were inappropriately diagnosed with AOD. The Chief Medical Officer educated the top pain management provider group regarding appropriate billing and coding related to the IET measure. By identifying the coding and billing issues and educating pain management providers, members began to receive the appropriate diagnosis. This is a sustainable change which has greatly impacted IET rates.*
- *In 2018, BlueCare is developing an IET flyer which will include coding and billing education. The intent of the flyer is to educate all types of providers.*

3. *IET Educational Webinar for Providers*
   - *Lack of provider knowledge related to IET initiation and engagement was identified as a barrier. A webinar was posted on bluecare.bcbst.com and providers were able to sign-on and view at their own time. Initiation and engagement education was provided per HEDIS Specifications. Providers were encouraged to use screening tools to identify alcohol and drug dependence issues, discuss the importance of follow-up care and attend all appointments.*
   - *Attaining the appropriate release of information to involve the member's support system and educating that support system about the diagnosis and follow-up care was also encouraged.*
   - *If barriers are encountered while attempting to treat the member, providers were informed that BlueCare Behavioral Case Managers are available to assist.*
   - *Lastly providers were reminded of the importance of appropriate billing and coding and the availability of screening tools and resources on bluecare.bcbst.com.*

4. *Emergency Department Initiative*
   - *Due to lack of emergency department education related to IET engagement, Covenant Health System, created a program called Recovery Link. They provided education to their emergency departments in the East Grand Region, however; they were unable to engage members due to the member's unwillingness to engage.*
   - *Their focus remained on getting treatment and they were unable to overcome this barrier, but they did continue to educate and support emergency department staff.*
   - *Recovery Link focused on educating emergency departments and a hotline number was provided for members along with brochures about alcohol/drug abuse.*
   - *The ED was also presented with education on current treatment and discharge best practices including but not limited to: appropriate follow-up care, referrals to treatment and community support. And how to educate members on other treatment options outside the emergency department was discussed.*
   - *BlueCare ended the contract with Covenant Health Systems in 2018.*

5. *IET Educational Letters to Providers*
   - *Letters were sent to providers outlining the IET measure per HEDIS specifications for initiation and engagement. Through data analysis, BlueCare identified the top twelve (12) providers putting members into the IET denominator. These providers were informed that their practice was identified as having a high volume of patients diagnosed with alcohol or drug dependence that never initiate, engage or follow-up with treatment.*
   - *Emphasis was placed on the importance of treatment and engaging the member's support system.*

Table 11b. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW

6. *IET Educational Phone Calls to Providers*
   - *BlueCare BH Medical Directors telephoned the top 4 providers identified through analysis as having a high-volume of members who never initiate, engage or follow-up.*
   - *The BH Medical Directors followed a call guide and discussed IET and the importance of treatment and follow-up. The targeted providers also had a chance to ask questions. Appropriate billing and coding was the top issue that providers focused on during the calls. Providers were informed about referral options and BlueCare resources such as tool kits on bcbst.com. BlueCare has decided to continue to target specific providers with phone calls.*
   - *In 2018, a pre-call script was developed to assist with scheduling the phone call. The IET educational flyer is also being developed and can be used to address billing and coding issues, as this was noted as a frequent question on the phone calls that took place. BlueCare Medical Directors are being engaged in the development of the pre-call script.*
   - *Based on an updated specialty provider analysis, BlueCare will target more providers.*
   - *With the addition of providers targeted, this intervention will be re-evaluated to determine the impact.*
7. *Face to Face Education-THL Providers*
   - *A Behavioral Health Quality Management Specialist educated THL providers regarding IET. Providers were given informational brochures about IET and the Behavioral Health toolkit on bcbst.com. The IET standard and timeline was presented and information emphasizing follow-up and treatment. The toolkit includes a referral line, crisis line, screening tools and resources for SUD. Tools include but are not limited to: CRAFFT Adolescent Screening Tool and Opioid Overdose Toolkit. All information was presented verbally or via presentation.*
   - *Face to face visits with THL providers is an ongoing action and IET rates will be monitored.*
8. *Face to Face Education and Mental Health Symposium*
   - *During the Mental Health Symposium and Behavioral Health Advisory Committee Meetings, providers in attendance were given IET informational brochures.*
   - *The brochures included information regarding IET initiation and treatment timeframes. The importance of follow-up treatment and engaging the member's support system was encouraged.*
   - *In 2018, BlueCare will deliver IET education at the Mental Health Symposium. Attendance records will be collected and evaluation of the outcome from the Mental Health Symposium will continue.*

Summary of Performance

Repeated measurements over comparable time periods demonstrate sustained improvement, or that a decline in improvement is not statistically significant.

Remeasurement 2:

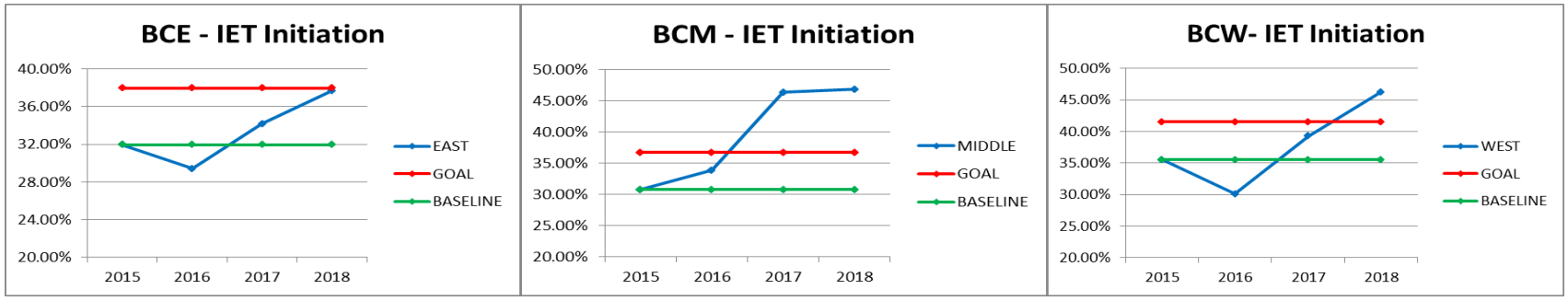
- *Baseline to Remeasurement 1 indicated very little change supporting that barriers were not appropriately identified.*
- *Remeasurement 1 to remeasurement 2 focused on study indicator elements and identified a barrier with approximately 23% of the members inappropriately entered into the denominator. These members had a very low compliance rate which is further proof that follow-up AOD treatment was not necessary. Once the barrier had been identified appropriate action and interventions were created, there was a reduction of non-compliant members entering the denominator.*
- *Remeasurement 2 rates improved and measures have been set up to prevent similar actions from occurring in the future.*
- *Remeasurement 2 observed significant improvements which appear to be sustainable over time.*

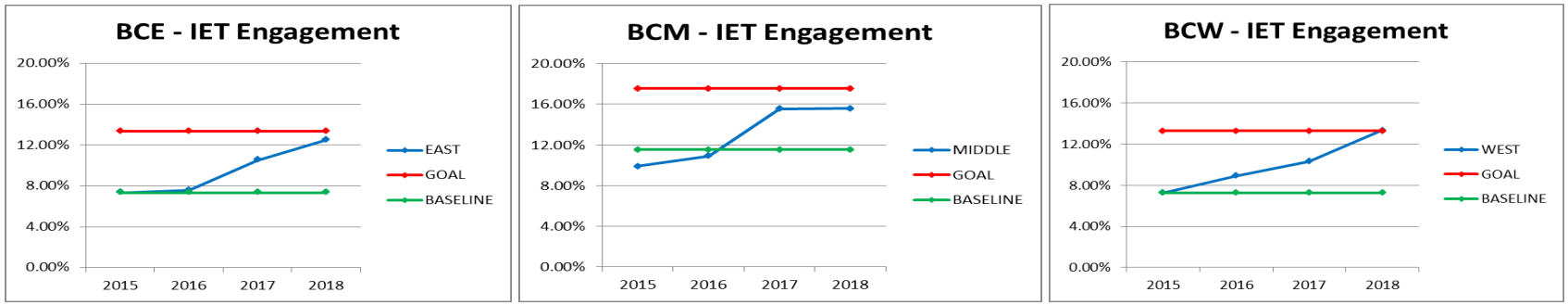
Table 11b. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW

Remeasurement 3:

- *Since Baseline, all indicators have observed significant improvement and many of the indicators surpassing baseline goal.*
- *There is support to indicate improvements resulted from interventions and improved rates that are sustainable.*
- *Ongoing management with these interventions has shown continuous improvement which stabilized the indicators.*
- *BlueCare is retiring this PIP but ongoing initiatives/interventions will continue to manage members with alcohol or other drug abuse/dependencies.*

Below are the final graphs showing sustained improvement in all regions for Initiation and Engagement. BCM Initiation and BCW Initiation surpassed their goals.





EQRO Discussion	Statistically significant increases of both study indicators suggested the improvements resulting from interventions, and the improved rates are sustainable. The MCO [**BC** all regions] noted that ongoing interventions management has improved and stabilized the indicators. In addition, the MCO stated that it is retiring this PIP but ongoing initiatives/interventions will continue to help manage members with AOD.

Table 11c. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW, and TCS	
Maternal Health: Improving Prenatal and Postpartum Care Rates (PPC)	
Validation Status	Met
Study Population	
The population for this study is determined by the specific guidelines for the Access and Availability of Care Measures Prenatal and Postpartum Care, which includes clear definitions for inclusion, exclusion, diagnosis criteria, and enrollment criteria as described in the NCQA Volume 2 HEDIS Technical Specifications. Study population includes the entire BlueCare East, BlueCare Middle and BlueCare West member population who met the PPC measure criteria based on HEDIS specifications. Specifically, BlueCare East, BlueCare Middle and BlueCare West members who have a live birth delivery from November 6 of the year prior to the measurement year through November 5 of the measurement year and are enrolled with the health plan at least 43 days prior to deliver through 56 days after delivery. All members meeting these criteria will be included in the study.	
Interventions and Improvement Strategies	
In 2015, the Maternity Workgroup identified numerous opportunities for improvement though barrier analysis. Among the barriers from workgroup analysis the following items were noted. Brainstorming strong and effective interventions to address the barriers were a significant part of the workgroup strategy in 2015, including the development of a Maternity Management Program. The Maternity Management Program is dedicated to all pregnant members (low and high risk), and focuses on member and provider engagement activities, including the offer of incentives to promote desired behavior changes. The program is also dedicated to revising processes associated with the Maternity Notification Form to provide accurate and timely data. Trends in this data will identify new opportunities for improvement we can provide to our maternity population. *In 2016, the Maternity Workgroup continued to meet. The workgroup conducted an inventory of existing interventions, best practices research and a review the HEDIS 2016 rates and initiative. Due to the success of the postpartum intervention, the decision was made to incorporate it as part of the regular maternal health program.* *In 2017 and 2018, the Maternity Workgroup continued to meet on a monthly basis. Interventions and HEDIS rates continued to be reviewed and evaluated for impact on improvement within the defined population. Also, strategy was developed around CPT II coding and member identification for the PPC measure.* *Overall, BlueCare Tennessee has identified a lack of member education regarding the importance of Prenatal and Postpartum Care. Best practices research has been done as well as analysis of the BlueCare population in order to determine the most effective interventions for implementation. In addition to the main interventions outlined in this PIP in the table above, the Maternity Workgroup has also brainstormed and then assisted in the implementation of the following programs/interventions:* *1. Member Education Outreach is an ongoing activity. Medical informatics provides an early identification of pregnancy report to assist in contacting existing [BlueCare/TCS] members who are pregnant as well as presumptive eligible members to:* *▪ Provide education* *▪ Assist with finding a provider and appointment scheduling when required* *▪ Member Education Customer Service Representatives also complete a mini health risk assessment and refer to High Risk Maternity Case Management as indicated by member responses to questions* *▪ Member Education Customer Service Representatives contact members to inform them of the importance of a postpartum visit and assist in appointment scheduling and transportation as necessary; the Edinburgh Postnatal Depression screen is conducted*	

Table 11c. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW, and TCS

- *All members identified in any maternity status (Presumptive Eligible, Prenatal, Postpartum) are sent an educational packet with thorough information regarding their pregnancy as well as the well-care necessary for their newborn*

2. *High Risk Maternity – Upon provider or other internal assessment, members are identified as 'high risk maternity' and require additional support and counseling to help ensure and promote positive health outcomes.*
3. *Presumptive Eligible Member Outreach – tracks and targets members newly enrolled in our plan and provides education, support, appointment scheduling and encourage strong prenatal and postpartum care during and after pregnancy.*
4. *Through Population Health's Caring Start in Your Neighborhood Program, Embedded Care Managers are located in UTMG to offer Pregnancy Education. This program offers members assigned to this practice incentives for receiving their needed care.*
5. *Standard provider education is disseminated through BlueAlert Newsletter articles and Specific Quality Measure fact sheets.*
6. *In addition to the educational packets sent to identified pregnant members, quarterly member newsletters are sent to all [BlueCare/ TennCareSelect] members including Maternity education materials.*
7. *[BC all regions only] In an effort to increase member motivation to receive Prenatal care, a monetary incentive was put into place for members who receive timely prenatal care. Phone calls and secure text messaging was used to notify members of the incentive and Maternity Program.*

Baseline to Re-measurement 1:

The following interventions were carried over from the baseline year:

Member Education Outreach is an ongoing activity. Information Delivery provides an early identification of pregnancy report to assist in contacting existing

1. *[BlueCare/TCS] members who are pregnant as well as presumptive eligible members to:*
   - *Provide education on the importance of early and ongoing prenatal care as well as a postpartum visit and staying healthy during pregnancy*
   - *Assist with finding a provider and appointment scheduling when required*
   - *Member Education Customer Service Representatives also complete a mini health risk assessment and refer to High Risk Maternity Case Management as indicated by member responses to questions*
   - *Member Education Customer Service Representatives contact members to inform them of the importance of a postpartum visit and assist in appointment scheduling and transportation as necessary; the Edinburgh Postnatal Depression screen is conducted*
   - *All members identified in any maternity status (Presumptive Eligible, Prenatal, Postpartum) are sent an educational packet with thorough information regarding their pregnancy as well as the well-care necessary for their newborn*
   - *Incentives are offered for both Timeliness of Prenatal Care and Postpartum Care.*

2. *Presumptive Eligible Member Outreach – tracks and targets members newly enrolled in our plan and provides education, support, appointment scheduling and encourage strong prenatal and postpartum care during and after pregnancy.*
3. *High Risk Maternity – Upon provider or other internal assessment, members are identified as 'high risk maternity' and require additional support and counseling to help ensure and promote positive health outcomes.*
4. *In addition to the educational packets sent to identified pregnant members, quarterly member newsletters are sent to all BlueCare members including Maternity education materials.*
5. *Education through social media (Facebook) is offered to members. The education is targeted to pregnant members and offers tips on staying healthy during pregnancy as well as information on the CaringStart maternity program.*

Table 11c. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW, and TCS

6. *An initiative to reimburse providers for filing CPT II codes 0500F and 0503F was implemented in August 2016. Providers can file a claim with the CPT II code for a prenatal visit and a postpartum visit and receive an additional $10. Since this initiative focused on prenatal visits, members and providers targeted for this intervention were in their first trimester August 2016 and would not fall into our HEDIS 2017 submission since members are captured into our study population based on the delivery date. These members will be in our HEDIS 2018 submission and intervention will be evaluated at that time.*

Re-measurement 1 to Re-measurement 2:

The following interventions were carried over from the baseline to re-measurement 2 year:

Member Education Outreach is an ongoing activity. Information Delivery provides an early identification of pregnancy report to assist in contacting existing

1. *[BlueCare/TCS] members who are pregnant as well as presumptive eligible members to:*
   - *Provide education on the importance of early and ongoing prenatal care as well as a postpartum visit and staying healthy during pregnancy.*
   - *Assist with finding a provider and appointment scheduling when required*
   - *Member Education Customer Service Representatives also complete a mini health risk assessment and refer to High Risk Maternity Case Management as indicated by member responses to questions*
   - *Member Education Customer Service Representatives contact members by telephone to inform them of the importance of a postpartum visit and assist in appointment scheduling and transportation as necessary; the Edinburgh Postnatal Depression screen is conducted*
   - *All members identified in any maternity status (Presumptive Eligible, Prenatal, Postpartum) are sent an educational packet with thorough information regarding their pregnancy as well as the well-care necessary for their newborn*
   - *Incentives are offered for both Timeliness of Prenatal Care and Postpartum Care.*
2. *Presumptive Eligible Member Outreach through telephone calls – tracks and targets members newly enrolled in our plan and provides education, support, appointment scheduling and encourage strong prenatal and postpartum care during and after pregnancy.*
3. *High Risk Maternity – Upon provider or other internal assessment, members are identified as 'high risk maternity' based upon risk stratification/ assessments and require additional support and counseling to help ensure and promote positive health outcomes.*
4. *In addition to the educational packets sent to identified pregnant members, quarterly member newsletters are sent to all [BlueCare/ TennCareSelect] members including Maternity education materials.*
5. *Education through social media (Facebook) is offered to members. The education is targeted to pregnant members and offers tips on staying healthy during pregnancy as well as information on the CaringStart maternity program.*
6. *An initiative to reimburse providers for filing CPT II codes 0500F and 0503F was implemented in August 2016. Providers can file a claim with the CPT II code for a prenatal visit and a postpartum visit and receive an additional $10. Since this initiative focused on prenatal visits, members and providers targeted for this intervention were in their first trimester August 2016 and would not fall into our HEDIS 2017 submission since members are captured into our study population based on the delivery date. These members will be in our HEDIS 2018 submission and intervention will be evaluated at that time.*
7. *Standard provider education is disseminated through BlueAlert Newsletter articles and Specific Quality Measure fact sheets.*

Re-measurement 2 to Re-measurement 3:

The following interventions were carried over from the baseline to re-measurement 3 year:

Table 11c. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW, and TCS

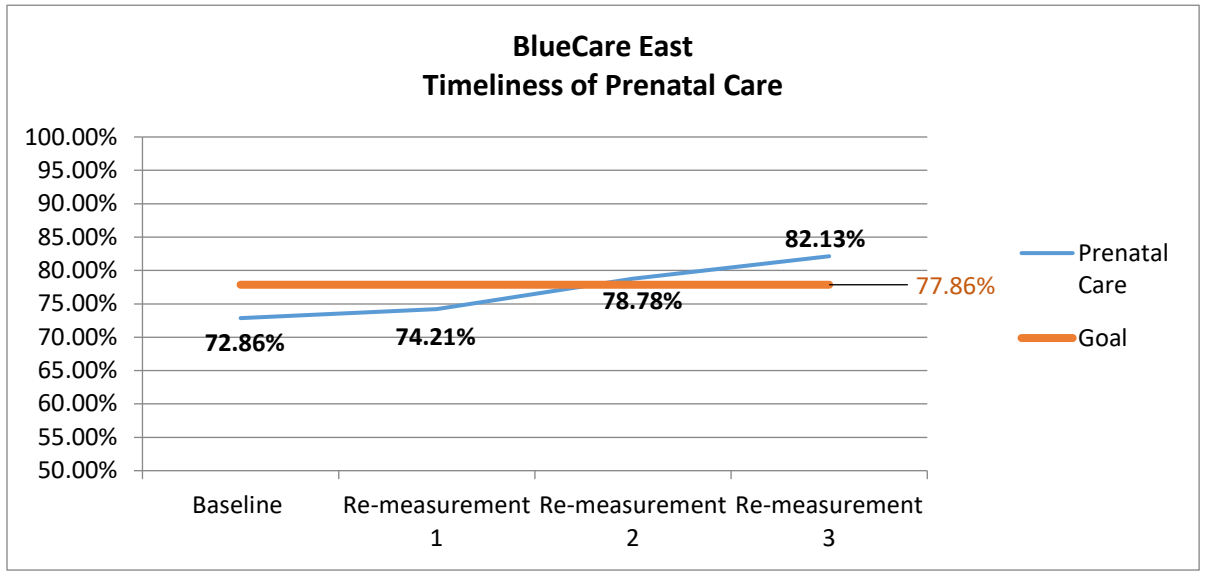
Member Education Outreach is an ongoing activity. Information Delivery provides an early identification of pregnancy report to assist in contacting existing

1. *[BlueCare/TCS] members who are pregnant as well as presumptive eligible members to:*
    - *Provide education on the importance of early and ongoing prenatal care as well as a postpartum visit and staying healthy during pregnancy.*
    - *Assist with finding a provider and appointment scheduling when required*
    - *Member Education Customer Service Representatives also complete a mini health risk assessment and refer to High Risk Maternity Case Management as indicated by member responses to questions*
    - *Member Education Customer Service Representatives contact members by telephone to inform them of the importance of a postpartum visit and assist in appointment scheduling and transportation as necessary; the Edinburgh Postnatal Depression screen is conducted*
    - *All members identified in any maternity status (Presumptive Eligible, Prenatal, Postpartum) are sent an educational packet with thorough information regarding their pregnancy as well as the well-care necessary for their newborn*
    - *Incentives are offered for both Timeliness of Prenatal Care and Postpartum Care.*
2. *Presumptive Eligible Member Outreach through telephone calls – tracks and targets members newly enrolled in our plan and provides education, support, appointment scheduling and encourage strong prenatal and postpartum care during and after pregnancy.*
3. *High Risk Maternity – Upon provider or other internal assessment, members are identified as 'high risk maternity' based upon risk stratification/ assessments and require additional support and counseling to help ensure and promote positive health outcomes.*
4. *In addition to the educational packets sent to identified pregnant members, quarterly member newsletters are sent to all [BlueCare/ TennCareSelect] members including Maternity education materials.*
5. *Education through social media (Facebook) is offered to members. The education is targeted to pregnant members and offers tips on staying healthy during pregnancy as well as information on the CaringStart maternity program.*
6. *An initiative to reimburse providers for filing CPT II codes 0500F and 0503F was implemented in August 2016. Providers can file a claim with the CPT II code for a prenatal visit and a postpartum visit and receive an additional $10. Since this initiative focused on prenatal visits, members and providers targeted for this intervention were in their first trimester August 2016 and would not fall into our HEDIS 2017 submission since members are captured into our study population based on the delivery date. These members will be in our HEDIS 2018 submission and intervention will be evaluated at that time.*
7. *Standard provider education is disseminated through BlueAlert Newsletter articles and Specific Quality Measure fact sheets.*

Table 11c. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW, and TCS

Summary of Performance

Overall Analysis:
BCE - Prenatal Care:

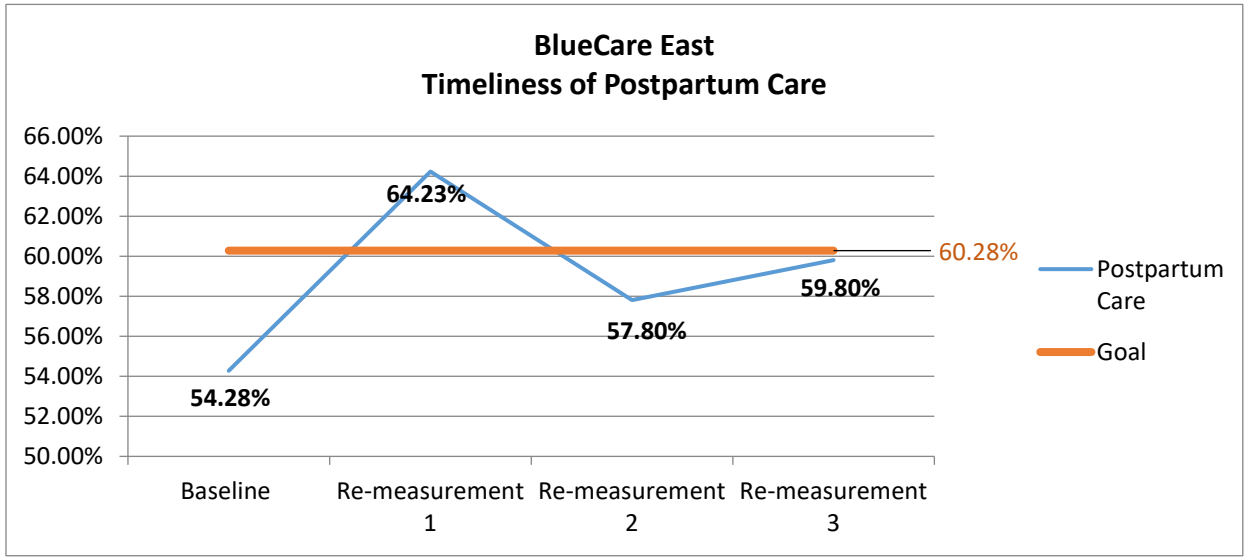


Re-measurement 2 rate increased over 2.74% points higher than baseline and 0.19% higher than re-measurement period 1. Current rate of 88.70% almost reached our targeted goal of 88.96%. Although changes not statistically significant, interventions and current management of population trending towards our goal expectations. There have been sustained improvement for prenatal care in BlueCare East.

Re-measurement 3 rates not significantly different when baseline compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.0585 and t-value of 1.89. Rates not significantly different when re-measurement 1 compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.3735 and t-value of 0.89. Rates not significantly different when re-measurement 2 compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.4169 and t-value of 0.81. Although, statistical significance has not been observed in comparison of current re-measurement period to any other period, there has been continuous improvement in BCE rates and current rate, 90.56% exceeded baseline goal.

Table 11c. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW, and TCS

Overall Analysis:
BCE - Postpartum Care:

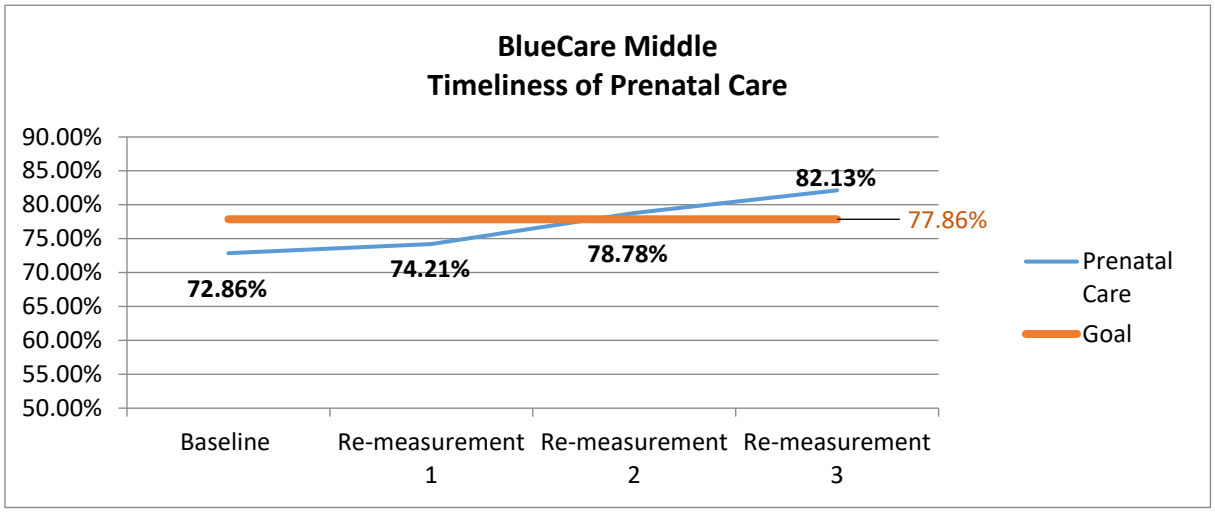


Re-measurement 2 rate fell 1.83% points from baseline and 0.61% from re-measurement period 1. Results indicate no significant variance from baseline to re-measurement 2 and re-measurement 1 to re-measurement 2 indicating postpartum interventions not heavily impacting outcomes of study population. We will focus new interventions on postpartum care due to lack of improvement.

Re-measurement 3 rates not significantly different when baseline compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.1860 and t-value of -1.32. Rates not significantly different when re-measurement 1 compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.3296 and t-value of -0.98. Rates not significantly different when re-measurement 2 compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.4226 and t-value of -0.8. Although significant variation has not been observed in comparing re-measurement 3 to any previous period, a downward trend is observed and further analysis recommended in attempt to address potential barriers for implementation of additional interventions.

Table 11c. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW, and TCS

BCM – Prenatal Care:

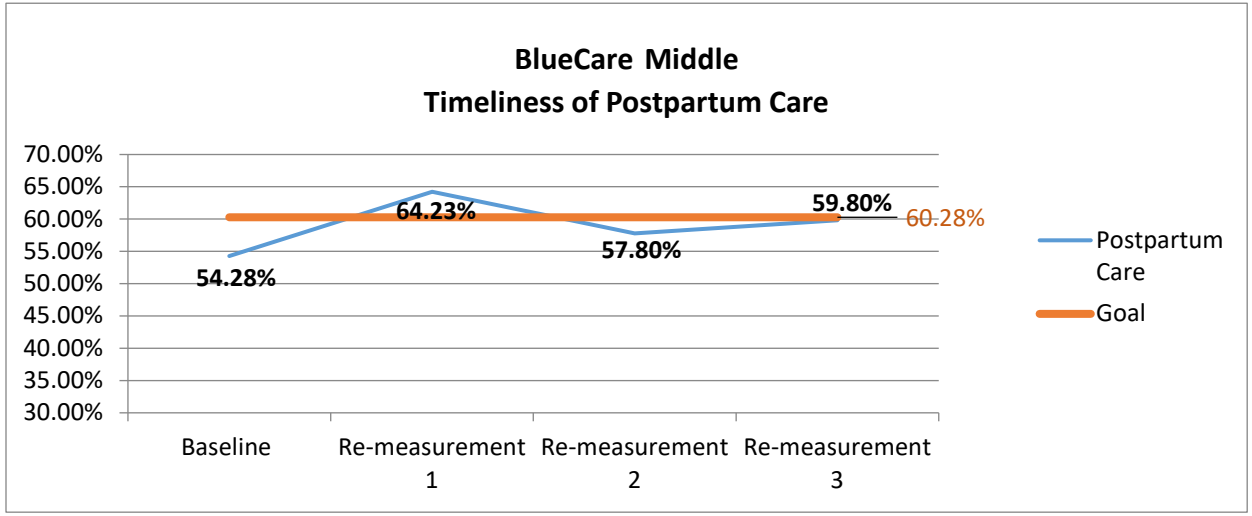


Re-measurement 2 rate is 5.84% points higher than baseline and 4.4% higher than re-measurement period 1. Results indicate although there was an observed significant increase from baseline to current re-measurement period and not a statistically significant change from re-measurement 1 to re-measurement 2 which supports interventions occurring from baseline to re-measurement 1 had the biggest impact on the final rate. There has been sustained improvements in the Middle region for prenatal care.

Re-measurement 3 rates significantly different when baseline compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.0184 and t-value of 2.36. Rates not significantly different when re-measurement 1 compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.0714 and t-value of 1.81. Rates not significantly different when re-measurement 1 compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.6909 and t-value of 0.40. Statistical significance observed in comparing baseline to current re-measurement period. Additionally, current BCM rate, 80.20% exceeded baseline goal of 78.24%. Lack of significant variation from re-measurement 1 and re-measurement 2 may indicate a stability in interventions implemented from baseline to re-measurement 2 and indicates sustainability.

Table 11c. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW, and TCS

BCM - Postpartum Care:

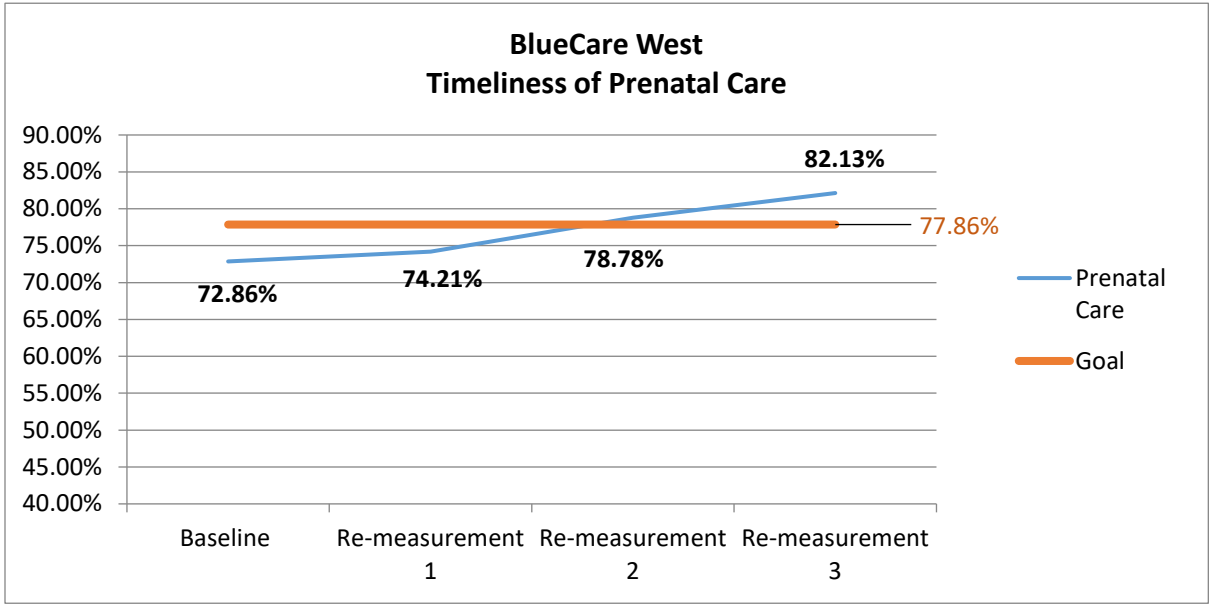


Re-measurement 2 rate increased 4.38% points from baseline and about 1.21% higher than re-measurement period 1. Results indicate although there was an observed increase from baseline to current re-measurement period and re-measurement 1 to re-measurement 2 rates within margin of error and may not truly reflect an increase. The current re-measurement rate has not exceeded our targeted goal of 56.36 however the trend does suggest improvement in rate which is a direct result from all interventions associated with the study population.

Re-measurement 3 rates significantly different when baseline compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.0003 and t-value of 3.63. Rates significantly different when re-measurement 1 compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.0069 and t-value of 2.71. Rates significantly different when re-measurement 2 compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.0186 and t-value of 2.36. Statistical significance observed in comparing baseline to current re-measurement period and re-measurement 1 to re-measurement 3 and re-measurement 2 to re-measurement 3. Additionally, current BCM rate, 62.84% exceeded baseline goal of 56.36%. Continuous increasing in rates along with statistically significant variation suggest positive impact from ongoing interventions.

Table 11c. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW, and TCS

BCW – Prenatal Care:

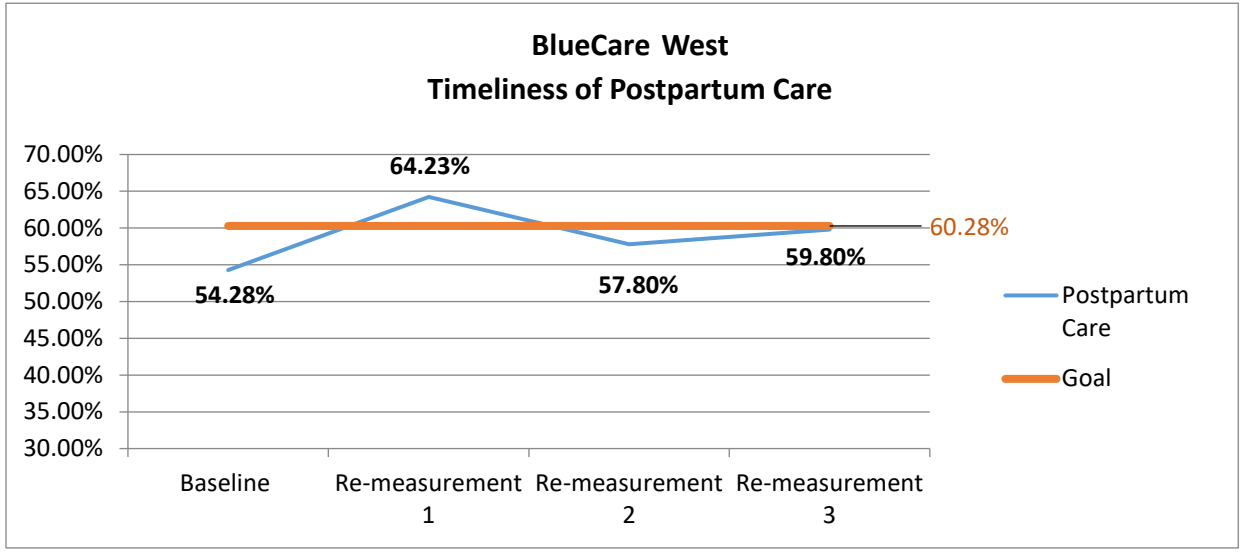


Re-measurement 2 rate increased 5.91% points higher than baseline and about 4.38% higher than re-measurement period 1. The current re-measurement rate exceeded our targeted goal of 77.86%. It appears that ongoing interventions have impacted study population and lead to sustained improvement in rates.

Re-measurement 3 rates significantly different when baseline compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.0015 and t-value of 3.18. Rates significantly different when re-measurement 1 compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.0062 and t-value of 2.74. Rates not significantly different when re-measurement 2 compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.2286 and t-value of 1.20. Statistical significance observed in comparing baseline to current re-measurement period and re-measurement 1 to re-measurement 3. Additionally, current BCW rate, 82.13% exceeded baseline goal of 77.86%. Lack of significant variation from re-measurement 2 may indicate a stability in interventions implemented from baseline to re-measurement 2 and may indicate sustainability.

Table 11c. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW, and TCS

BCW - Postpartum Care:

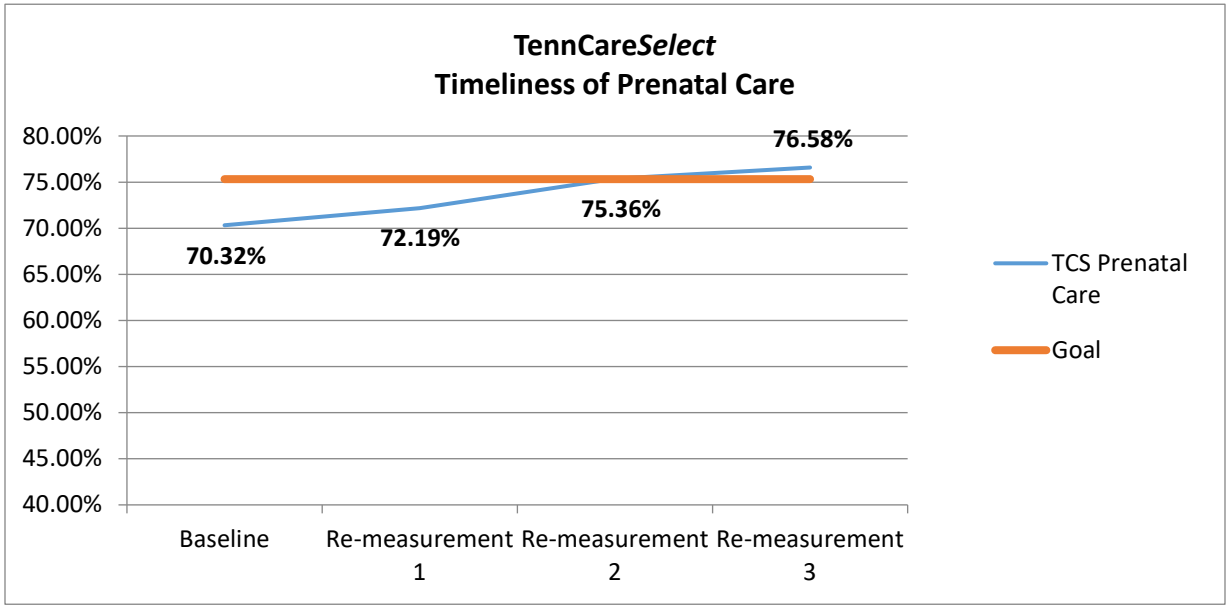


Re-measurement 2 rate 3.66% points higher than baseline and about 6.43% lower than re-measurement period 1. The current re-measurement rate did not exceed our targeted goal of 60.28% but re-measurement 1 did and additional analysis should be performed to determine change from re-measurement 1 to re-measurement 2 and we will focus on identifying the cause of the rate drop so that those barriers may be addressed.

Re-measurement 3 rates not significantly different when baseline compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.1122 and t-value of 1.59. Rates not significantly different when re-measurement 1 compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.1931 and t-value of -1.3. Rates not significantly different when re-measurement 2 compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.5917 and t-value of 0.54. Although significant variation has not been observed in comparing re-measurement 3 to any previous period, a fluctuating trend is observed and further analysis recommended in attempt to address potential barriers for implementation of additional interventions. Current rate, 59.8% has not met baseline goal of 60.28%.

Table 11c. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW, and TCS

Prenatal Care:



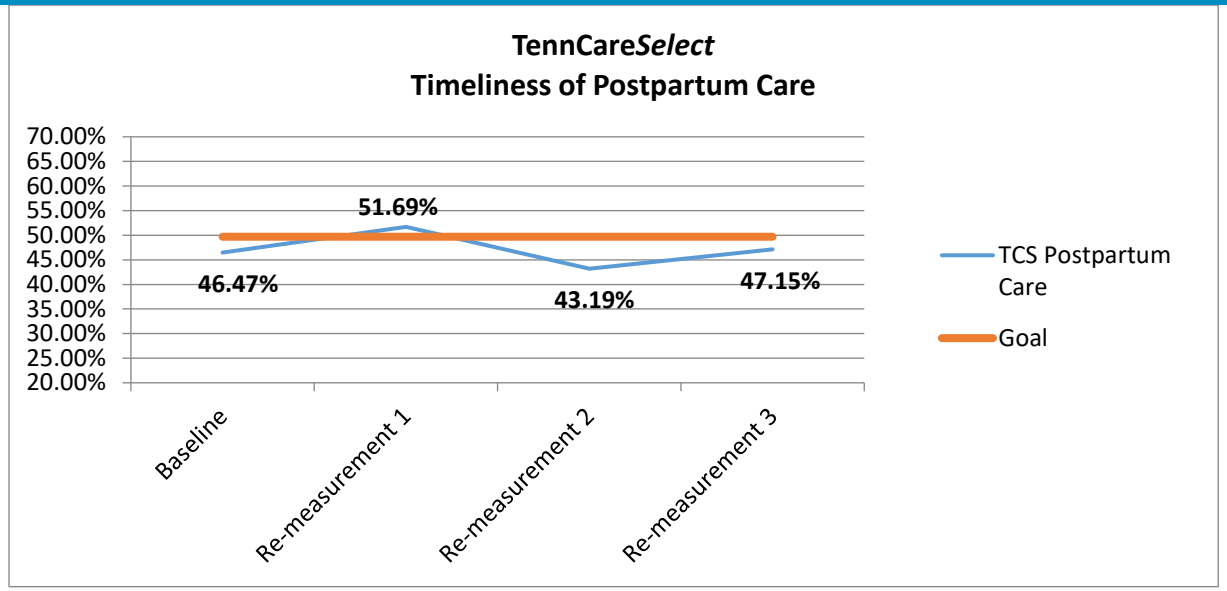
Re-measurement 2 rate did increase over 5.04% points higher than baseline and 3.17% increase from re-measurement period 1. Current rate of 75.36% did exceed targeted goal of 75.32% - meeting NCQA Minimum Effect Size Change from baseline. Although changes not statistically significant, interventions and current management of population met our goal expectations.

Re-measurement 3 rates significantly different when baseline compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.0475 and t-value of 1.99. Rates not significantly different when remeasurement 1 compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.1663 and t-value of 1.39. Rates not significantly different when remeasurement 2 compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.6606 and t-value of 0.44.

Continuous rate increase since baseline and remeasurement 2 and remeasurement 3 surpassing baseline goals suggests that interventions created since inception of PIP report have led to increase rates that have been sustainable through the last 3 remeasurement periods.

Postpartum Care:

Table 11c. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW, and TCS



Re-measurement 2 rate fell 3.28% points from baseline and 8.50% from re-measurement period 1. Due to drop in rates and lower than expected outcomes, recommend further root cause analysis to determine if drop in rate due to changes within the TennCare Select Population, intervention or other barrier.

Re-measurement 3 rates not significantly different when baseline compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.8488 and t-value of 0.19. Rates not significantly different when remeasurement 1 compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.2498 and t-value of - 1.15. Rates significantly different when remeasurement 2 compared to re-measurement 3 using T-test to compare population mean with a p-value of 0.2999 and t-value of 1.04.

Fluctuation in rates since the inception of PIP report suggest that interventions have not led to desired outcomes, consistently. At this point, assessment of rates and significant testing over the last three remeasurement periods does not support sustainable outcomes.

Re-measurement 3:

Prenatal Care:

Repeated measurements over comparable time periods demonstrate sustained improvement. If declines or no significant changes are observed over time, results and causes are analyzed.

- *For Prenatal Care, each line of business has exceeded baseline goal. Continuous improvement in rates suggest interventions impacted rates and sustainability of current outcomes.*

Table 11c. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW, and TCS	
Postpartum Care: ***Repeated measurements over comparable time periods demonstrate sustained improvement. If declines or no significant changes are observed over time, results and causes are analyzed.*** • *For Postpartum Care, each line of business has experienced completely different outcomes despite the same interventions being applied to each line of business. Because of the variation in outcomes, current assessment cannot conclude if rate variation due to ongoing intervention or assess sustainability in outcomes.* ***This PIP is retiring. This is the final submission for this PIP.***	
EQRO Discussion	The MCO [**BC** all regions and **TCS**] included graphs for both study indicators to illustrate the percentage changes from Baseline to Remeasurement 3. The MCO [**BCE**] reported that sustained improvement occurred in Timeliness of Prenatal Care rates based on a significant increase from Baseline to Remeasurement 3, that the continuous rate increases suggest that interventions implemented have led to the improvement, and that the rate exceeded the baseline goal. For Postpartum Care rates, the MCO reported there were no significant changes between measurement years and that the fluctuations in rates suggest a downward trend, indicating further analysis is needed to address potential barriers for implementation of additional interventions. The MCO [**BCM**] noted that Timeliness of Prenatal Care rates increased from Baseline to Remeasurement 3 and suggested that the significant increase achieved at Remeasurement 2 was sustained at Remeasurement 3 despite lack of significant variation from Remeasurement 1 and 2 to Remeasurement 3. In addition, the baseline goal was exceeded. For Postpartum Care rates, the MCO observed continuous increases in rates, along with statistically significant variations that suggest positive impact from ongoing interventions. For Timeliness of Prenatal Care rates, the MCO [**BCW**] reported Remeasurement 3 rates increased significantly from Baseline and Remeasurement 1; however, lack of significant variation from Remeasurement 2 may indicate the significant increase achieved at Remeasurement 2 was sustained at Remeasurement 3. In addition, the baseline goal was exceeded. For Postpartum Care rates, the MCO reported that a fluctuating trend was observed and further analysis needed to address potential barriers for implementation of additional interventions. The MCO [**TCS**] reported that sustained improvement occurred in prenatal care rates based on significant increases from Baseline to Remeasurement 3, and the continuous rate increases suggest that interventions implemented have led to the improvement, and exceeded the baseline goal. For postpartum care rates, the MCO reported there were no significant changes between measurement years, that the fluctuations in rates suggest interventions did not lead to desired outcomes, and that results do not support sustained improvement. The MCO did not report the significant decline from Remeasurement 1 to Remeasurement 2, and incorrectly reported the difference between Remeasurement 2 and Remeasurement 3 as a statistically significant increase. For postpartum care rates, the MCO should correctly describe the lack of significance in comparing Remeasurement 2 to Remeasurement 3.

Table 11c. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW, and TCS	
Improving Provider Satisfaction Survey (PSS) Response Rates	
Validation Status	Met
Study Population	

1. The study population is accurately and completely defined. (Critical Element)

Baseline through Remeasurement 2:

The study population consists of all providers eligible to participate in one of the three surveys used in the annual Provider Satisfaction Report deliverable to TennCare. These surveys, and the eligibility criteria for each are shown below:

1. *Network Enrollment Survey – all newly enrolled providers within the measurement year to the BlueCare network*
2. *Network Recredentialing – all BlueCare providers who went through the recredentialing processing during the measurement year*
3. *Provider Satisfaction - All Primary care, specialists, and behavior health providers participating in the BlueCare network who:*
   - *Were not under special investigation*
   - *Were not surveyed within the past 12 months*
   - *Filed at least ten BlueCare claims within 12 months from the date of survey*
   - *Had a valid email address registered with our health plan*

Remeasurement 3:

The study population consists of all provider TINs eligible to participate in the Provider Satisfaction Report deliverable to TennCare. These surveys, and the eligibility criteria for each are shown below:

1. *Provider Satisfaction - All TINs that include primary care, specialists, and behavior health providers participating in the BlueCare network who:*
   - *Were not under special investigation*
   - *Filed at least one BlueCare claim within 12 months from the date of survey*
   - *Had a valid email address registered with our health plan*

2. The study population includes requirements for the length of an enrollee's enrollment in the MCO and captures all enrollees to whom the study question applies. (Critical Element)

Baseline to Remeasurement 2:

BlueCare Providers are the target of this study and will focus on his/her interaction with the health plan so that we can monitor barriers in providing quality care to members. No provider meeting the specified requirements for this population will be excluded from the sample pool.

There are no requirements for the length of an enrollee's enrollment in BlueCare (East, Middle, or West) as it relates to primary care, specialist and behavior health providers being eligible for inclusion into the study.

Table 11c. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW, and TCS

Remeasurement 3

BlueCare Provider TINs are the target of this study and will focus on his/her interaction with the health plan so that we can monitor barriers in providing quality care to members. All providers meeting the specified requirements for this population will be included in study.

There are no requirements for the length of an enrollee's enrollment in BlueCare (East, Middle, or West) as it relates to primary care, specialist and behavior health providers being eligible for inclusion into the study.

The study population…

1. ***The study population is accurately and completely defined. (Critical Element)***

Baseline through Remeasurement 2

The study population consists of all providers eligible to participate in one of the three surveys used in the annual Provider Satisfaction Report deliverable to TennCare. These surveys, and the eligibility criteria for each are shown below:

1. *Network Enrollment Survey – all newly enrolled providers within the measurement year to the BlueCare network*
2. *Network Recredentialing – all BlueCare providers who went through the recredentialing processing during the measurement year*
3. *Provider Satisfaction - All Primary care, specialists, and behavior health providers participating in the BlueCare network who:*
   - *Were not under special investigation*
   - *Were not surveyed within the past 12 months*
   - *Filed at least ten BlueCare claims within 12 months from the date of survey*
   - *Had a valid email address registered with our health plan*

Remeasurement 3

The study population consists of all provider TINs eligible to participate in the Provider Satisfaction Report deliverable to TennCare. These surveys, and the eligibility criteria for each are shown below:

1. *Provider Satisfaction - All TINs that include primary care, specialists, and behavior health providers participating in the BlueCare network who:*
   - *Were not under special investigation*
   - *Filed at least one BlueCare claims within 12 months from the date of survey*
   - *Had a valid email address registered with our health plan*

2. ***The study population includes requirements for the length of an enrollee's enrollment in the MCO and captures all enrollees to whom the study question applies. (Critical Element)***

Baseline to Remeasurement 2

TennCareSelect Providers are the target of this study and will focus on his/her interaction with the health plan so that we can monitor barriers in providing quality care to members. No provider meeting the specified requirements for this population will be excluded from the sample pool.

There are no requirements for the length of an enrollee's enrollment in TennCareSelect (East, Middle, or West) as it relates to primary care, specialist and behavior health providers being eligible for inclusion into the study.

Remeasurement 3

TennCareSelect Provider TINs are the target of this study and will focus on his/her interaction with the health plan so that we can monitor barriers in providing quality care to members. All providers meeting the specified requirements for this population will be included in study.

Table 11c. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW, and TCS

There are no requirements for the length of an enrollee's enrollment in TennCareSelect (East, Middle, or West) as it relates to primary care, specialist and behavior health providers being eligible for inclusion into the study.

Interventions and Improvement Strategies

1. ***Whether they are related to causes/barriers identified through data analysis and quality improvement processes. (Critical Element)***
   The primary barriers accounting for low provider response rates were related primarily to the long length of the survey, limitations and requirements of paper only surveys and the possibility of providers receiving multiple surveys for multiple lines of business. The interventions specifically targeted these barriers to create a shorter survey with multiple formats in order to improve ease of submission for providers. The distribution hierarchy was used to eliminate the possibility of providers getting multiple surveys as well as target providers with a minimum number of claims per line of business to ensure adequate activity for that line of business. The specific timeline of survey distribution allowed for increased focus on provider responses.
2. ***Whether they are system changes that are likely to induce permanent change.***
   Do to the success of electronic surveys and noted preference of providers to receive electronic communications the electronic email survey will continue and increase as additional email addresses are obtained from providers. Provider selection per the claims date submission hierarchy will continue. The survey distribution time line window will also continue with dates based on current business needs.
3. ***Whether they are revised if original interventions are not successful.***
   Although the All Blues Workshops were successful in direct contact with providers and onsite survey responses, provider requests for electronic communication indicate time and cost are better placed at the email survey format. All Blues Workshops were utilized to educate providers on the survey and promote the electronic options by obtaining email addresses.

4. ***Whether they are standardized and monitored if interventions are successful.***
   The electronic survey format and distribution hierarchy based on claims data will be utilized again this year.

Describe interventions:

Decreasing the number of questions and expanding the survey delivery mechanisms produced the desired outcome, which was an increase in response rate. A workgroup was established to evaluate the existing survey tool. The survey was redesigned with a reduced number of questions. A hierarchy was established based on claims volume in order to target appropriate providers by line of business/contract. Surveys were distributed in person beginning in August 2016 at the All Blues Workshops and continued via paper and email distribution with responses accepted through December 2016. Email reminders were utilized when possible to encourage provider responses.

Baseline to Remeasurement 1:

East	*2015*	***2016***
Surveys Sent:	*5,583*	*3,184*
Surveys Returned:	*290*	*603*
Response Rate:	*5.19%*	*18.94%*

Middle	*2015*	***2016***
Surveys Sent:	*5,397*	*2,774*
Surveys Returned:	*230*	*475*
Response Rate:	*4.26%*	*17.12%*

West	*2015*	***2016***
Surveys Sent:	*3,834*	*2,057*
Surveys Returned:	*206*	*300*
Response Rate:	*5.37%*	*14.58%*

Table 11c. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW, and TCS

Overall	*TCS*	
	2015	*2016*
Surveys Sent	*5,583*	*6,058*
Surveys Returned	*290*	*907*
Response Rate	*5.19%*	*14.97%*

Remeasurement 1 to Remeasurement 2:

Describe interventions/improvement strategies. *Thoroughly discuss interventions implemented during each measurement period. The interventions should address the following required evaluation elements:*

Based on other deliverables, 19 questions Provider Satisfaction survey increased to 24 questions. Five additional questions resolved around member wait times which pertain to a separate TennCare deliverable. Based on prior results, it was observed that there is a potential correlation between response rates and number of questions asked however business obligations meant that additional questions be added to the provider satisfaction survey.

1. ***Whether they are related to causes/barriers identified through data analysis and quality improvement processes. (Critical Element)***
   The additional questions added to the provider satisfaction survey were not related to barriers discovered within this study but due to barriers within satisfying other business requirements. Specifically, the five additional questions added to the survey relate to patient wait times and exploring if collecting this information from providers was a valid avenue to minimize collection via other means.

2. ***Whether they are system changes that are likely to induce permanent changes.***
   The additional questions added to provider satisfaction were meant to test whether collecting patient wait times from providers was a valid and reliable collection source. Further analysis of the outcomes compared to other collection channels for this same information will be assessed for future provider satisfaction surveys.

3. ***Whether they are revised if original interventions are not successful.***
   The implementation of two interventions has led to strong successful outcomes including reduction of provider satisfaction question and changing a paper survey to an electronic survey. The response rates pertaining to the provider satisfaction survey displayed very strong outcomes and were successful. The current modification of adding five questions may have led to the current reduction of provider satisfaction responses and will be addressed to determine if the reduction of response rates outweighs the benefits of patient wait time data being collected.

4. ***Whether they are standardized and monitored if interventions are successful.***
   Provider Satisfaction response rates are monitored. There has been an increase in response rates since the conversion from paper to electronic delivery. The addition of five questions during remeasurement 2 led to a reduction in response rates from remeasurement 1 to remeasurement 2 however; there have still been strong increases in response rates from baseline to remeasurement 2.

Table 11c. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW, and TCS

Remeasurement 2 to Remeasurement 3:

Describe interventions/improvement strategies. *Thoroughly discuss interventions implemented during each measurement period. The interventions should address the following required evaluation elements:*

The Provider Satisfaction survey decreased from 24 questions to 21 questions. The Provider Satisfaction survey tool was redesigned to include questions related to re-credentialing and enrollment. So, a separate survey for the provider re-credentialing and provider enrollment surveys were removed. Based on prior results, it was observed that there is a potential correlation between response rates and number of questions asked. The Provider Satisfaction survey decreased because the Division of TennCare could not do a true comparison between MCO's. Therefore, collaborative meetings were held between the Division of TennCare and all 3 MCO's to align the Provider Satisfactions Survey questions and collection methods.

1. ***Whether they are related to causes/barriers identified through data analysis and quality improvement processes. (Critical Element)***
   The methodology for collecting results were not related to barriers discovered within this study but The Division of TennCare began comparing results from all MCOs and discovered that each health plan had slightly different methodology for collecting results. In order to compare Provider Satisfaction results to other MCO's, TennCare directed the MCOs to align their collection methods. Therefore in 2018, the Provider Satisfaction survey was conducted at the Provider TIN level. There are fewer TINs than individual provider IDs. As a result all providers meeting the required criteria were surveyed. This change to the reporting unit and in sampling during remeasurement 3 makes comparisons across time difficult.

2. ***Whether they are system changes that are likely to induce permanent changes.***
   Changes to the Provider Satisfaction survey questions and collection methods, during remeasurement 3 removed the provider re-credentialing and provider enrollment survey's and improved response rates. Changing the reporting unit from random sample of individual providers to 100% of provider TINs made during remeasurement 3 may impact the validity of response rate comparisons. However, the current survey method (email) along with reduced volume of questions appears sustainable and it would be expected that we would have higher survey responses by maintaining this methodology.

3. ***Whether they are revised if original interventions are not successful.***
   Although the All Blues Workshops were successful in direct contact with providers and onsite survey responses, provider requests for electronic communication indicate time and cost are better placed at the email survey format. However, the All Blues Workshops were utilized to educate providers on the survey and encourage providers to give feedback.
   The implementation of two interventions has led to strong successful outcomes including reduction of provider satisfaction questions this includes removal of the provider re-credentialing and provider enrollment surveys and changing collection methods (Provider Satisfaction Surveys conducted at the Provider TIN Level). The response rates pertaining to the provider satisfaction survey displayed very strong outcomes and were successful.

4. ***Whether they are standardized and monitored if interventions are successful.***
   Provider Satisfaction response rates are monitored. There has been an increase in response rates since the conversion from paper to electronic delivery. In 2018, the survey was conducted at the Provider TIN level. This change was the main intervention done from

Table 11c. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW, and TCS

remeasurement 2 to remeasurement 3. As a result all providers meeting the required criteria were surveyed. This change to the reporting unit and in sampling during remeasurement 3 makes comparisons across time difficult.

The current survey method (email) along with reduced volume of questions appears sustainable and it would be expected that we would have higher survey responses by maintain this methodology. The significant increase in response rates and surpassing baseline goals suggests that current interventions have impacted the overall response rate and continued efforts may continue to improve outcomes.

Summary of Performance

Repeated measurements over comparable time periods demonstrate sustained improvement, or that a decline in improvement is not statistically significant.

Remeasurement 2:

Interventions to provider satisfaction surveys such as reduction of study question and delivery method appears to have positive impact to response rates. When questions are reduced, provider response rates go up – this trend was observed in both remeasurement 1 and remeasurement 2 with statistical significance. Likewise, the shift from mail responses to electronic collection methods also led to an improvement in response rates. The changes made from this study will be ongoing. The increase from baseline to remeasurement 1 and remeasurement 2 suggests that changes implemented in this study have helped improve the overall response rate in provider satisfaction surveys.

Remeasurement 3:

Interventions to provider satisfaction surveys such as reduction of study question and delivery method appears to have positive impact to response rates. Assessment from remeasurement 1 through remeasurement 2 supports this notion. When the number of questions was reduced, provider response rates went up – this trend was observed in both remeasurement 1 and remeasurement 2 with statistical significance. Likewise, the shift from mail responses to electronic collection methods also led to an improvement in response rates. Changes done, at the request of TennCare, during remeasurement 3 removed the provider re-credentialing and provider enrollment surveys and improved response rates even more. Changing the reporting unit from a random sample of individual providers to 100% of provider TINs made during remeasurement 3 may impact the validity of response rate comparisons. The current survey method (email) along with reduced volume of questions appears sustainable and it would be expected that we would have higher survey responses by maintaining this methodology.

BlueCare is retiring this PIP and will continue to monitor, track and trend the interventions that have been shown to have an impact on response rates.

The grid below shows the overall analysis tables with year over year comparisons.

Overall	BCE				BCM				BCW			
	2015	**2016**	**2017**	**2018**	**2015**	**2016**	**2017**	**2018**	**2015**	**2016**	**2017**	**2018**
Surveys Sent	5,583	3,184	3,315	291	5,397	2,774	2,417	251	3,834	2,057	1,623	158
Surveys Returned	290	603	336	78	230	475	231	73	206	300	142	35
Response Rate	5.19%	18.94%	10.14%	26.80%	4.26%	17.12%	9.56%	29.08%	5.37%	14.58%	8.75%	22.15%

Table 11c. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW, and TCS

Overall	TCS			
	2015	2016	2017	2018
Surveys Sent	13,557	6,058	6,411	186
Surveys Returned	708	907	607	700
Response Rate	5.22%	14.97%	9.47%	26.57%

EQRO Discussion

BCE reported statistically significant increases in rates from Baseline to Remeasurements 1, 2, and 3. The MCO indicated improvement in rates occurred as a result of the interventions that included the reduction of survey questions and survey delivery methodology during Remeasurement 1 through Remeasurement 2, and the further reduction of survey questions and removal of provider recredentialing and enrollment surveys during Remeasurement 3. The MCO noted that the change from individual sampling to 100% of provider TINs during Remeasurement 3 may have affected the validity of response rate comparisons. The MCO concluded that the interventions (reducing survey questions, changing the survey methodology, and eliminating provider recredentialing and enrollment surveys) positively influenced the rate increases. The MCO will continue to monitor, track, and trend the interventions and corresponding rates.

BCM reported statistically significant increases in rates from Baseline to Remeasurements 1, 2, and 3. The MCO indicated improvement in rates occurred as a result of the interventions that included the reduction of survey questions and survey delivery methodology during Remeasurement 1 through Remeasurement 2, and the further reduction of survey questions and removal of provider recredentialing and enrollment surveys during Remeasurement 3. The MCO noted that the change from individual sampling to 100% of provider TINs during Remeasurement 3 may have affected the validity of response rate comparisons. The MCO concluded that the interventions (reducing survey questions, changing the survey methodology, and eliminating provider recredentialing and enrollment surveys) positively influenced the rate increases. The MCO will continue to monitor, track, and trend the interventions and corresponding rates.

BCW reported statistically significant increases in rates from Baseline to Remeasurements 1, 2, and 3. The MCO indicated improvement in rates occurred as a result of the interventions that included the reduction of survey questions and survey delivery methodology during Remeasurement 1 through Remeasurement 2, and the further reduction of survey questions and removal of provider recredentialing and enrollment surveys during Remeasurement 3. The MCO noted that the change from individual sampling to 100% of provider TINs during Remeasurement 3 may have affected the validity of response rate comparisons. The MCO concluded that the interventions (reducing survey questions, changing the survey methodology, and eliminating provider recredentialing and enrollment surveys) positively influenced the rate increases. The MCO will continue to monitor, track and trend, the interventions and corresponding rates.

TCS reported statistically significant increases in rates from Baseline to Remeasurements 1, 2, and 3. The MCO indicated improvement in rates occurred as a result of the interventions that included the reduction of survey questions and survey delivery methodology during Remeasurement 1 through Remeasurement 2, and the further reduction of survey questions and removal of provider recredentialing and enrollment surveys during Remeasurement 3. The MCO noted that the change from individual sampling to 100% of provider TINs during Remeasurement 3 may have affected the validity of response rate comparisons. The MCO concluded that the interventions (reducing survey questions, changing the survey

Table 11c. Performance Summary for 2019 PIPs ≥ Three Years: BCE, BCM, BCW, and TCS	
	methodology, and eliminating provider recredentialing and enrollment surveys) positively influenced the rate increases. The MCO will continue to monitor, track, and trend the interventions and corresponding rates.

Table 11d. Performance Summary for 2019 PIPs ≥ Three Years: TCS	
Improving the Rate of Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	
Validation Status	Met
Study Population	
The study population includes TennCareSelect Medicaid enrolled members ages three to six as of December 31st of the baseline or remeasurement year with no more than a 45 day gap in enrollment during the baseline or remeasurement period and enrolled with the health plan as of December 31st of the baseline or remeasurement year. The population for this study is based off specific Guidelines for Utilization Measures Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life; which includes clear definitions for inclusion, exclusion, diagnosis criteria, and enrollment criteria as described in the NCQA Volume 2 HEDIS Technical Specifications. Study population includes the entire TennCareSelect member population who met the Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) measure criteria based on HEDIS specifications and no one who meets the criteria was excluded from the study.	
Interventions and Improvement Strategies	
Describe interventions: *In October 2015 the Childhood Wellness/ TennCare kids workgroup was established in to identify barriers, assess effectiveness of interventions and develop further interventions as needed through brainstorming processes to improve the HEDIS W34 quality performance measure and EPSDT screening rates in children. The purpose of this multidisciplinary team is to design, develop and monitor effectiveness of member and provider interventions to improve screenings rates and ultimately health outcomes in children.* *The TennCare Kids workgroup includes representation from Clinical Quality Improvement, Information Delivery/HEDIS Analytics, Member Education and Community Outreach. This team meets regularly to identify and address barriers, analyze data, oversee the implementation of interventions for improvement, and evaluate the effectiveness or impact of interventions on the W34 and CMS 416 rates.* *Identified barriers and proposed interventions are reported to BlueCare Tennessee quality committees for feedback, suggestions and approval. The CMS-416 and other available resources (i.e. Financial and Clinical Insight Report, Racial/Ethnic Health Disparity Population Assessment, hot spot maps, HEDIS Compliance Impact Reports and Gap Lists) as well as our monthly contact files were utilized to analyze screening rates by region and base our efforts.* *An analysis was requested to evaluate the effectiveness of regular outreach including but not limited to ongoing reactive and inactive mailings.* *Members with gaps in care received outreach telephonically and by mail to educate on the importance in obtaining well care visits though the Member Centric Decision Management (MCDM) process.* *Community Outreach has developed relationships with providers and other community partners, including delivery systems and Health Departments, to schedule events and reach the target market members and focus on assuring that these members have access to and receive appropriate EPSDT/TennCare Kids services.*	

Table 11d. Performance Summary for 2019 PIPs ≥ Three Years: TCS

HEDIS focus of the month messages are developed to educate staff on the importance of well care visits, and to provide and encourage consistent messaging to members and providers.

The effectiveness of interventions will be monitored on an ongoing basis utilizing BlueCare Tennessee's HEDIS Performance Indicator Reports to determine any trends, evaluate outcomes, and plan future actions.

The HEDIS Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life rate will be assessed annually and compared to goal and 90th percentile Medicaid Quality Compass benchmark.

Baseline to Remeasurement 1:

In 2016 the TennCare kids workgroup continued to meet routinely to identify and address barriers, analyze data and oversee the implementation of interventions for improvement to increase the HEDIS W34 quality performance measure and EPSDT screening rates in children. The Provider Quality Program collaborated with high volume practices to facilitate initiatives to improve clinical outcomes, develop strategies for providers and to conduct patient-focused interventions.

Based on an analysis of the SSI population and barriers identified, many times they have other health conditions and well child checkups are not the highest on the list of priorities and have low screening rates. An SSI postcard reminder was developed educating members on statewide community resources, transportation availability and encourage them to follow up with their PCP to close gaps in care. Children in DCS custody were identified and their gaps were communicated directly to the resource parent along with education on closing the gaps.

In the 3rd Q 2016 an indicator scorecard was mailed to BlueCare Tennessee members, providing a list of all of the preventive screenings/tests including W34 screening that are appropriate for their age and gender according to the 2016 HEDIS specs. Members were offered a gift card to close the W34 gap in care.

Our Monthly Contact Files and Hot Spot maps for well child visits are our primary data source for what counties we need to target for well child screenings which help in tailoring our initiatives to meet the needs of the populations. We continue to work with DCS and notify them of any children who are due or past due for screenings.

An analysis was requested to evaluate the effectiveness of regular outreach including but not limited to ongoing reactive, inactive mailings, Hispanic mailing and the EMED member scorecard.

The TennCare Kids workgroup and Population Health Improvement Committee are internal committees, which monitor initiatives and interventions, as well as their effectiveness. These committees also routinely monitor the CMS-416 rates, and analyze the screening and participation rates by age group, gender, ethnicity, and county as well as monitor other key metrics.

Remeasurement 1 to Remeasurement 2:

Ongoing Interventions include the following:

- *Inactive mailer – ongoing, every January, age 1-20*
- *Reactive mailer – for Hispanic and SSI populations age 3-20*
- *QCR – ongoing*
- *EMED Scorecard – ongoing, annual, all ages*
- *Inactive phone calls – ongoing, every July, age 1-20, currently doing pilot to test different timing schedule*

In the TennCareSelect population inactive mailers are mailed to members ages 1-20 every January. In 2017 the TennCare Kids workgroup continued to meet routinely to identify and address barriers, analyze data and oversee the implementation of interventions for improvement to increase the HEDIS W34 quality performance measure and EPSDT screening rates in children. The Provider Quality Program collaborated

Table 11d. Performance Summary for 2019 PIPs ≥ Three Years: TCS

with high volume practices to facilitate initiatives to improve clinical outcomes, develop strategies for providers and to conduct patient-focused interventions.

Reactive mailers continued to be mailed to the TennCareSelect Hispanic and SSI populations ages 3-20.

An indicator EMED ScoreCard has continued to be mailed to the TennCareSelect population. This provides a list of all of the preventive screenings/tests including W34 screening that are appropriate for their age and gender according to the 2018 HEDIS specs.

Inactive phone calls are ongoing for TennCareSelect members. These are completed in July for ages 1-20. Currently we are doing a pilot to test different timing schedules.

Our Monthly Contact Files and Hot Spot maps for well child visits are our primary data source for what counties we need to target for well child screenings which help in tailoring our initiatives to meet the needs of the populations. We continue to work with DCS and notify them of any children who are due or past due for screenings.

The TennCare Kids workgroup and Population Health Improvement Committee are internal committees, which monitor initiatives and interventions, as well as their effectiveness. These committees also routinely monitor the CMS-416 rates, and analyze the screening and participation rates by age group, gender, ethnicity, and county as well as monitor other key metrics.

Remeasurement 2 to Remeasurement 3:

Ongoing Interventions include the following:

- *Inactive mailer – ongoing, every January, age 1-20*
- *Reactive mailer – for Hispanic and SSI populations age 3-20*
- *QCR – ongoing*
- *EMED Scorecard – ongoing, annual, all ages*
- *Inactive phone calls – ongoing, every July, age 1-20, currently doing pilot to test different timing schedule*

Reactive mailers continued to be mailed to the TennCareSelect Hispanic and SSI populations ages 3-20.

An indicator EMED ScoreCard has continued to be mailed to the TennCareSelect population. This provides a list of all of the preventive screenings/tests including W34 screening that are appropriate for their age and gender according to the 2019 HEDIS specs.

Interactive phone calls are ongoing for TennCareSelect members. These are completed in July for ages 1-20.

In this remeasurement period several interventions were introduced to impact rates from the perspectives of the member, provider and health plan.

Texting: *Outreach texts began providing education and encouragement for member to receive important well-care visits. Enrolling members under 18 also began during this time.*

Integrated Appointment Scheduling: *BlueCare collaborated with an integrated appointment scheduling platform in order to improve appointment scheduling rates. This allows BlueCare Member Education Specialists to directly access provider appointment inventory while on the phone with members. This allows BlueCare staff to schedule the member immediately, instead of relying on the member to schedule at a later time. This platform streamlines the process of scheduling by eliminating the need for the BlueCare staff to call the provider office and coordinate appointment scheduling on the phone with the office and the member. By utilizing this platform, the BlueCare Specialists can place the member directly onto provider office schedule.*

Table 11d. Performance Summary for 2019 PIPs ≥ Three Years: TCS
Additionally, this platform provides text/email/call reminder capability for providers that may not have this resource. The platform also automates transportation scheduling and appointment reminders. Providers are able to report appointment attendance using this technology. As another benefit, providers receive face-to-face support and education regarding this technology and workflow. This has provided an opportunity to build relationships with providers and to identify needs and opportunities for partnerships. 100% of participating providers reported that the platform was valuable to their practice and they would recommend other providers to work with BlueCare. *This process has allowed an easier process that improves the experience for the provider office, member, and Blue Care staff. Phone call times decreased by 9 minutes, and appointment scheduling increased by 104%. By making this change, BlueCare was able to increase the number of members receiving the EPSDT screenings that are vital to their healthcare.* *Tennessee Primary Care Association (TPCA): Partnered with TPCA to provide backpack incentives. Backpacks were filled with school supplies and also included well-care messaging to educate and encourage timely well-care. These backpacks were handed out by providers to members who attended well-care visits.* ***PCMH:** Quarterly face-to-face meetings occurred for PCP's in the PCMH program-education was provided about members with gaps in care and educational resources were shared and FAQ's addressed.* ***KaBOOM:** Assisted in building playgrounds with well-care related signage in underserved areas of Nashville.* ***United Way of Greater Nashville:** By partnering with United Way, provided well-care messaging on the 2-1-1 helpline.* ***Read20:** With Read20 BlueCare assisted in building a mobile library in an underserved Chattanooga elementary school. This included providing backpacks with school supplies as well as well-care messaging.* ***Imagination Library:** Collaborated with Imagination Library to provide well-care information in 121,000 books that were sent to young children.* ***SignalCenter Inc.:** Through this initiative, provided Train the Trainer sessions for 38 early childhood educators in order to increase awareness and education related to importance of well-care screening.* ***Memphis Dream Center:** Packed and distributed backpacks with healthy meals and well-care messaging to 9 elementary schools.*
Summary of Performance
The study question for this study was do targeted member, provider and health plan interventions improve Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)? • *The W34 rate has shown a slight decrease from baseline but administrative and hybrid rates were not statistically significant, meaning the interventions have not impacted the overall rate. Out of state members within the TennCareSelect population appear to be the biggest barrier in reaching targeted goals and also skew analysis on the overall study due to the percentage of out-of-state members fluctuating within each year of the study. Out of state member data is unable to be fully captured and this further drives the rate down.* • *Sustained improvement has yet to be shown from baseline through re-measurement 2, and there is no significant variance from baseline to re-measurement 2. New interventions will be designed and implemented during the next measurement year. Current interventions will continue to be evaluated for effectiveness, and redesigned as necessary. A major focus will be placed on capturing out of state member data as well as reaching a majority of the population with in-state intervention efforts.* • *Sustained improvement has yet to be shown from baseline through re-measurement 2. There is no significant variance from baseline to re-measurement 2.*

Table 11d. Performance Summary for 2019 PIPs ≥ Three Years: TCS
• *In conclusion, overall rates, hybrid and administrative had a slight decreased from baseline but administrative and hybrid rates were not statistically significant. Out of state members within the W34 population appear to be the biggest barrier in reaching targeted goals and also impair analysis on overall study due to the percentage of out-of-state members fluctuating within years of study.* • *Out of state member data is unable to be captured and this further drives the rate down. Final submission rates show a decrease year over year, we will continue interventions and re-measurement of study will be completed in the next cycle.* ***Remeasurement 3:*** *Repeated measurements over comparable time periods demonstrate sustained improvement. If declines or no significant changes are observed over time, results and causes are analyzed* ***Baseline to Remeasurement 3:*** *Proportions are significantly different comparing Baseline to Remeasurement 3 using a T-test with a p-value of 0.0051 and t-value of 2.81.* ***Remeasurement 1 to Remeasurement 3:*** *Proportions are significantly different comparing Remeasurement 1 to Remeasurement 3 using a T-test with a p-value of <0.0001 and t-value of 4.18.* ***Remeasurement 2 to Remeasurement 3:*** *Proportions are significantly different comparing Remeasurement 2 to Remeasurement 3 using a T-test with a p-value of 0.0012 and t-value of 3.24.* *Explain sustained improvement, sustained declines, or lack of change in all study indicators over time.* *Remeasurement 3 saw statistically significant increases in comparison to all previous remeasurement periods. Increases appear to be a result of recent population changes (declines during the remeasurement period) and ongoing interventions. Assessment on population lost appears to have removed a high volume of non-engaged members resulting in higher rates.*

EQRO Discussion	The MCO reported statistically significant increases between Baseline and Remeasurement 3, between Remeasurement 1 and Remeasurement 3, and between Remeasurement 2 and Remeasurement 3. The MCO stated that increases appear to be a result of recent population changes (declines during the remeasurement period) and ongoing interventions. The MCO concluded that the assessment revealed that a high volume of non-engaged members were removed from the population, which resulted in higher rates.

Table 11e. Performance Summary for 2019 PIPs ≥ Three Years: UHC	
Improving Medication Adherence for Major Depression Disorder (AMM)	
Validation Status	Met
Study Population	
The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported.	

Table 11e. Performance Summary for 2019 PIPs ≥ Three Years: UHC

1. *Effective Acute Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).*
2. *Effective Continuation Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).*

Ages	*18 years and older as of April 30 of the measurement year.*
Continuous enrollment	*105 days prior to the IPSD through 231 days after the IPSD.*
Allowable gap	*One gap in enrollment of up to 45 days. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).*

Description	***Prescription***		
Miscellaneous antidepressants	• *Bupropion*	• *Vilazodone*	• *Vortioxetine*
Monoamine oxidase inhibitors	• *Isocarboxazid* • *Phenelzine*	• *Selegiline* • *Tranylcypromine*	
Phenylpiperazine antidepressants	• *Nefazodone*	• *Trazodone*	
Psychotherapeutic combinations	• *Amitriptyline-chlordiazepoxide* • *Amitriptyline-perphenazine*		• *Fluoxetine-olanzapine*
SNRI antidepressants	• *Desvenlafaxine* • *Duloxetine*	• *Levomilnacipran* • *Venlafaxine*	
SSRI antidepressants	• *Citalopram* • *Escitalopram*	• *Fluoxetine* • *Fluvoxamine*	• *Paroxetine* • *Sertraline*
Tetracyclic antidepressants	• *Maprotiline*	• *Mirtazapine*	
Tricyclic antidepressants	• *Amitriptyline* • *Amoxapine* • *Clomipramine*	• *Desipramine* • *Doxepin (>6 mg)* • *Imipramine*	• *Nortriptyline* • *Protriptyline* • *Trimipramine*

Table 11e. Performance Summary for 2019 PIPs ≥ Three Years: UHC

Required Exclusion:

Exclude members who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Members who meet any of the following criteria remain in the eligible population:

- *An outpatient visit, ED visit, telehealth, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Any of the following code combinations meet criteria:*
  - *AMM Stand Alone Visits Value Set* ***with*** *Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).*
  - *AMM Visits Value Set* ***with*** *AMM POS Value Set* ***with*** *Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).*
  - *Telephone Visits Value Set* ***with*** *Major Depression Value Set.*
  - *ED Value Set* ***with*** *Major Depression Value Set.*
- *An acute or nonacute inpatient stay with any diagnosis of major depression (Major Depression Value Set). To identify acute and nonacute inpatient stays:*

Identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria.

Exclude members who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Members who meet any of the following criteria remain in the eligible population:

- *An outpatient visit, ED visit, telehealth, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Any of the following code combinations meet criteria:*
  - *AMM Stand Alone Visits Value Set* ***with*** *Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).*
  - *AMM Visits Value Set* ***with*** *AMM POS Value Set* ***with*** *Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).*
  - *Telephone Visits Value Set* ***with*** *Major Depression Value Set.*
  - *ED Value Set* ***with*** *Major Depression Value Set.*
- *An acute or nonacute inpatient stay with any diagnosis of major depression (Major Depression Value Set). To identify acute and nonacute inpatient stays:*
  1. *Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).*
  2. *Identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria.*

No one who meets criteria is excluded from the population.

Table 11e. Performance Summary for 2019 PIPs ≥ Three Years: UHC

Interventions and Improvement Strategies

Baseline to Remeasurement 1:

Baseline to Remeasurement 1: The intervention in 2016 focused on the development and initiation of the AMM Pharmacy report. This intervention focused on the practitioner and enrollee levels, with the intention of providing a system change to positively affect the targeted population on a permanent basis. UHCCP quality analysts developed a report, with the feedback from providers (3 in East TN, 2 in Middle TN, 2 in West TN) for use statewide, which identifies members who will potentially be included in AMM Effective Acute Phase Treatment. UHCCP believes by identifying and focusing efforts on those individuals in AMM Effective Acute Phase Treatment, changes will also be noted in Effective Continuation Phase Treatment. The report is populated with pharmacy claims data which is run utilizing HEDIS AMM requirements. Additionally, behavioral health service claims are used to identify if members are currently or recently in treatment from one of the pilot participants. This report includes the member's identifying information, brand name of the medication prescribed, quantity and days of supply of the dispensed medication, as well as the prescriber's name. The report also identifies where the member has received community mental health services within the last 6 months, or if they are attributed to or enrolled in THL with the identified provider. Reports are completed on a weekly basis, beginning 12/2016, and e-mailed to the pilot provider's identified contact person for review. The providers are then to designate or utilize currently assigned staff to make contact with the members to discuss the newly prescribed medication, to provide education and respond to questions the member may have about the importance of medication adherence. UHCCP quality analyst contact information is provided to the provider participants in the event there are any questions or concerns regarding the list. Quarterly touch base contacts are made with the provider's identified contact person to determine if the pilot participant is utilizing the data, how they are utilizing it and if they have run into any issues to date. This information is then used to provide any sort of education needed or to make revisions based on the issues identified. At the time of this report, two touch base contacts had been made with each provider and all identified they were using the data effectively and there were no issues identified.

Remeasurement 1 to Remeasurement 2:

The intervention in 2017 focused on UHCCP quality analysts continuing to provide weekly reports to providers (3 in East TN, 2 in Middle TN, 2 in West TN), which identified members who would potentially be included in AMM Effective Acute Phase Treatment. UHCCP hypothesized that by identifying and focusing efforts on those individuals in AMM Effective Acute Phase Treatment, changes would also be noted in Effective Continuation Phase Treatment. The report was populated with pharmacy claims data which is run utilizing HEDIS AMM requirements. Additionally, behavioral health service claims were used to identify if members were currently or recently in treatment from one of the pilot participants. This report included the member's identifying information, brand name of the medication prescribed, quantity and days of supply of the dispensed medication, as well as the prescriber's name. The report also identified where the member has received community mental health services within the last 6 months, or if they were attributed to or enrolled in THL with the identified provider. Reports are completed and e-mailed each week to the pilot provider's identified contact person for review. The providers designate or utilize staff to make contact with the members to discuss the newly prescribed medication, to provide education and respond to questions the member may have about the importance of medication adherence. Providers reach out to UHCCP quality analyst as needed with questions or concerns regarding the lists. Quarterly touch base contacts were made with the provider's identified contact person four times in 2017-18 to determine if the pilot participant was utilizing the data, how they were utilizing it and if they had run into any issues with the data. UHCCP identified two providers (1 in Middle TN, 1 in West) who were not opening their e-mails timely to review the data. Outreach was made to those providers by quality staff to educate them on the importance of reviewing the data in a manner where members could be outreached quickly. The issue was immediately resolved through this effort. In addition to quality analyst providing this outreach, BH staff also participate in quarterly THL meetings to review provider quality metrics as they related to the AMM HEDIS measure. During these meeting staff brainstormed with

Table 11e. Performance Summary for 2019 PIPs ≥ Three Years: UHC

providers to identify barriers and review their scores. UHCCP has also implemented similar value based contracting through Patient Centered Medical Homes (PCMH) and will address possible interventions with Physical Health quality staff.

Remeasurement 2 to Remeasurement 3:

There were two primary interventions in remeasurement 2. The first intervention focused on UHCCP quality analysts continuing to provide weekly reports to providers (3 in East TN, 2 in Middle TN, 2 in West TN), which identified members who would potentially be included in AMM Effective Acute Phase Treatment. After a review of the data, additional high volume THL providers were added to those receiving the weekly lists. There was one added in West Tennessee and one added in East Tennessee, who also serves Middle Tennessee. Using HEDIS® AMM requirements, pharmacy claims data was used to populate the report. Behavioral health service claims were also used to determine the appropriate THL provider, and if the individual had received mental health services from any other behavioral health provider in the last 6 months. The reports, which included the member's identifying information, brand name of the medication prescribed, quantity and days of supply of the dispensed medication, as well as the prescriber's name, were e-mailed each week to the provider's identified contact person for review. Upon review, the providers were to make contact with the members to discuss the newly prescribed medication, provide education and respond to questions the member may have about the importance of medication adherence. UHCCP analysts were available to providers as needed if there were questions or concerns regarding the lists. Touch base contacts were made with the provider's identified contact person throughout the year to determine if the pilot participant was utilizing the data, how they were utilizing it and if they had run into any issues with the data. UHCCP identified one provider in Middle TN who discontinued opening the reports early in the year and did not respond to any outreaches made to remedy this situation. Lists continued to be sent to his provider throughout the year. In addition to the quality analyst providing outreach, BH staff also participated in quarterly THL meetings to review provider quality metrics as they related to the AMM HEDIS measure. During these meetings staff worked with providers to identify barriers and review their scores. Additionally, behavioral health quality staff met with medical quality staff to determine how to most effectively provide information to the primary care/ general practitioners. It was determined one way to affect the number of members who are maintaining on antidepressant medications may be to ensure those individuals prescribed antidepressants actually needed them. UHCCP staff reviewed the SAMSHA endorsed Macarthur Depression Management tool kit and developed a one page handout regarding the use of the PHQ-9 to assist medical providers in accurately identifying the appropriate time to prescribe or refer to specialized behavioral health care. It was determined these handouts would be provided to high volume practices by clinical practice engagement consultants during face to face visits, or reviewed during trainings provided via telephone or WebEx.

Summary of Performance

During baseline to remeasurement 1, there was little fluctuation in the rates for each measure in each region. For remeasurement 1 to remeasurement 2, rates for both the effective acute and effective continuation phases of this measure in all regions saw a decrease. There were statistically significant decreases in East and West for the effective acute phase and all regions for the effective continuation phase. Upon receipt of these results, meetings have been held weekly to discuss possible reasons for the decline in rates from baseline. Data has been reviewed and as mentioned in sections VIIb and VIIIb, barriers have been revisited and interventions determined to attempt to address these issues. As previously mentioned, a consistent decrease in membership each year from baseline to remeasurement 2 period; a noticeable decline in the SPMI membership; and continuous enrollment due to TennCare' s redetermination effort may be affecting the drive for improvement. Additionally, it has been noted the national 2017 HEDIS 75th percentile benchmark standard set by the NCQA was lowered, which indicates a downward trend nationally for this measure. For remeasurement 2 to remeasurement 3, rates increased in both measures, in all regions, except for the acute phase in Middle. The rates, although improved, did not reach the benchmark for any of the regions, and were very similar to rates noted in previous measurement years. Continued decreases in membership, declines in the SPMI membership and increases in the members attributed to this measure may be contributing to the difficulty in improving member compliance with these

Table 11e. Performance Summary for 2019 PIPs ≥ Three Years: UHC	
measures, and therefore decreasing the possibility of sustained improvement. Due to the lack of sustained improvement through the 3 year cycle, it has been determine this PIP will be retired at this time.	
EQRO Discussion	The MCO described significant improvements and declines with corresponding explanations and interpretations for both indicators over the measurement years from Baseline to Remeasurement Year 3. In addition, the MCO reported that the rates did not meet the benchmark for both indicators. The MCO noted that variations in the population and the severe and persistent mental illness (SPMI) membership may have contributed to the difficulty in improving the indicators. The MCO concluded that the PIP will be retired due to lack of sustained improvement.
Increasing Health Risk Assessment (HRA) Annual Completion Rates	
Validation Status	Met
Study Population	
The study population is the non-CHOICES Medicaid membership for UHCCP in the Grand Regions of East, Middle and West Tennessee. CHOICES members are excluded from this project because every CHOICES member is required to have a comprehensive assessment, which satisfies the HRA requirements under the CRA. Subsequently, the opportunity to improve completion rates is found in the non-CHOICES Medicaid membership. There are no age or diagnoses criteria or any other exclusion criteria, and no enrollee is excluded based on special health care needs.	
Interventions and Improvement Strategies	
Baseline to Remeasurement 1: *UHCCP HRA completion interventions are designed to change behaviors of both our members and our internal staff. To achieve the goal of annual HRA completion for our entire non-CHOICES population, interventions are designed to educate on the need to attempt HRA completion at all touch points and on the health plan offering various completion methods and outreach modalities.* *From baseline to remeasurement 1, UHCCP intervention efforts directly targeting members included quarterly member newsletter articles that began with our Q3 2015 edition. These are newsletter articles are designed to educate our members on the purpose and importance of completing a health risk assessment, as well as informing them of the telephonic and internet based options for completing them.* *Our community based outreach events were also targeted as an opportunity for HRA completion due to their face-to-face nature. Therefore, supplies of both the adult and child HRAs were printed and made available to our Community Outreach team.* *Lastly, the small but vulnerable population of our members receiving services under the DIDD waiver was identified as a target so that their HRA information could accurately and adequately drive their care. A team of nurses assigned to support this population was trained on and tasked with the ensuring that this entire population received individual telephonic outreach to complete the assessment.* ***Remeasurement 1 to Remeasurement 2:*** *From remeasurement 1 to remeasurement 2, UHCCP focused our efforts on the implementation of an interactive voice response (IVR) intervention. Utilizing a vendor, Eliza, we are now able to outreach to more members for the purpose of completing a health risk assessment through automated phone calls that allow our members to answer the HRA questions telephonically. The vendor then captures the individual question responses and reports that data back to the health plan.*	

Table 11e. Performance Summary for 2019 PIPs ≥ Three Years: UHC	
Remeasurement 2 to Remeasurement 3: *From remeasurement 1 to remeasurement 2, we worked to expand the efforts of the interactive voices response (IVR) intervention implemented in the previous remeasurement cycle. With the use of IVR allowing us to more members and in a cost effective way, the health plan evaluated opportunities to expand that outreach by providing a second opportunity for members to complete the annual HRA if they did not complete it during their first outreach attempt. A decision was made to add in a second outreach attempt to be conducted once per year in February. This attempt includes all members who received a monthly annual IVR call in the 12 months prior and still have yet to complete an annual HRA. The health plan selected the timing in an effort to allow at least a minimum of 30 days between the two attempts for any given member so that we could avoid any potential member abrasion issues with too many attempts in too short of a time span.*	
Summary of Performance	
During the first year of remeasurement, we were unable to meet our baseline goal of a 35% or the industry benchmark of a 50% completion rate with rates of 9.08% in East TN, 8.56% in Middle TN and 8.59% in West TN. However, we were able to see a statistically significant improvement in our annual HRA completion rates across each of the three regions. *Although we have already experienced significant improvement between baseline and remeasurement 1, we will continue to increase our interventions and strive to meet the industry benchmark and sustain improvement in the coming measurement period.* *From measurement 1 to measurement 2 there was a statistically significant increase in our annual HRA completion rates for each of the three regions. With remeasurement 2 rates of 20.07% in East TN, 18.83% in Middle TN, and 16.74% in West TN, UHCCP experienced an increase of 10.99 percentage points or a 121.04% increase in East. It is an increase of 10.27 percentage points or a 119.98% increase in Middle, and an increase of 8.15 percentage points or a 94.88% increase in West.* *When comparing baseline to remeasurement 2, we had an increase of 12.72 percentage points or a 173.06% increase when compared to the baseline rate of 7.35% in East TN. We had an increase of 11.37 percentage points or a 152.41% increase in Middle TN when comparing remeasurement 2 to baseline, and an increase of 9.32 percentage points or a 125.61% increase in West TN.* *For remeasurement 3, we had a rate of 40.45% in East TN, 44.65% in Middle TN and a 35.78% in West TN. That is an increase of 20.38 percentage points or a 101.54% increase for East TN when compared to remeasurement 2. It is a 25.82 percentage point increase or 137.12% increase for Middle TN when compared to remeasurement 2. It is a 19.04 percentage point increase or 113.74% increase for West TN when compared to remeasurement 2.* *When comparing remeasurement 3 to baseline, we had a 33.10 percentage point increase or a 450.34% increase in East TN. From baseline to remeasurement 3, we had a 37.19 percentage point increase or a 498.53% increase in Middle TN. From baseline to remeasurement 3, we had a 28.36 percentage point increase or a 382.21% increase in West TN.* *We feel our efforts to increase the annual HRA completion rates have been successful during this measurement period and throughout the entire study as a whole. We were able to meet our baseline goal of 35% in each of the three regions, and we have been able to demonstrate sustained improvement throughout the study and significantly improved our annual HRA completion rates. While the study will be retired, we will continue with each of the interventions implemented during this study in an effort to continue to meet benchmark goal for this measure.*	
EQRO Discussion	The MCO described the success of interventions and sustained improvements made over the years from Baseline to Remeasurement 3, which was evidenced by the continuous statistically significant increases in the annual HRA completion rates.

Conclusions Drawn

To help improve MCC performance, Qsource identified strengths, suggestions, and/or AONs (**Table 12**) regardless of validation status.

Table 12. PIP Strengths, Suggestions, and AONs

PIP Topic	Identified Area for Improvement or Strength
Activity I: Choose the Study Topics	
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	**Strength:** The MCO [**BC** All Regions and **TCS**] provided a thorough description of the need for and scope of EPSDT services for eligible members bolstered by data and references.
Transitions of CHOICES Individuals	**Suggestion:** The MCO [**UHC** All Regions] should ensure that the narrative regarding the population represented in the graph is clear and accurate.
Acute Use of Opioids	**Suggestion:** The PBM should explain why the specified members with special healthcare needs were excluded from the study.
Activity III: Use a Representative and Generalizable Study Population	
Impact of Member and Provider Outreach on Immunization Rates for CIS Combo 10	**Suggestion:** The MCO [**UHC** All Regions] could include the anchor dates used to determine member age in the study population inclusion criteria.
Transitions of CHOICES Individuals	**AON:** The MCO [**UHC** All Regions] should ensure that the study population is accurately and consistently defined throughout the PIP Summary Form, particularly when describing the number and make-up of the population groups. The MCO should also ensure that information regarding continuous enrollment requirements is accurate in this activity and consistent throughout the PIP Summary Form.
Increasing Provider Use of Silver Diamine Fluoride (SDF) as a Preventive Measure	**Suggestion:** The DBM could add the specific dates used for identifying age in inclusion criteria in this section of its PIP Summary Form.
Activity IV: Select the Study Indicators	
Improve EPSDT Screening Rates in the 18–20-Year-Old Age Group	**Suggestion:** The MCO [**AG** All Regions] could consider using a benchmark closer to the State-required CMS-416 screening rate of 90%.
Increase Percentage of Members with Documented In-Home Assessment of Nine Core Elements within 90 Days	**Suggestion:** The MCO [**AG** All Regions] could set the benchmark at 90% as described in the study indicator selection details. The study indicator could also be stated simply as the HEDIS measure, as it is in Activity V, and not as an "increase" of the percentage.
Critical Incident in CHOICES Members	**Suggestion:** All information for a baseline PIP should be completed for Activities I–VI only. The MCO [**BC** All Regions] should ensure the required table in Activity IV is completed correctly and includes the baseline rate. The MCO should also ensure that data are accurate and consistent throughout the PIP Summary Form and are interpreted correctly for tables and graphs.

Table 12. PIP Strengths, Suggestions, and AONs	
PIP Topic	**Identified Area for Improvement or Strength**
Improving Provider Satisfaction Survey [PSS] Response Rates	**Suggestion:** The MCO [**BCE**] should ensure baseline results are accurately and consistently presented in the PIP Summary Form.
Transitions of CHOICES Individuals	**Suggestion:** The MCO [**UHC** All Regions] should ensure that the baseline results are accurately calculated, and include baseline results for each region. The MCO should also ensure that the population data provided for the numerator and denominator are accurate in this activity and consistent throughout the PIP Summary Form. Finally, the MCO should include starting and ending dates for the measurement period in this activity. **AON:** The MCO [**UHC** All Regions] should ensure that each study indicator aligns with the study question and allows for it to be answered.
Perception of Care Coordination	**Suggestion** [**UHC** All Regions]**:** The study indicators could be stated as they are in Activity V, including the specific question being used from each survey.
Activity V. Use Sound Sampling Methods	
Perception of Care Coordination	**AON:** For Study Indicator 1, the MCO [**UHCE** and **UHCM**] should describe the sampling methodology, including confidence level, population size, and acceptable margin of error, as well as a description of how the sample was representative of the eligible population and how sampling techniques were used in accordance with generally accepted principles of research design.
Activity VI: Use Valid and Reliable Data Collection Procedures	
Increasing the Percentage of Complex Case Management and High-Risk OB Members Who Complete the 2nd Quality of Life Survey (SF-12)	**Suggestion:** To clarify the data source, the MCO [**AG** All Regions] should include all supporting documentation in the Survey Data Source section of the PIP Summary Form.
Critical Incident in CHOICES Members	**AON:** The MCO [**BC** All Regions] should identify the correct data source (Administrative Only for this PIP) in the PIP Summary Form.
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	**Suggestion:** The MCO [**BC** All Regions] should ensure consistency in rates provided in the submitted PIP Summary Form and attachments provided.
Follow-Up after Hospitalization for Mental Illness	**Suggestion:** Though it can be inferred from the cover page, the MCO [**TCS**] should include a data collection timeline with the starting and ending dates for the measurement period in Activity VI.
Perception of Care Coordination	**Suggestion:** The MCO [**UHC** All Regions] could include information about the database used to collect and analyze PSS information.

Table 12. PIP Strengths, Suggestions, and AONs	
PIP Topic	**Identified Area for Improvement or Strength**
Increasing Provider Use of Silver Diamine Fluoride (SDF) as a Preventive Measure	**Suggestion:** Though it can be inferred from the cover page, the DBM should include a timeline in this activity for the collection of data with specific starting and ending dates for baseline and remeasurement years.
Activity VII: Analyze Data and Interpret Study Results	
Antidepressant Medication Management (AMM)	**Suggestion:** The MCO [**AG** All Regions] could state that no factors affected its ability to compare rates or specifically state any factors that may have affected the year-to-year comparisons.
Increasing Member Participation in the EPSDT Healthy Rewards Incentive Program Draft	**Suggestion:** The MCO [**AG** All Regions] should state that the change in methodology affected validity and the ability to compare results from Baseline to Remeasurement 1.
Increasing the Percentage of Complex Case Management and High-Risk OB Members Who Complete the 2nd Quality of Life Survey (SF-12)	**Suggestion:** Although the MCO [**AG** All Regions] stated that no factors affected validity and that the methodology did not change, the MCO could state that no factors were identified that could affect the ability to compare rates.
Maternal Health: Improving Prenatal and Postpartum Care Rates	**Suggestion:** The MCO [**BCM**] could correct the duplicate reporting of the Timeliness of Prenatal Care hybrid rate comparison between Baseline and Remeasurement 3, and include in its PIP Summary Form a comparison between Remeasurement 2 and Remeasurement 3 with a corresponding t-value and p-value, as shown in the form's attachment. **Suggestion:** The MCO [**TCS**] could state no factors were identified that could affect the ability to compare results from Baseline to Remeasurement 3. The MCO should correctly describe comparisons between Remeasurements 2 and 3 as not statistically significant in Activities VII and IX, having reported a p-value of 0.2999, which is not less than 0.05.
Improving Medication Adherence for Major Depression Disorder	**Strength:** The MCO [**UHC** All Regions] provided extensive discussion of its improvement strategies, which it plans to continue past the duration of the PIP. **Suggestion:** For the statistical tests conducted for each indicator, the MCO [**UHC** All Regions] could report the resulting chi-square test value for each remeasurement year.
Impact of Provider Incentives on Screening Rates for Adolescents Ages 12–21	**Strength:** The MCO [**UHC** All Regions] thoroughly described how what was learned from two pilots launched during Remeasurement 1 will guide incentive choices and structures moving forward.
Increasing Provider Use of Silver Diamine Fluoride (SDF) as a Preventive Measure	**Suggestion:** The DBM could ensure noting the correct percentage increase from one measurement year to another.

Table 12. PIP Strengths, Suggestions, and AONs	
PIP Topic	**Identified Area for Improvement or Strength**
Acute Use of Opioids	**Suggestion:** The PBM should identify factors that affect the ability to compare the baseline results with remeasurement 1 results or state that no factors were identified. The PBM could identify threats to external validity or state that no factors affected external validity. The specific test of proportions could be identified such as a z-test or chi-squared test. The p-values could be reported as p< .05 or p< .01. **AON:** The PBM should report the baseline and remeasurement results and statistical differences between measurement years for each of the three study indicators.
Decreasing Call Center Volume Related to Attestations	**Strength:** The PBM stated that the goal reductions were not met and provided an explanation for the results. **Suggestion:** The PBM reported that it identified no threats to validity or factors that could affect the ability to compare baseline to remeasurement 1 results. However, this information was mistakenly included in Activity VII of the old form, rather than Activity VIII in the old form. The PBM could ensure that it organizes study information correctly for Remeasurement 2. In addition, the PBM could report the p-values as p< .05 or p< .01. The PBM could also report the specific percentages obtained in Remeasurement 1 for each study indicator.
Activity VIII: Include Improvement Strategies	
Decreasing TennCare Enrollees Receiving Opioid Prescriptions	**Suggestion:** The DBM could provide a fishbone diagram that shows how barriers were identified, and should ensure that information included in the List Intervention section of the PIP Summary Form is complete (i.e., the link for the Opioid Tool Kit was introduced but not included).
Increasing Provider Use of Silver Diamine Fluoride (SDF) as a Preventive Measure	**Suggestion:** The DBM should provide a fishbone diagram that shows how the barriers were identified, and not include improvements in the Barriers column of the PIP Summary Form.
Acute Use of Opioids	**Suggestion:** The PBM could include details from the additional analysis conducted by TennCare and an explanation of how this information led to increasing the daily dose limit to 60 MME.
Activity IX: Assess for Real Improvement	
Reducing Transportation (NEMT) Member Complaints	**Suggestion:** The MCO [**AG** All Regions] should discuss potential reasons for the significant increase in complaints observed during Remeasurement Year 3.
Antidepressant Medication Management (AMM)	**Suggestion:** The MCO [**AGE** and **AGW**] could report that the interventions had a negative effect on the AMM Acute Phase rates over the course of the study, as evidenced by the significant decline from Baseline to Remeasurement 3.

Table 12. PIP Strengths, Suggestions, and AONs	
PIP Topic	**Identified Area for Improvement or Strength**
	Suggestion: The MCO [**AGM**] could report that the interventions had a negative effect on the AMM Acute and Continuation Phase rates over the course of the study, as evidenced by the significant decline from Baseline to Remeasurement 4.
Maternal Health: Improving Prenatal and Postpartum Care Rates	**Suggestion:** The MCO [**BCM**] could test prenatal indicator rates for comparisons between Remeasurement 2 and Remeasurement 3.
Decreasing Call Center Volume Related to Attestations	**Suggestion:** The PBM could report the z-test statistic and the level of significance of the p-values as p< .05 or p< .01. The PBM could also ensure that Industry Benchmark and Baseline Result percentages are reported consistently and accurately.
Activity X. Assess for Sustained Improvement	
Antidepressant Medication Management (AMM)	**Strength:** The MCO [**BC** All Regions] included graphs for each study indicator that displayed the results over time. **Suggestion:** The MCO [**AG** All Regions] could discuss the barriers to intervention effectiveness and the implications for the study's results.
Maternal Health: Improving Prenatal and Postpartum Care Rates	**Strength:** The MCO [**BC** All Regions and **TCS**] included graphs for both study indicators to illustrate the percentage changes from Baseline to Remeasurement 3. **Suggestion:** For postpartum care rates, the MCO [**TCS**] should correctly describe the lack of significance in comparing Remeasurement 2 to Remeasurement 3.

Recommendations, Areas for Improvement

Suggestions can be identified when documentation for an evaluation element includes the basic components to meet requirements, but enhanced documentation would demonstrate a stronger understanding of CMS protocols. AONs arise from evaluation elements that receive a Not Met score, indicating that those elements are not in full compliance with CMS protocols. Specific suggestions and AONs identified in 2019 are included in Table 12.

The majority of suggestions involved recommendations to MCCs to discuss factors and constraints that could affect results, their validity, and/or their comparability, and providing complete information about indicators, measurement results, and statistical tests. AONs concerned deficiencies in information about study indicators, study populations, and sampling and data collection methodologies.

For studies that received AONs for any element, Qsource provides technical assistance to help MCCs understand CMS

protocol and revise PIPs as needed to improve performance. In subsequent validation years, MCCs should update their PIP Summary Forms with additional information to address any suggestions and elements assessed as Not Met.

For 2019, TennCare also began requiring MCCs submit a CAP for any AONs, a similar evaluation/monitoring process to the AQS. AONs were identified in four PIP topics (seven studies total) in 2019. One AON requiring a CAP was noted in each of the following activities:

- Activity III: The MCO should ensure that the study population and eligibility requirements are accurately and consistently defined throughout the PIP Summary Form.
- Activity IV: The MCO should ensure that each study indicator aligns with the study question and allows for it to be answered.
- Activity V—Use Sound Sampling Methods: The MCO should describe the sampling methodology, including confidence level, population size, and acceptable margin of error.
- Activity VI: The MCO should identify the correct data source in the PIP Summary Form.
- Activity VII: The MCC should report the baseline and remeasurement results and statistical differences between measurement years for each indicator.

MCC Strengths and Best Practices

Strengths indicate that the MCC demonstrated particular proficiency on a given activity and can be identified regardless of validation status. The lack of an identified strength should not be interpreted as a shortcoming on the part of an MCC. This year, strengths were identified primarily in the areas of data analysis and interpretation, and MCOs were commended for conducting thorough analyses of results and employing effective approaches to improve studies. Specific strengths identified are included in Table 12.

Conclusions and Recommendations

Areas for Improvement

ANA Review

Provider Shortages

The following MCOs should address the provider shortages in specified counties identified in the ANA section of this report:

1. East Grand Region
   - **AGE**—one county each for OB/GYN, optometry, and contracted hospitals; 19 counties for opioid use disorder treatment for children and adults and for CHOICES peer-to-peer person-centered planning, self-direction, employment, and community support and navigation; 10 for CHOICES adult day care; 13 for CHOICES pest control; all counties for CHOICES community support development, organization, and navigation; and 23 for CHOICES specialized consultation and training
   - **BCE**—18 counties for opioid use disorder treatment; 10 for CHOICES adult day care; and 12 for CHOICES specialized consultation and training
   - **UHCE**—one county for OB/GYN; 22 for opioid use disorder treatment; and 12 for CHOICES adult day care
2. Middle Grand Region
   - **AGM**—seven counties for OB/GYN; two for optometry; 13 for opioid use disorder treatment; 17 for CHOICES adult day care; nine for CHOICES pest control; all counties for CHOICES community support development, organization, and navigation; and 22 for CHOICES peer-to-peer person-centered planning, self-direction, employment, and community support and navigation
   - **BCM**—14 counties for opioid use disorder; 8 for CHOICES adult day care; and 18 for CHOICES specialized consultation and training
   - **UHCM**—seven counties for OB/GYN; 24 for opioid use disorder treatment; and 11 for CHOICES adult day care
3. West Grand Region
   - **AGW**—two counties for optometry; one for contracted hospitals; 13 for opioid use disorder treatment; and 18 for CHOICES adult day care
   - **BCW**—12 counties for opioid use disorder; 10 for CHOICES adult day care; and one for CHOICES specialized consultation and training
   - **UHCW**—three counties for OB/GYN; two for contracted hospitals; three for substance abuse outpatient treatment services; and five for CHOICES adult day care
4. Statewide
   - **AG**—had no identified providers for CHOICES community transportation in all three Grand Regions
   - **TCS**—17 counties for opioid use disorder providers
   - **DQ**—nine counties for dental providers

Other Recommendations

While all MCOs should ensure every provider has a signed and dated contract with a correct TennCare provider number prior to furnishing member services, the review team identified files from **UHCE** and **BCM** that did not.

TCS should ensure Member Handbooks and plan documents contain complete information about reconstructive breast surgery and about tissue transplants for members age 21 years and older as covered by Medicare and for members younger than 21 years as medically necessary.

UHC should address evidencing members' being informed of plan benefits in plan documents, including rehabilitation hospital services for members 21 years and older, coverage for surgery to establish symmetry of a non-diseased breast after breast surgery, standard information and compliant age requirements for mammography screenings, residential substance abuse benefits, and nursing facility stay limitations and alternative, community-based residential benefits for CHOCIES Groups 2 and 3. The MCO also needs to make improvements in documentation to meet availability and accessibility requirements, including information to access Tennessee Health Link; correct information for geographic access and travel time to psychiatric inpatient hospital services, outpatient and intensive outpatient non-MD behavioral health services, inpatient and outpatient substance abuse services, and opioid use disorder treatment.

AQS

To improve in AONs identified in the 2019 AQS, the following CAPs (by QP standard or PA file review) will need to be met:

- **Network: Contracting, Availability, Access, and Documentation**
  - Element #1, Specialist Termination: The MCO should ensure that timely notifications are sent to members after a specialist and/or specialty group terminates participation with the MCO. (**UHC**)
  - Element #2, Notice of Provider Termination: The MCO should ensure that timely notifications are sent to members after a PCP terminates participation with the MCO. (**UHC**)
- **Appeals File Review**
  The DBM should ensure it meets the time standard in resolving appeals; this issue was noted in one file. (**DQ**)
- **CHOICES Credentialing File Review (Quantity)**
  The MCO should ensure that all files in the credentialing file sample are initial credentialing records rather than recredentialing records; this issue was noted in two files. (**AG** and **BC**)
- **CHOICES Recredentialing File Review (Quantity and Quality)**—For the quantity rating, the MCO should ensure that all files included in the recredentialing sample are recredentialing records rather than initial credentialing records; this issue was noted in two files.

For the quality rating, the MCO should ensure that ongoing CHOICES providers are recredentialed at least annually, and that all other CHOICES providers are recredentialed at least every three years; this issue was noted in three files. (**UHC**)

- **UM Denials File Review**
  The MCO should ensure that timely member notifications are sent to members after UM denial decisions are made; this issue was noted in one file. (**AGM**)

PMV

During the 2019 audit, no areas for improvement were identified for the MCOs.

PIP Validation

Suggestions

Suggestions are given when a PIP includes the basic components needed to meet requirements, but enhanced reporting and analyses could yield more reliable results and demonstrate a better understanding of CMS protocol.

Qsource offered suggestions for improvement for the majority of PIP studies this year. Many were offered for Activity VII, for which MCCs were advised to provide statements about factors and constraints that could affect results, their validity, and/or their comparability; provide complete and standardized information about test values; and provide complete and accurate information about statistical tests and comparisons between remeasurements. Many suggestions were also given for Activity IV: Select the Study Indicators concerning setting appropriate benchmarks; including accurate and thorough descriptions of indicators; accurately calculating indicator rates; and ensuring that results, data, and tables and graphs are reported accurately and consistently throughout the PIP Summary Form. A large number of suggestions were given for Activity VI: Use Valid and Reliable Data Collection Procedures, recommending that MCCs include a data collection timeline; clarify the data source in the PIP Summary Form; ensure consistency among rates provided in the Summary Form and attachments; and include information about databases used to collect data.

Finally, MCCs were also advised to ensure that discussions of the study topic are clear, accurate, and include reasons for excluding members from the study population (Activity I); include the anchor dates used to determine member age in the population inclusion criteria (Activity III: Use a Representative and Generalizable Study Population); include thorough details about additional analyses, and provide fishbone diagrams to show how barriers are identified (Activity VIII: Include Improvement Strategies); accurately report statistics, benchmarks, and results throughout the form, and thoroughly discuss potential causes and significance of rate changes over time (Activity IX: Assess for Real Improvement); and thoroughly discuss barriers to intervention effectiveness,

statistical significance or lack thereof between remeasurements, and implications for the study's results (Activity X).

AONs

AONs are identified for evaluation elements that receive a Not Met status, indicating that those elements are not in full compliance with CMS protocol.

AONs were identified in four PIP topics (seven studies total) in 2019. One AON was noted in each of the following activities:

- Activity III: The MCO should ensure that the study population and eligibility requirements are accurately and consistently defined throughout the PIP Summary Form.
- Activity IV: The MCO should ensure that each study indicator aligns with the study question and allows for it to be answered.
- Activity V—Use Sound Sampling Methods: The MCO should describe the sampling methodology, including confidence level, population size, and acceptable margin of error.
- Activity VI: The MCO should identify the correct data source in the PIP Summary Form.
- Activity VII: The MCC should report the baseline and remeasurement results and statistical differences between measurement years for each indicator.

MCC Recommendations for improvement

For improvement, all of **AG**'s regions were advised to include more specific information about factors that may affect validity and comparability of results; more thoroughly discuss intervention effectiveness and how interventions might affect indicator rates; set more appropriate benchmarks; and clarify data sources.

For improvement, all **BC**'s regions were advised to ensure consistency among rates provided in attachments and the PIP Summary Form, and ensure that data are accurate, consistent, and interpreted correctly throughout the form. **BCE** could further ensure that baseline results are accurately presented throughout the form, while **BCM** could test a comparison between specific remeasurements and eliminate duplicate reporting of a comparison between rates. To achieve 100% overall scores for each submitted PIP, all regions should provide accurate information about the data source.

For improvement, **TCS** was advised to include thorough and clear information about factors that may affect comparability of results; accurately report statistical significance of comparisons between remeasurements; and include a data collection timeline.

For improvement, all **UHC**'s regions were advised to include thorough information about test values, indicators, and databases used to collect study data; include specific dates used to determine the age of the study population; ensure that narratives are clear and accurate; and accurately calculate

measurement results. To achieve 100% overall scores and a Met status for each submitted PIP, all **UHC**'s regions should accurately and consistently define the study population and eligibility requirements, and ensure that each study indicator aligns with and allows for the study question to be answered. **UHCE** and **UHCM** should further include thorough information about the sampling method used, including confidence level, population size, and acceptable margin of error, as well as a description of how the sample was representative of the eligible population and how sampling techniques were used in accordance with generally accepted principles of research design.

For improvement, **Magellan** was advised to explain population exclusion criteria; report test values and levels of significance consistently; include more specific information about factors that may affect validity and comparability of results; and include information about additional analyses that affected the study. To achieve 100% overall scores on all PIPs, **Magellan** should report the baseline and remeasurement results and statistical differences between measurement years for each indicator.

For improvement, **DQ** was advised to include fishbone diagrams to show how barriers are identified; include specific dates used to determine member age in population inclusion criteria; include a timeline for data collection; and correctly calculate percentage differences.

MCC Strengths, Best and Emerging Practices

This section summarizes strengths and identifies best and emerging practices of TennCare's MCCs that were effective in demonstrating improvements in care or service or that positively impacted outcomes specific to each EQR activity. Qsource has identified the following promising practices from all 2019 EQR activities. These practices could potentially serve as exemplary performances in quality healthcare delivery. Overall, TennCare's MCCs demonstrated a continued dedication to providing high-quality services to TennCare members.

ANA Review

Several best practices were identified from review year 2018 for each MCC. **AG** identified member needs through feedback sessions, migrated to a new member web portal in early 2018 that was mobile friendly and supported needed customization with more effective communication, easier navigation, secure messaging and enhanced ease in accessing information about care, coverage, and customer service, as well as additional services offered, such as smoking cessation, weight loss, and reward programs.

After many members relayed a preference for text message communications, **BC** and **TCS** used a new texting platform in 2018 to encourage members to complete preventive screenings, including monthly identifying and texting members with gaps in care. The overall percentage of claims received as a result of the text messages was 13.59%, improving member experience and health by closing gaps in care.

UHC enhanced communications with members by creating a page on its website with age-appropriate preventive care information and providing a mobile app to instantly access personal health information, check claims, find a provider and urgent/ emergency care, view plan details, and generate a plan ID card 24 hours a day, 7 days a week. Further, **UHC**'s *Talk to Me* tool allowed members to request a call from a service representative to answer coverage and benefits questions.

DQ implemented three initiatives to engage providers and increase attendance to provider education/training sessions: offering CEUs for statewide provider sessions, during which breakout case workgroups offered additional information on priority topics and separate orthodontic discussions offered deeper discussion and feedback from the DBM.

AQS

During the 2019 AQS, MCCs demonstrated their serious dedication to quality by achieving 100% compliance with all or a majority of measures. MCOs also made improvements in the following evaluation categories:

- Credentialing/Recredentialing P&Ps QP standard—**AG** raised its score from 93.9% to 100%
- UM Denials PA—**AGE** raised its score from 97.6% to 100%

Moreover, three MCOs were commended for exhibiting particular strengths, with **AG**'s receiving praise for its behavioral health specialty case managers, and **BC** and **UHC** lauded for their commitment to the CHOICES programs and their member advisory committees. The DBM also demonstrated a strong commitment to quality during the 2019 AQS, achieving 100% compliance with all QP standards and two of three file reviews. **DQ** raised its score to 100% in the Complaints PA (from 95.0%). All CAPs submitted by MCCs after last year's AQS met improvement objectives.

PMV

Qsource identified improvements and best practices for two MCOs during the PMV in 2019. For **AG** (**AGE**, **AGM**, and **AGW**), is looking to contract with a single electronic data interchange (EDI) vendor, which will add efficiencies and reduce administrative burden as their 2018 process involved four sources. Onsite, **AG** demonstrated an excellent trending process with variance calculations in its spreadsheet to systematically identify aberrations over time. For **BC** (**BCE**, **BCM**, **BCW**, and **TCS**), receipt of enrollment files smoothly

shifted from Automated Health Systems (AHS) to the Bureau in October 2018, with collaboration between the two and consultation with the MCO, and all issues were resolved to ensure accurate HEDIS reporting.

PIP Validation

Strengths are noted when an MCC demonstrates particular proficiency in a given activity, and can be identified regardless of validation status. This year, strengths were noted in six PIP topics. The most strengths were identified in Activity VII: Analyze Data and Interpret Study Results, for which MCCs were commended for thoroughly analyzing results and planning future interventions to improve performance. Multiple strengths were also noted in Activity X: Assess for Sustained Improvement, for which MCOs were lauded for providing supplementary graphs to illustrate indicator results over time. Another strength was noted in Activity I: Choose the Study Topic(s), for which MCOs were commended for using data and references to bolster the topic description.

MCCs achieved a 100% critical element score and a Met validation status for the vast majority of PIPs submitted in 2019.

The following lists detail further highlights by MCC from this year's PIP validation.

- Each region of **AG** achieved a Met status and overall scores of 100% for all six submitted PIPs.
- Each region of **BC** achieved a Met status for all six submitted PIPs, and overall scores of 100% for five PIPs.
- **BCE**, **BCM**, **BCW**, and **TCS** were commended in multiple PIPs for conducting careful research of topics and the significance of each, and providing supplementary information about how indicator rates changed over time.
- **TCS** achieved a Met status and overall scores of 100% for all six submitted PIPs.
- **UHCW** achieved a Met status for five of six submitted PIPs, while **UHCE** and **UHCM** achieved a Met status for four of six PIPs. All regions were commended for including extensive discussions of improvement strategies and how those strategies will affect the study moving forward.
- **Magellan** achieved a Met status for both submitted PIPs and was commended for including a thorough description of how and why study goals were not met.
- **DQ** achieved a Met status and overall scores of 100% for both submitted PIPs

APPENDIX A | MCC Findings

In accordance with CMS guidelines for EQRO technical reporting, this appendix presents MCC-specific results for the 2019 ANA, AQS, and PIP Validation activities. The MCC results for the 2019 PMV can be found in the PMV Section.

ANA Review

The following Network Adequacy and Benefits Delivery scoring were results of 2019 evaluations for each MCC as described in the ANA Review section of this report.

Network Adequacy

The information in **Tables A-1** and A-2 for all MCCs was obtained from analyses performed on provider and member data.

Table A-1. 2019 ANA Review Network Adequacy Scores—MCO Access/Availability

Measure	Standard (max)	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
Primary Care Provider (PCP) Average		**>99.9%**	**99.9%**	**100%**	**100%**	**100%**	**100%**	**100%**	**>99.9%**	**99.9%**	**99.9%**
Primary Care Service Providers—Member-to-Provider Ratio Analysis											
Primary Care Provider (PCP) or Physician Extender	2,500:1 or 1,250:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TennCare Kids (Members <21 years)		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OB/GYN (Females >13yrs)		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Primary Care Service Providers—Distance Analysis											
Urban PCP Time/Distance	20 miles	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Suburban/Frontier/Rural PCP Time/Distance	30 miles	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TennCare Kids (Members <21 years)	20 miles urban/ 30 suburban	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OB/GYN (Females >13yrs)		>99.9%	99.4%	100%	100%	100%	100%	100%	>99.9%	99.3%	99.6%
Specialty Care Provider (SCP) Average		**100%**	**99.9%**	**99.4%**	**97.0%**	**100%**	**99.1%**	**100%**	**100%**	**100%**	**100%**
Specialty Care Service Providers—Member-to-Provider Ratio Analysis											
Allergy and Immunology	100,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Cardiology	20,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Dermatology	40,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table A-1. 2019 ANA Review Network Adequacy Scores—MCO Access/Availability

Measure	Standard (max)	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
Endocrinology	25,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Gastroenterology	30,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
General Surgery	15,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Nephrology	50,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Neurology	35,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Neurosurgery	45,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Oncology/Hematology	80,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Ophthalmology	20,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Opioid Use Disorders	10,000:1	100%	97.8%	81.3%	0%	100%	71.0%	100%	100%	100%	100%
Orthopedics/ Orthopedic Surgery	15,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Otolaryngology	30,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Psychiatry (Adult)	25,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Psychiatry (Child and Adolescent)	150,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Urology	30,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physical Health-Specific Specialties Distance Analysis											
Allergy and Immunology[1]	Two standards: 1 within 60/90 miles	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Cardiology[1]		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Dermatology[1]		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Endocrinology[1]		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Gastroenterology[1]		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
General Surgery[1]		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Nephrology[1]		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Neurology[1]		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table A-1. 2019 ANA Review Network Adequacy Scores—MCO Access/Availability

Measure	Standard (max)	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
Neurosurgery[1]	Two standards: 1 within 60/90 miles	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Oncology/Hematology[1]		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Ophthalmology[1]		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Orthopedics/Orthopedic Surgery[1]		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Otolaryngology[1]		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Psychiatry (Adult)[1]		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Psychiatry (Child & Adolescent)[1]		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Urology[1]		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Behavioral Health (BH) Provider Average		**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**>99.9%**
BH-Specific Specialties Distance Analysis											
Psychiatric Inpatient	≤90 miles and ≤120 minutes	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Outpatient (Non-MD Services)[1]	Two: ≤30 miles and ≤45 mins./ ≤60 and ≤60	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Substance Abuse—Inpatient Facility Services	≤90 miles and ≤120 minutes for all members	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Intensive Outpatient (may include Day Treatment [Adult], Intensive Day Treatment [Child and Adolescent], or Partial Hospitalization)[1]	Two: ≤90 miles and ≤90 mins./ ≤120 and ≤120	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table A-1. 2019 ANA Review Network Adequacy Scores—MCO Access/Availability

Measure	Standard (max)	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
Substance Abuse—Outpatient Treatment Services[1]	Two: ≤30 miles and ≤30 mins./ ≤45 and ≤45	100%	100%	100%	100%	100%	100%	100%	100%	100%	>99.9%
Opioid Use Disorder Treatment Providers[1]	Two: ≤45 miles and ≤45 mins./ ≤60 and ≤60	**97.2%**	**>99.9%**	**99.8%**	**99.1%**	**99.6%**	**99.8%**	**99.2%**	**97.5%**	**96.5%**	**100%**
General Optometry and Hospitals Avg.		**>99.9%**	**99.8%**	**99.9%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**>99.9%**
General Optometry and Hospitals Distance Analysis											
General Optometry	≤30 miles and ≤45 minutes	>99.9%	99.6%	99.9%	100%	100%	100%	100%	100%	100%	100%
Hospitals		>99.9%	100%	>99.9%	100%	100%	100%	100%	100%	100%	99.9%
Special Programs Average		**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Special Programs—Essential Hospital Services											
Neonatal	At least one tertiary care center per Grand Region	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Perinatal		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Pediatric		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Trauma		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Burn		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Special Programs—Centers of Excellence (COEs)											
People With HIV/AIDs	At least two COEs	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
People With BH Needs	All COEs	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Children in or at Risk for State Custody	All COEs							100%			
Special Programs—Weight and Tobacco											
Weight Management		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table A-1. 2019 ANA Review Network Adequacy Scores—MCO Access/Availability

Measure	Standard (max)	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
Tobacco Cessation	At least one program	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
CHOICES Providers Average		**95.6%**	**97.0%**	**96.4%**	**99.7%**	**99.2%**	**99.3%**		**99.2%**	**98.8%**	**99.7%**
CHOICES HCBS Providers											
Adult Day Care Providers (Applied to Group 2 and 3 Members)	≤20 miles and ≤30 minutes urban, ≤30 and ≤45 suburban, ≤60 and ≤90 rural/frontier	83.9%	86.7%	56.3%	96.4%	90.3%	92.2%		90.7%	86.0%	95.9%
Nursing Facility Services	All that meet CMS Cert. and willing	100%	100%	100%	100%	100%	100%		100%	100%	100%
Assisted Care Living Facility	At least 1	100%	100%	100%	100%	100%	100%		100%	100%	100%
Assistive Technology	2 providers per county	100%	100%	100%	100%	100%	100%		100%	100%	100%
Attendant Care		100%	100%	100%	100%	100%	100%		100%	100%	100%
Home-Delivered Meals		100%	100%	100%	100%	100%	100%		100%	100%	100%
In-Home Respite Care		100%	100%	100%	100%	100%	100%		100%	100%	100%
Inpatient Respite Care		100%	100%	100%	100%	100%	100%		100%	100%	100%
Minor Home Modifications		100%	100%	100%	100%	100%	100%		100%	100%	100%
Personal Care Visits		100%	100%	100%	100%	100%	100%		100%	100%	100%
Personal Emergency Response System (PERS)		100%	100%	100%	100%	100%	100%		100%	100%	100%
Pest Control		62.9%	76.9%	100%	100%	100%	100%		100%	100%	100%

Table A-1. 2019 ANA Review Network Adequacy Scores—MCO Access/Availability

Measure	Standard (max)	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
ECF CHOICES Providers Average		**87.2%**	**89.7%**	**96.0%**	**98.6%**	**98.2%**	**99.8%**		**100%**	**100%**	**100%**
ECF CHOICES Providers											
Respite Services	2 providers per county	100%	100%	100%	100%	100%	100%		100%	100%	100%
Supportive Home Care		100%	100%	100%	100%	100%	100%		100%	100%	100%
Community Integration Support Services		100%	100%	100%	100%	100%	100%		100%	100%	100%
Community Transportation		0%	0%	0%	100%	100%	100%		100%	100%	100%
Independent Living Skills Training		100%	100%	100%	100%	100%	100%		100%	100%	100%
Assistive Technology, Adaptive Equipment, and Supplies		100%	100%	100%	100%	100%	100%		100%	100%	100%
Minor Home Modifications		100%	100%	100%	100%	100%	100%		100%	100%	100%
Community Support Development, Organization, and Navigation		0%	0%	100%	100%	100%	100%		100%	100%	100%
Conservatorship and Alternatives to Conservatorship Counseling and Assistance		100%	100%	100%	100%	100%	100%		100%	100%	100%
Health Insurance Counseling/ Forms Assistance		100%	100%	100%	100%	100%	100%		100%	100%	100%
Personal Assistance		100%	100%	100%	100%	100%	100%		100%	100%	100%
Community Living Supports (CLS)		100%	100%	100%	100%	100%	100%		100%	100%	100%
CLS—Family Model		100%	100%	100%	100%	100%	100%		100%	100%	100%
Peer-to-Peer Person-Centered Planning, Self-Direction, Employment, and Community Support and Navigation		45.7%	43.6%	100%	100%	100%	100%		100%	100%	100%
Specialized Consultation and Training		34.3%	100%	100%	65.7%	53.8%	95.2%		100%	100%	100%

Table A-1. 2019 ANA Review Network Adequacy Scores—MCO Access/Availability

Measure	Standard (max)	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
ECF CHOICES Providers—Employment Services/Supports to include:											
Exploration	2 providers per county	100%	100%	100%	100%	100%	100%		100%	100%	100%
Benefits Counseling[2]		11.4%	17.9%	90.5%	100%	100%	100%		37.1%	30.8%	19.0%
Discovery		100%	100%	100%	100%	100%	100%		100%	100%	100%
Situational Observation and Assessment		100%	100%	100%	100%	100%	100%		100%	100%	100%
Job Development Plan or Self-Employment Plan		100%	100%	100%	100%	100%	100%		100%	100%	100%
Job Development or Self-Employment Start-Up		100%	100%	100%	100%	100%	100%		100%	100%	100%
Job Coaching for Individualized, Integrated Employment, or Self-Employment		100%	100%	100%	100%	100%	100%		100%	100%	100%
Coworker Supports		100%	100%	100%	100%	100%	100%		100%	100%	100%
Career Advancement		100%	100%	100%	100%	100%	100%		100%	100%	100%
Supported Employment-Small Group Supports	2 providers per county	100%	100%	100%	100%	100%	100%		100%	100%	100%
Integrated Employment Path Services		100%	100%	100%	100%	100%	100%		100%	100%	100%
Overall Network Adequacy Score		**96.0%**	**96.9%**	**98.3%**	**98.5%**	**99.4%**	**99.6%**	**>99.9%**	**99.9%**	**99.8%**	**>99.9%**

Note: Boxes that are grayed out were 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%.
[1] The overall score is based on the combination of scores for Standard 1 (75% of members) and Standard 2 (100% of members). 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]After conferring with TDCI, the requirement of having two benefits counseling providers per county was removed from the final report. The rate was not included in the network adequacy final score for ECF CHOICES providers

Table A-2. 2019 ANA Review Network Adequacy Scores—DBM Access/Availability			
Measure	**Standard (max)**	**Members <Age 21 Years**	**ECF CHOICES**
General Dental Provider (GDP) Ratio	2,500:1	100%	
GDP Distance	30 miles	100%	98.3%
Overall Network Adequacy Results		**100%**	**98.3%**

Benefit Delivery

The information in **Table A-3** for all MCCs was obtained from reviews of the six areas used to determine the effectiveness of the MCC's delivery of covered benefits.

Table A-3. 2019 ANA Review Benefits Delivery Scores—MCC Averages										
AGE	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**DQ**
Covered Benefits—Member Handbook										
98.5%	98.5%	98.5%	97.0%	97.0%	97.0%	94.3%	91.0%	91.0%	91.0%	100%
Covered Benefits—Provider Manual										
98.5%	98.5%	98.5%	100%	100%	100%	100%	100%	100%	100%	100%
Appointment Availability—Policies and Procedures										
97.4%	97.4%	97.4%	100%	100%	100%	100%	81.6%	81.6%	81.6%	100%
Appointment Availability—MCO Complaints										
99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	>99.9%	99.9%	99.9%	99.9%	>99.9%
MCO Provider Contracts—Quantity										
100%	100%	100%	100%	95.0%	100%	100%	90.0%	100%	85.0%	100%
MCO Provider Contracts—Quality										
100%	100%	100%	100%	95.0%	100%	100%	95.0%	100%	85.0%	100%
Overall Benefit Delivery Results										
99.1%	**99.1%**	**99.1%**	**99.5%**	**97.8%**	**99.5%**	**99.0%**	**92.9%**	**95.4%**	**90.4%**	**>99.9%**

**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%.*

AQS

QP Standards

Tables A-4 and **A-5** display each MCC's compliance in documentation, P&Ps with each QP standard.

Table A-4. 2019 AQS QP Standard Results: MCOs

Standard	AG	BC	TCS	UHC
Network: Contracting, Availability, Access and Documentation	100%	100%	100%	88.9%
QI Activities	100%	100%	100%	100%
Clinical Criteria for UM Decisions	100%	100%	100%	100%
Member Rights and Responsibilities	100%	100%	100%	100%
EPSDT	100%	100%	100%	100%
TennCare Medical Services Grievance and Appeal Process	100%	100%	100%	100%
Non-Discrimination Compliance	100%	100%	100%	100%
Credentialing and Recredentialing P&Ps	100%	100%	100%	100%

Table A-5. 2019 AQS QP Standard Results: DBM

Standard	Score	Standard	Score
Written QMP Description	100%	Standards for Facilities	100%
Systematic Process of Quality Assessment and Improvement	100%	Dental Records	100%
Accountability to the Governing Body	100%	Utilization Review	100%
Active Quality Monitoring Committee	100%	Coordination of QM Activity with Other Management Activity	100%
Quality Monitoring Supervision	100%	EPSDT	100%
Adequate Resources	100%	Non-Discrimination Compliance	100%
Provider Participation in the QMP	100%	Credentialing/Recredentialing P&Ps	100%
Member Rights and Responsibilities	100%		

File Reviews

The results in **Tables A-6** and **A-7** present each MCC's compliance with each PA assessed through review of a sampling of member/provider files as applicable to the MCC's member population.

Table A-6. 2019 AQS File Review Results: MCOs by Operational Region

PA	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
UM Denials (ages 20 years and youngers)	100%	97.5%	100%	100%	100%	100%	100%	100%	100%	100%
Appeals	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
EPSDT Information System Tracking	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
CHOICES Annual Level of Care Assessment	100%	100%	100%	100%	100%	100%	*	100%	100%	100%
Transition of CHOICES Members Between MCOs	100%	100%	*	100%	100%	100%	*	100%	100%	100%
CHOICES Credentialing (reported as a statewide score with two ratings)										
Quantity	83.3%			88.9%			*	100%		
Quality	100%			100%			*	100%		
CHOICES Recredentialing (reported as a statewide score with two ratings)										
Quantity	100%			100%			*	89.5%		
Quality	100%			100%			*	92.7%		

** Gray cells designate where a file review was Not Applicable (NA).*

Table A-7. 2019 AQS File Review Results: DBM

PAs	Score
Appeals	97.5%
Complaints	100%
UM Denials (ages 20 years and younger)	100%

PIP Validation

TennCare required that all PIPs submitted by MCCs be validated for CY2018. Individual elements were assessed as Met, Not Met, or Not Assessed (NA). Elements were designated NA if they were not applicable to the PIP or the study had not progressed to that point at the time of the review, thereby varying the number of activities and elements validated for each. An overall Met validation status indicates confidence in the study's results, whereas Not Met requires revisions of the PIP as relayed in recommendations and suggestions in the PIP section of this report.

Beginning in 2019, PIP activities III, IV, VII, and VIII in the Qsource PIP Summary Form and reporting were reordered to ensure alignment with CMS protocol. The following tables summarize the MCCs' overall PIP scores by activity, including the topics validated, the progression of the topic (B=Baseline, RM=Remeasurement Year), the total number of evaluation elements assessed and Met, the number of critical elements assessed and Met, the percentage of elements that were Met, as well as the overall validation status:

- Amerigroup by operational region: Tables A-8 to A-10
- BlueCare by operational region: Tables A-11 to A-13
- TennCare*Select*: Table A-14
- UnitedHealthcare: Tables A-15 to A-17
- DentaQuest (DBM) and Magellan (PBM): Table A-18

Table A-8. 2019 PIP Validation Scores by Review Activity: AGE

Study Year	RM3		B		RM2		RM3		RM1		B	
Study Topic Scored as All (A) and Critical (C) Elements Met/Assessed	Antidepressant Medication Management		Improve EPSDT Screening Rates in the 18–20-Year-Old Age Group		Increasing the Percentage of Complex Case Management and High-Risk OB Members Who Complete the 2nd Quality of Life Survey (SF-12)		Reducing Transportation (NEMT) Member Complaints		Increasing Member Participation in the EPSDT Healthy Rewards Incentive Program		Increase Percentage of Members with Documented In-Home Assessment of Nine Core Elements within 90 Days	
Review Activities	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**
I. Choose the Study Topic(s)	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1
II. Define the Study Question(s)	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
III. Use a Representative and Generalizable Study Population	3/3	2/2	3/3	2/2	2/2	2/2	2/2	2/2	2/2	2/2	3/3	2/2
IV. Select the Study Indicators	6/6	3/3	6/6	3/3	7/7	3/3	6/6	3/3	6/6	3/3	6/6	3/3
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
VI. Use Valid and Reliable Data Collection Procedures	6/6	0/0	6/6	0/0	9/9	1/1	6/6	0/0	6/6	0/0	11/11	1/1
VII. Analyze and Interpret Study Results	8/8	1/1	0/0	0/0	8/8	1/1	8/8	1/1	8/8	1/1	0/0	0/0
VIII. Include Improvement Strategies	3/3	1/1	0/0	0/0	3/3	1/1	3/3	1/1	4/4	1/1	0/0	0/0
IX. Assess for Real Improvement	4/4	0/0	0/0	0/0	4/4	0/0	4/4	0/0	3/3	0/0	0/0	0/0
X. Assess for Sustained Improvement	1/1	0/0	0/0	0/0	1/1	0/0	1/1	0/0	0/0	0/0	0/0	0/0
Overall Score	**39/39**	**10/10**	**23/23**	**8/8**	**42/42**	**11/11**	**38/38**	**10/10**	**37/37**	**10/10**	**28/28**	**9/9**
Percentage of Elements Met	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Validation Status	**Met**		**Met**		**Met**		**Met**		**Met**		**Met**	

Table A-9. 2019 PIP Validation Scores by Review Activity: AGM

Study Year	RM4		B		RM2		RM3		RM1		B	
Study Topic Scored as All (A) and Critical (C) Elements Met/Assessed	Antidepressant Medication Management		Improve EPSDT Screening Rates in the 18–20-Year-Old Age Group		Increasing the Percentage of Complex Case Management and High-Risk OB Members Who Complete the 2nd Quality of Life Survey (SF-12)		Reducing Transportation (NEMT) Member Complaints		Increasing Member Participation in the EPSDT Healthy Rewards Incentive Program		Increase Percentage of Members with Documented In-Home Assessment of Nine Core Elements within 90 Days	
Review Activities	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**
I. Choose the Study Topic(s)	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1
II. Define the Study Question(s)	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
III. Use a Representative and Generalizable Study Population	3/3	2/2	3/3	2/2	2/2	2/2	2/2	2/2	2/2	2/2	3/3	2/2
IV. Select the Study Indicators	6/6	3/3	6/6	3/3	7/7	3/3	6/6	3/3	6/6	3/3	6/6	3/3
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
VI. Use Valid and Reliable Data Collection Procedures	6/6	0/0	6/6	0/0	9/9	1/1	6/6	0/0	6/6	0/0	11/11	1/1
VII. Analyze and Interpret Study Results	8/8	1/1	0/0	0/0	8/8	1/1	8/8	1/1	8/8	1/1	0/0	0/0
VIII. Include Improvement Strategies	3/3	1/1	0/0	0/0	3/3	1/1	3/3	1/1	4/4	1/1	0/0	0/0
IX. Assess for Real Improvement	4/4	0/0	0/0	0/0	4/4	0/0	4/4	0/0	3/3	0/0	0/0	0/0
X. Assess for Sustained Improvement	1/1	0/0	0/0	0/0	1/1	0/0	1/1	0/0	0/0	0/0	0/0	0/0
Overall Score	**39/39**	**10/10**	**23/23**	**8/8**	**42/42**	**11/11**	**38/38**	**10/10**	**37/37**	**10/10**	**28/28**	**9/9**
Percentage of Elements Met	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Validation Status	**Met**		**Met**		**Met**		**Met**		**Met**		**Met**	

Table A-10. 2019 PIP Validation Scores by Review Activity: AGW

Study Year	RM3		B		RM2		RM3		RM1		B	
Study Topic Scored as All (A) and Critical (C) Elements Met/Assessed	Antidepressant Medication Management		Improve EPSDT Screening Rates in the 18–20-Year-Old Age Group		Increasing the Percentage of Complex Case Management and High-Risk OB Members Who Complete the 2nd Quality of Life Survey (SF-12)		Reducing Transportation (NEMT) Member Complaints		Increasing Member Participation in the EPSDT Healthy Rewards Incentive Program		Increase Percentage of Members with Documented In-Home Assessment of Nine Core Elements within 90 Days	
Review Activities	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**
I. Choose the Study Topic(s)	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1
II. Define the Study Question(s)	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
III. Use a Representative and Generalizable Study Population	3/3	2/2	3/3	2/2	2/2	2/2	2/2	2/2	2/2	2/2	3/3	2/2
IV. Select the Study Indicators	6/6	3/3	6/6	3/3	7/7	3/3	6/6	3/3	6/6	3/3	6/6	3/3
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
VI. Use Valid and Reliable Data Collection Procedures	6/6	0/0	6/6	0/0	9/9	1/1	6/6	0/0	6/6	0/0	11/11	1/1
VII. Analyze and Interpret Study Results	8/8	1/1	0/0	0/0	8/8	1/1	8/8	1/1	8/8	1/1	0/0	0/0
VIII. Include Improvement Strategies	3/3	1/1	0/0	0/0	3/3	1/1	3/3	1/1	4/4	1/1	0/0	0/0
IX. Assess for Real Improvement	4/4	0/0	0/0	0/0	4/4	0/0	4/4	0/0	3/3	0/0	0/0	0/0
X. Assess for Sustained Improvement	1/1	0/0	0/0	0/0	1/1	0/0	1/1	0/0	0/0	0/0	0/0	0/0
Overall Score	**39/39**	**10/10**	**23/23**	**8/8**	**42/42**	**11/11**	**38/38**	**10/10**	**37/37**	**10/10**	**28/28**	**9/9**
Percentage of Elements Met	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Validation Status	**Met**		**Met**		**Met**		**Met**		**Met**		**Met**	

Table A-11. 2019 PIP Validation Scores by Review Activity: BCE

Study Year	RM3		RM3		RM3		B		RM3		RM2	
Study Topic Scored as All (A) and Critical (C) Elements Met/Assessed	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)**		**Maternal Health: Improving Prenatal and Postpartum Care Rates**		**Improving Provider Satisfaction Survey Response Rates**		**Critical Incident in CHOICES Members**		**Antidepressant Medication Management (AMM)**		**Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)**	
Review Activities	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**
I. Choose the Study Topic(s)	6/6	1/1	6/6	1/1	5/5	1/1	6/6	1/1	6/6	1/1	6/6	1/1
II. Define the Study Question(s)	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
III. Use a Representative and Generalizable Study Population	3/3	2/2	3/3	2/2	1/1	1/1	2/2	2/2	3/3	2/2	3/3	2/2
IV. Select the Study Indicators	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
VI. Use Valid and Reliable Data Collection Procedures	6/6	0/0	11/11	1/1	4/4	0/0	5/6	0/0	6/6	0/0	6/6	0/0
VII. Analyze and Interpret Study Results	8/8	1/1	9/9	2/2	8/8	1/1	0/0	0/0	8/8	1/1	8/8	1/1
VIII. Include Improvement Strategies	4/4	1/1	3/3	1/1	4/4	1/1	0/0	0/0	3/3	1/1	4/4	1/1
IX. Assess for Real Improvement	4/4	0/0	4/4	0/0	4/4	0/0	0/0	0/0	4/4	0/0	4/4	0/0
X. Assess for Sustained Improvement	1/1	0/0	1/1	0/0	1/1	0/0	0/0	0/0	1/1	0/0	1/1	0/0
Overall Score	**40/40**	**10/10**	**45/45**	**12/12**	**35/35**	**9/9**	**21/22**	**8/8**	**39/39**	**10/10**	**40/40**	**10/10**
Percentage of Elements Met	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**95.5%**	**100%**	**100%**	**100%**	**100%**	**100%**
Validation Status	**Met**		**Met**		**Met**		**Met**		**Met**		**Met**	

Table A-12. 2019 PIP Validation Scores by Review Activity: BCM

Study Year	RM3		RM3		RM3		B		RM3		RM2	
Study Topic Scored as All (A) and Critical (C) Elements Met/Assessed	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)**		**Maternal Health: Improving Prenatal and Postpartum Care Rates**		**Improving Provider Satisfaction Survey Response Rates**		**Critical Incident in CHOICES Members**		**Antidepressant Medication Management (AMM)**		**Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)**	
Review Activities	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**
I. Choose the Study Topic(s)	6/6	1/1	6/6	1/1	5/5	1/1	6/6	1/1	6/6	1/1	6/6	1/1
II. Define the Study Question(s)	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
III. Use a Representative and Generalizable Study Population	3/3	2/2	3/3	2/2	1/1	1/1	2/2	2/2	3/3	2/2	3/3	2/2
IV. Select the Study Indicators	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
VI. Use Valid and Reliable Data Collection Procedures	6/6	0/0	11/11	1/1	4/4	0/0	5/6	0/0	6/6	0/0	6/6	0/0
VII. Analyze and Interpret Study Results	8/8	1/1	9/9	2/2	8/8	1/1	0/0	0/0	8/8	1/1	8/8	1/1
VIII. Include Improvement Strategies	4/4	1/1	3/3	1/1	4/4	1/1	0/0	0/0	3/3	1/1	4/4	1/1
IX. Assess for Real Improvement	4/4	0/0	4/4	0/0	4/4	0/0	0/0	0/0	4/4	0/0	4/4	0/0
X. Assess for Sustained Improvement	1/1	0/0	1/1	0/0	1/1	0/0	0/0	0/0	1/1	0/0	1/1	0/0
Overall Score	**40/40**	**10/10**	**45/45**	**12/12**	**35/35**	**9/9**	**21/22**	**8/8**	**39/39**	**10/10**	**40/40**	**10/10**
Percentage of Elements Met	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**95.5%**	**100%**	**100%**	**100%**	**100%**	**100%**
Validation Status	**Met**		**Met**		**Met**		**Met**		**Met**		**Met**	

Table A-13. 2019 PIP Validation Scores by Review Activity: BCW

Study Year	RM3		RM3		RM3		B		RM3		RM2	
Study Topic Scored as All (A) and Critical (C) Elements Met/Assessed	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)**		**Maternal Health: Improving Prenatal and Postpartum Care Rates**		**Improving Provider Satisfaction Survey Response Rates**		**Critical Incident in CHOICES Members**		**Antidepressant Medication Management (AMM)**		**Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)**	
Review Activities	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**
I. Choose the Study Topic(s)	6/6	1/1	6/6	1/1	5/5	1/1	6/6	1/1	6/6	1/1	6/6	1/1
II. Define the Study Question(s)	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
III. Use a Representative and Generalizable Study Population	3/3	2/2	3/3	2/2	1/1	1/1	2/2	2/2	3/3	2/2	3/3	2/2
IV. Select the Study Indicators	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
VI. Use Valid and Reliable Data Collection Procedures	6/6	0/0	11/11	1/1	4/4	0/0	5/6	0/0	6/6	0/0	6/6	0/0
VII. Analyze and Interpret Study Results	8/8	1/1	9/9	2/2	8/8	1/1	0/0	0/0	8/8	1/1	8/8	1/1
VIII. Include Improvement Strategies	4/4	1/1	3/3	1/1	4/4	1/1	0/0	0/0	3/3	1/1	4/4	1/1
IX. Assess for Real Improvement	4/4	0/0	4/4	0/0	4/4	0/0	0/0	0/0	4/4	0/0	4/4	0/0
X. Assess for Sustained Improvement	1/1	0/0	1/1	0/0	1/1	0/0	0/0	0/0	1/1	0/0	1/1	0/0
Overall Score	**40/40**	**10/10**	**45/45**	**12/12**	**35/35**	**9/9**	**21/22**	**8/8**	**39/39**	**10/10**	**40/40**	**10/10**
Percentage of Elements Met	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**95.5%**	**100%**	**100%**	**100%**	**100%**	**100%**
Validation Status	**Met**		**Met**		**Met**		**Met**		**Met**		**Met**	

Table A-14. 2019 PIP Validation Scores by Review Activity: TCS

Study Year	RM3		RM3		RM2		B		RM3		B	
Study Topic Scored as All (A) and Critical (C) Elements Met/Assessed	**Maternal Health: Improving Prenatal and Postpartum Care Rates**		**Improving Provider Satisfaction Survey Response Rates**		**Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)**		**Social Determinants of Health Data Collection Process**		**Improving the Rate of Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life**		**Follow-Up after Hospitalization for Mental Illness**	
Review Activities	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**
I. Choose the Study Topic(s)	6/6	1/1	5/5	1/1	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1
II. Define the Study Question(s)	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
III. Use a Representative and Generalizable Study Population	3/3	2/2	1/1	1/1	3/3	2/2	2/2	2/2	3/3	2/2	3/3	2/2
IV. Select the Study Indicators	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
VI. Use Valid and Reliable Data Collection Procedures	11/11	1/1	4/4	0/0	6/6	0/0	6/6	0/0	11/11	1/1	6/6	0/0
VII. Analyze and Interpret Study Results	8/8	1/1	8/8	1/1	8/8	1/1	0/0	0/0	9/9	2/2	0/0	0/0
VIII. Include Improvement Strategies	3/3	1/1	4/4	1/1	4/4	1/1	0/0	0/0	3/3	1/1	0/0	0/0
IX. Assess for Real Improvement	4/4	0/0	4/4	0/0	4/4	0/0	0/0	0/0	4/4	0/0	0/0	0/0
X. Assess for Sustained Improvement	1/1	0/0	1/1	0/0	1/1	0/0	0/0	0/0	1/1	0/0	0/0	0/0
Overall Score	**44/44**	**11/11**	**35/35**	**9/9**	**40/40**	**10/10**	**22/22**	**8/8**	**45/45**	**12/12**	**23/23**	**8/8**
Percentage of Elements Met	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Validation Status	**Met**		**Met**		**Met**		**Met**		**Met**		**Met**	

Table A-15. 2019 PIP Validation Scores by Review Activity: UHCE

Study Year	B		RM3		RM1		B		RM3		B	
Study Topic Scored as All (A) and Critical (C) Elements Met/Assessed	Impact of Member and Provider Outreach on Immunization Rates for CIS Combo 10		Improving Medication Adherence for Major Depression Disorder		Impact of Provider Incentives on Screening Rates for Adolescents Ages 12–21		Perception of Care Coordination		Increasing Health Risk Assessment (HRA) Annual Completion Rates		Transitions of CHOICES Individuals	
Review Activities	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**
I. Choose the Study Topic(s)	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1
II. Define the Study Question(s)	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
III. Use a Representative and Generalizable Study Population	3/3	2/2	3/3	2/2	3/3	2/2	3/3	2/2	2/2	1/1	1/3	1/2
IV. Select the Study Indicators	6/6	3/3	6/6	3/3	6/6	3/3	7/7	3/3	6/6	3/3	5/6	2/3
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0	2/6	0/1	0/0	0/0	0/0	0/0
VI. Use Valid and Reliable Data Collection Procedures	11/11	1/1	6/6	0/0	11/11	1/1	9/9	1/1	6/6	0/0	6/6	0/0
VII. Analyze and Interpret Study Results	0/0	0/0	8/8	1/1	9/9	2/2	0/0	0/0	8/8	1/1	0/0	0/0
VIII. Include Improvement Strategies	0/0	0/0	4/4	1/1	2/2	1/1	0/0	0/0	3/3	1/1	0/0	0/0
IX. Assess for Real Improvement	0/0	0/0	4/4	0/0	4/4	0/0	0/0	0/0	4/4	0/0	0/0	0/0
X. Assess for Sustained Improvement	0/0	0/0	1/1	0/0	0/0	0/0	0/0	0/0	1/1	0/0	0/0	0/0
Overall Score	**28/28**	**9/9**	**40/40**	**10/10**	**43/43**	**12/12**	**29/33**	**9/10**	**38/38**	**9/9**	**20/23**	**6/8**
Percentage of Elements Met	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**87.9%**	**90.0%**	**100%**	**100%**	**87.0%**	**75.0%**
Validation Status	**Met**		**Met**		**Met**		**Not Met**		**Met**		**Not Met**	

Table A-16. 2019 PIP Validation Scores by Review Activity: UHCM

Study Year	B		RM3		RM1		B		RM3		B	
Study Topic Scored as All (A) and Critical (C) Elements Met/Assessed	Impact of Member and Provider Outreach on Immunization Rates for CIS Combo 10		Improving Medication Adherence for Major Depression Disorder		Impact of Provider Incentives on Screening Rates for Adolescents Ages 12–21		Perception of Care Coordination		Increasing Health Risk Assessment (HRA) Annual Completion Rates		Transitions of CHOICES Individuals	
Review Activities	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**
I. Choose the Study Topic(s)	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1
II. Define the Study Question(s)	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
III. Use a Representative and Generalizable Study Population	3/3	2/2	3/3	2/2	3/3	2/2	3/3	2/2	2/2	1/1	1/3	1/2
IV. Select the Study Indicators	6/6	3/3	6/6	3/3	6/6	3/3	7/7	3/3	6/6	3/3	5/6	2/3
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0	2/6	0/1	0/0	0/0	0/0	0/0
VI. Use Valid and Reliable Data Collection Procedures	11/11	1/1	6/6	0/0	11/11	1/1	9/9	1/1	6/6	0/0	6/6	0/0
VII. Analyze and Interpret Study Results	0/0	0/0	8/8	1/1	9/9	2/2	0/0	0/0	8/8	1/1	0/0	0/0
VIII. Include Improvement Strategies	0/0	0/0	4/4	1/1	2/2	1/1	0/0	0/0	3/3	1/1	0/0	0/0
IX. Assess for Real Improvement	0/0	0/0	4/4	0/0	4/4	0/0	0/0	0/0	4/4	0/0	0/0	0/0
X. Assess for Sustained Improvement	0/0	0/0	1/1	0/0	0/0	0/0	0/0	0/0	1/1	0/0	0/0	0/0
Overall Score	**28/28**	**9/9**	**40/40**	**10/10**	**43/43**	**12/12**	**29/33**	**9/10**	**38/38**	**9/9**	**20/23**	**6/8**
Percentage of Elements Met	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**87.9%**	**90.0%**	**100%**	**100%**	**87.0%**	**75.0%**
Validation Status	**Met**		**Met**		**Met**		**Not Met**		**Met**		**Not Met**	

Table A-17. 2019 PIP Validation Scores by Review Activity: UHCW

Study Year	B		RM3		RM1		B		RM3		B	
Study Topic Scored as All (A) and Critical (C) Elements Met/Assessed	Impact of Member and Provider Outreach on Immunization Rates for CIS Combo 10		Improving Medication Adherence for Major Depression Disorder		Impact of Provider Incentives on Screening Rates for Adolescents Ages 12–21		Perception of Care Coordination		Increasing Health Risk Assessment (HRA) Annual Completion Rates		Transitions of CHOICES Individuals	
Review Activities	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**
I. Choose the Study Topic(s)	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1
II. Define the Study Question(s)	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
III. Use a Representative and Generalizable Study Population	3/3	2/2	3/3	2/2	3/3	2/2	3/3	2/2	2/2	1/1	1/3	1/2
IV. Select the Study Indicators	6/6	3/3	6/6	3/3	6/6	3/3	7/7	3/3	6/6	3/3	5/6	2/3
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
VI. Use Valid and Reliable Data Collection Procedures	11/11	1/1	6/6	0/0	11/11	1/1	9/9	1/1	6/6	0/0	6/6	0/0
VII. Analyze and Interpret Study Results	0/0	0/0	8/8	1/1	9/9	2/2	0/0	0/0	8/8	1/1	0/0	0/0
VIII. Include Improvement Strategies	0/0	0/0	4/4	1/1	2/2	1/1	0/0	0/0	3/3	1/1	0/0	0/0
IX. Assess for Real Improvement	0/0	0/0	4/4	0/0	4/4	0/0	0/0	0/0	4/4	0/0	0/0	0/0
X. Assess for Sustained Improvement	0/0	0/0	1/1	0/0	0/0	0/0	0/0	0/0	1/1	0/0	0/0	0/0
Overall Score	**28/28**	**9/9**	**40/40**	**10/10**	**43/43**	**12/12**	**27/27**	**9/9**	**38/38**	**9/9**	**20/23**	**6/8**
Percentage of Elements Met	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**87.0%**	**75.0%**
Validation Status	**Met**		**Met**		**Met**		**Met**		**Met**		**Not Met**	

Table A-18. 2019 PIP Validation Scores by Review Activity: DBM and PBM								
Benefits Manager	**DentaQuest**				**Magellan**			
Study Year	**RM1**		**RM1**		**RM1**		**RM1**	
Study Topic Scored as All (A) and Critical (C) Elements Met/Assessed	**Decreasing TennCare Enrollees Receiving Opioid Prescriptions**		**Increasing Provider Use of Silver Diamine Fluoride (SDF) as a Preventive Measure**		**Acute Use of Opioids**		**Decreasing Call Center Volume Related to Attestations**	
Review Activities	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**
I. Choose the Study Topic(s)	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1
II. Define the Study Question(s)	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
III. Use a Representative and Generalizable Study Population	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
IV. Select the Study Indicators	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
VI. Use Valid and Reliable Data Collection Procedures	6/6	0/0	6/6	0/0	6/6	0/0	6/6	0/0
VII. Analyze and Interpret Study Results	8/8	1/1	8/8	1/1	7/8	1/1	8/8	1/1
VIII. Include Improvement Strategies	2/2	1/1	2/2	1/1	2/2	1/1	2/2	1/1
IX. Assess for Real Improvement	4/4	0/0	4/4	0/0	4/4	0/0	4/4	0/0
X. Assess for Sustained Improvement	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
Overall Score	**36/36**	**10/10**	**36/36**	**10/10**	**35/36**	**10/10**	**36/36**	**10/10**
Percentage of Elements Met	**100%**	**100%**	**100%**	**100%**	**97.2%**	**100%**	**100%**	**100%**
Validation Status	**Met**		**Met**		**Met**		**Met**	

APPENDIX B | 2019 Sample Assessment Tools

The assessment tools presented in this appendix represent a comprehensive sample of the tools used to evaluate performance for each EQR activity:

- ANA
- AQS
- PMV
- PIP Validation

The complete, individual MCC tools used for these listed reviews are contained within the individual MCC reports previously submitted to TennCare. Acronyms, abbreviations, and initialisms from these tools were not added to this report's list in the front matter.

ANA Review

The ANA tool templates are grouped by MCC and include all tools designed for MCOs and the DBM. The following were used to assess **Network Adequacy** and **Benefit Delivery** for TennCare's MCOs and DBM as part of the 2018 ANA:

- ANA Questionnaires (MCO and DBM)
- Evaluation Tools (MCO and DBM)
- Contract File Review Tools (MCO and DBM)

ANA Review Questionnaire

MCO General Information

Name of Managed Care Organization _____

Parent Organization _____

Mailing Address

Primary Street Mailing Address, Telephone Number and Fax Number:

Street _____

City _____ State _____

ZIP _____

Phone _____ Fax _____

Website _____

Address for Onsite Survey (if different from above):

Street _____

City _____ State _____

ZIP _____

Contact Information

Chief Executive Officer

Prefix ____ First Name _____ Last Name _____

Title _____

Address _____ Suite _____

City _____ State _____ ZIP _____

Phone _____ Fax _____ Email _____

Contact for Survey

Prefix ____ First Name _____ Last Name _____

Title _____

Address _____ Suite _____

City _____ State _____ ZIP _____

Phone _____ Fax _____ Email _____

Medical Director Prefix ____ First Name _____ Last Name _____

Title _____

Address _____ Suite _____

City _____ State _____ ZIP _____

Phone _____ Fax _____ Email _____

Number of TennCare members assigned to your plan as of November 30, 2018:

_____

MCO East Region–Network Standards

Attachments III and IV to the Contractor Risk Agreement (CRA) (Specialty Network Standards) requires provider agreements for specific specialist services.

If you do not have one or more of the specialist services listed in this table, please list the specialist type and explain the reason for the deficiency and the plan for correction.

Specialist Service	Number of Non-Dual Members
Allergy and 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	10,000
Orthopedic Surgery	15,000
Otolaryngology	30,000
Urology	30,000
Optometry	Distance of ≤30 Miles
Psychiatry (Adult)	25,000
Psychiatry (Child/Adolescent)	150,000

As specified in CRA A.2.11.3.1, provide the names of the hospitals with which you are contracted to provide each of the essential hospital services listed below:

Essential Hospital Service	Hospital Name
Neonatal	
Perinatal	
Pediatric	
Trauma	
Burn	

As specified in CRA A.2.6.1.5.3 and CRA A.2.6.7.2.3.1, list the name of the CHOICES HCBS providers with whom you are contracted to provide assisted care living facility services.

CHOICES HCBS	Facility Name
Assisted-care living facility services	

As specified in CRA A.2.11.3.1.2, provide your contracted centers of excellence (COEs) for people with HIV/AIDS (at least two per region).

COE: HIV/AIDS	Facility Name
COE: HIV/AIDS	
COE: HIV/AIDS	

As specified in CRA A.2.11.3.1.3, the contractor demonstrates a contractual arrangement with all COEs for behavioral health located within each Grand Region. Please provide your contracted centers.

COE: Behavioral Health	Facility Name
COE: Behavioral Health	

As specified in CRA A.2.8.4.3.4, the contractor has a weight management program that is provided as a cost-effective alternative service for members identified as overweight or obese. Please describe your services for these members.

As specified in CRA A.2.8.4.3.5, the contractor has a tobacco cessation program designed to address and reduce this health risk for members identified as users of tobacco. Please describe your services for these members.

MCO East Region—Covered Services

Does your MCO provide coverage for the treatment of phenylketonuria, including licensed professional medical services and special dietary formulas? *(Reference: T.C.A. 56-7-2505)*

☐ Yes ☐ No

Does your MCO provide coverage for conditions or disorders of hearing, or conditions or disorders of speech, voice or language, so long as such conditions or disorders receive treatment from duly licensed audiologists or speech pathologists? *(Reference: T.C.A. 56-7-2603)*

☐ Yes ☐ No

Does your MCO provide coverage for diabetic equipment, supplies and outpatient self-management training and education, including medical nutrition counseling, when medically necessary? *(Reference: T.C.A. 56-7-2605)*

☐ Yes ☐ No

Does your MCO provide coverage for one annual chlamydia screening test in conjunction with an annual Pap smear for females 29 years of age and younger, if deemed medically necessary? *(Reference: T.C.A. 56-7-2606)*

☐ Yes ☐ No

☐ Section A.2.11.6.1 of the CRA included the requirement that your MCO contracts with all current nursing facilities (as defined in T.C.A. 71-5-1412[a]) that meet all the Centers for Medicare & Medicaid Services (CMS) certification requirements. Does your MCO have contracts with all current nursing facilities willing to contract with your MCO in the state?
Yes ☐ No

If the answer is No, please state the reason(s) your MCO has not contracted with all current nursing facilities in the region(s).

_____

_____

MCO Middle Region–Network Standards

Attachments III and IV to the CRA (Specialty Network Standards) requires provider agreements for specific specialist services.

If you do not have one or more of the specialist services listed in this table, please list the specialist type and explain the reason for the deficiency and the plan for correction.

Specialist Service	Number of Non-Dual Members
Allergy and 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	10,000
Orthopedic Surgery	15,000
Otolaryngology	30,000
Urology	30,000
Optometry	Distance of ≤30 Miles
Psychiatry (Adult)	25,000
Psychiatry (Child/Adolescent)	150,000

As specified in CRA A.2.11.3.1, provide the names of the hospitals with which you are contracted to provide each of the essential hospital services listed below:

Essential Hospital Service	Hospital Name
Neonatal	
Perinatal	
Pediatric	
Trauma	
Burn	

As specified in CRA A.2.6.1.5.3 and CRA A.2.6.7.2.3.1, list the name of the CHOICES HCBS providers with whom you are contracted to provide assisted care living facility services.

CHOICES HCBS	Facility Name
Assisted-care living facility services	

As specified in CRA A.2.11.3.1.2, provide your contracted centers of excellence (COEs) for people with HIV/AIDS (at least two per region).

COE: HIV/AIDS	Facility Name
COE: HIV/AIDS	
COE: HIV/AIDS	

As specified in CRA A.2.11.3.1.3, the contractor demonstrates a contractual arrangement with all COEs for behavioral health located within each Grand Region. Please provide your contracted centers.

COE: Behavioral Health	Facility Name
COE: Behavioral Health	

As specified in CRA A.2.8.4.3.4, the contractor has a weight management program that is provided as a cost-effective alternative service for members identified as overweight or obese. Please describe your services for these members.

As specified in CRA A.2.8.4.3.5, the contractor has a tobacco cessation program designed to address and reduce this health risk for members identified as users of tobacco. Please describe your services for these members.

MCO Middle Region—Covered Services

Does your MCO provide coverage for the treatment of phenylketonuria, including licensed professional medical services and special dietary formulas? *(Reference: T.C.A. 56-7-2505)*

☐ Yes ☐ No

Does your MCO provide coverage for conditions or disorders of hearing, or conditions or disorders of speech, voice or language, so long as such conditions or disorders receive treatment from duly licensed audiologists or speech pathologists? *(Reference: T.C.A. 56-7-2603)*

☐ Yes ☐ No

Does your MCO provide coverage for diabetic equipment, supplies and outpatient self-management training and education, including medical nutrition counseling, when medically necessary? *(Reference: T.C.A. 56-7-2605)*

☐ Yes ☐ No

Does your MCO provide coverage for one annual chlamydia screening test in conjunction with an annual Pap smear for females 29 years of age and younger, if deemed medically necessary? *(Reference: T.C.A. 56-7-2606)*

☐ Yes ☐ No

☐ Section A.2.11.6.1 of the CRA included the requirement that your MCO contracts with all current nursing facilities (as defined in T.C.A. 71-5-1412[a]) that meet all the Centers for Medicare & Medicaid Services (CMS) certification requirements. Does your MCO have contracts with all current nursing facilities willing to contract with your MCO in the state?
Yes ☐ No

If the answer is No, please state the reason(s) your MCO has not contracted with all current nursing facilities in the region(s).

_____

_____

MCO West Region–Network Standards

Attachments III and IV to the CRA (Specialty Network Standards) requires provider agreements for specific specialist services.

If you do not have one or more of the specialist services listed in this table, please list the specialist type and explain the reason for the deficiency and the plan for correction.

Specialist Service	Number of Non-Dual Members
Allergy and 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	10,000
Orthopedic Surgery	15,000
Otolaryngology	30,000
Urology	30,000
Optometry	Distance of ≤30 Miles
Psychiatry (Adult)	25,000
Psychiatry (Child/Adolescent)	150,000

As specified in CRA A.2.11.3.1, provide the names of the hospitals with which you are contracted to provide each of the essential hospital services listed below:

Essential Hospital Service	Hospital Name
Neonatal	
Perinatal	
Pediatric	
Trauma	
Burn	

As specified in CRA A.2.6.1.5.3 and CRA A.2.6.7.2.3.1, list the name of the CHOICES HCBS providers with whom you are contracted to provide assisted care living facility services.

CHOICES HCBS	Facility Name
Assisted-care living facility services	

As specified in CRA A.2.11.3.1.2, provide your contracted centers of excellence (COEs) for people with HIV/AIDS (at least two per region).

COE: HIV/AIDS	Facility Name
COE: HIV/AIDS	
COE: HIV/AIDS	

As specified in CRA A.2.11.3.1.3, the contractor demonstrates a contractual arrangement with all COEs for behavioral health located within each Grand Region. Please provide your contracted centers.

COE: Behavioral Health	Facility Name
COE: Behavioral Health	

As specified in CRA A.2.8.4.3.4, the contractor has a weight management program that is provided as a cost-effective alternative service for members identified as overweight or obese. Please describe your services for these members.

As specified in CRA A.2.8.4.3.5, the contractor has a tobacco cessation program designed to address and reduce this health risk for members identified as users of tobacco. Please describe your services for these members.

MCO West Region—Covered Services

Does your MCO provide coverage for the treatment of phenylketonuria, including licensed professional medical services and special dietary formulas? *(Reference: T.C.A. 56-7-2505)*

☐ Yes ☐ No

Does your MCO provide coverage for conditions or disorders of hearing, or conditions or disorders of speech, voice or language, so long as such conditions or disorders receive treatment from duly licensed audiologists or speech pathologists? *(Reference: T.C.A. 56-7-2603)*

☐ Yes ☐ No

Does your MCO provide coverage for diabetic equipment, supplies and outpatient self-management training and education, including medical nutrition counseling, when medically necessary? *(Reference: T.C.A. 56-7-2605)*

☐ Yes ☐ No

Does your MCO provide coverage for one annual chlamydia screening test in conjunction with an annual Pap smear for females 29 years of age and younger, if deemed medically necessary? *(Reference: T.C.A. 56-7-2606)*

☐ Yes ☐ No

☐ Section A.2.11.6.1 of the CRA included the requirement that your MCO contracts with all current nursing facilities (as defined in T.C.A. 71-5-1412[a]) that meet all the Centers for Medicare & Medicaid Services (CMS) certification requirements. Does your MCO have contracts with all current nursing facilities willing to contract with your MCO in the state?
Yes ☐ No

If the answer is No, please state the reason(s) your MCO has not contracted with all current nursing facilities in the region(s).

_____

_____

MCO Statewide Network Standards

Attachments III and IV to the TennCare*Select* Agreement (TSA) (Specialty Network Standards) requires provider agreements for specific specialist services.

If you do not have one or more of the specialist services listed in this table, please list the specialist type and explain the reason for the deficiency and the plan for correction.

Specialist Service	Number of Non-Dual Members
Allergy and 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	10,000
Orthopedic Surgery	15,000
Otolaryngology	30,000
Urology	30,000
Optometry	Distance of ≤30 Miles
Psychiatry (Adult)	25,000
Psychiatry (Child/Adolescent)	150,000

As specified in TSA 2.11.3.1, provide the names of the hospitals with which you are contracted to provide each of the essential hospital services listed below:

Essential Hospital Service	Hospital Name
Neonatal	
Perinatal	
Pediatric	
Trauma	
Burn	

As specified in TSA 2.6.1.5.3 and A.2.6.7.2.3.1, list the name of the CHOICES HCBS providers with whom you are contracted to provide assisted care living facility services.

CHOICES HCBS	Facility Name
Assisted-care living facility services	

As specified in TSA 2.11.3.1.2, provide your contracted centers of excellence (COEs) for people with HIV/AIDS (at least two per region).

COE: HIV/AIDS	Facility Name
COE: HIV/AIDS	
COE: HIV/AIDS	

As specified in TSA 2.11.3.1.3, the contractor demonstrates a contractual arrangement with all COEs for behavioral health located within each Grand Region. Please provide your contracted centers.

COE: Behavioral Health	Facility Name
COE: Behavioral Health	

As specified in TSA 2.8.4.3.4, the contractor has a weight management program that is provided as a cost-effective alternative service for members identified as overweight or obese. Please describe your services for these members.

As specified in TSA 2.8.4.3.5, the contractor has a tobacco cessation program designed to address and reduce this health risk for members identified as users of tobacco. Please describe your services for these members.

As specified in TSA 2.11.3.1.4, the contractor must have a contractual arrangement with all Centers of Excellence for children in or at risk of State custody:

> State your contracted COEs for children in or at risk of State custody and the timeframe of the contract (e.g., January 1 to December 31, 2018).

MCO Statewide Covered Services

Does your MCO provide coverage for the treatment of phenylketonuria, including licensed professional medical services and special dietary formulas? *(Reference: T.C.A. 56-7-2505)*

☐ Yes ☐ No

Does your MCO provide coverage for conditions or disorders of hearing, or conditions or disorders of speech, voice or language, so long as such conditions or disorders receive treatment from duly licensed audiologists or speech pathologists? *(Reference: T.C.A. 56-7-2603)*

☐ Yes ☐ No

Does your MCO provide coverage for diabetic equipment, supplies and outpatient self-management training and education, including medical nutrition counseling, when medically necessary? *(Reference: T.C.A. 56-7-2605)*

☐ Yes ☐ No

Does your MCO provide coverage for one annual chlamydia screening test in conjunction with an annual Pap smear for females 29 years of age and younger, if deemed medically necessary? *(Reference: T.C.A. 56-7-2606)*

☐ Yes ☐ No

Section 2.11.6.1 of the TSA included the requirement that your MCO contracts with all current nursing facilities (as defined in T.C.A. 71-5-1412[a]) that meet all the Centers for Medicare & Medicaid Services (CMS) certification requirements. Does your MCO have contracts with all current nursing facilities willing to contract with your MCO in the state? Yes ☐ No

If the answer is No, please state the reason(s) your MCO has not contracted with all current nursing facilities in the region(s).

_____

_____

DBM General Information

Name of Dental Benefits Manager _____

Parent Organization _____

Mailing Address

Primary Street Mailing Address, Telephone Number and Fax Number:

Street _____

City _____ State _____

ZIP _____

Phone _____ Fax _____

Website _____

Address for Onsite Survey (if different from above):

Street _____

City _____ State _____

ZIP _____

Contact Information

Chief Executive Officer

Prefix ____ First Name _____ Last Name _____

Title _____

Address _____ Suite _____

City _____ State _____ ZIP _____

Phone _____ Fax _____ Email _____

Contact for Survey

Prefix ____ First Name _____ Last Name _____

Title _____

Address _____ Suite _____

City _____ State _____ ZIP _____

Phone _____ Fax _____ Email _____

Dental Director Prefix ____ First Name _____ Last Name _____

Title _____

Address _____ Suite _____

City _____ State _____ ZIP _____

Phone _____ Fax _____ Email _____

Number of TennCare members assigned to the DBM as of November 30, 2018:

_____

Number of participating dentists and other dental specialists for your TennCare population by specialty as of November 30, 2018.

_____

Provider Type	Number of Providers	Percent With Open Panels
Dentists		
Orthodontists		
Endodontists		
Oral Surgeons		
Periodontists		
Other (please explain)		
Total		

The TennCare Dental Benefit Manager Contract (TDC), Section A.19, Access to Care, requires that dental providers' wait times for a regular appointment not exceed three weeks from the date of a patient's request or 48 hours for urgent care. Waiting time after arrival for a scheduled appointment is not to exceed 45 minutes. Please explain how you track and measure these requirements, and provide your most recent results in the table below.

Provider Type	Percentage of Regular Appointments Exceeding 3 Weeks	Percentage of Urgent Appointments Exceeding 48 Hours	Percentage of Wait Times Exceeding 45 Minutes
GDPs			
SDPs			

Explain how you collect and measure the data in the table above:

What actions are taken if providers exceed the appointment availability and office wait time requirements?

MCC Attestation Statement

I hereby certify that I have reviewed the information entered on this questionnaire and that, to the best of my knowledge, the information is complete and accurate as of the date below.

_____ _____

Signature of CEO or responsible individual Date

_____

Print name and title

Please mail or scan and upload the signed attestation statement by **January 11, 2019**, to:

Debra L. Chotkevys, DHA, MBA
Executive Director, Professional Services
Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 300
Phoenix, Arizona 85016
dchotkevys@hsag.com

Thank you for your prompt response.

Evaluation Tool

MCO

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO***
			Value	**Score**	
Standards for Availability and Accessibility					
1. Informing Members of Emergency Medical Services CRA A.2.7.1.1 TSA 2.7.1.1 TCA 56-7-2356(a)(1)	There is evidence through a review of P&Ps and the Member Handbook that members are informed that emergency medical services are available at any available emergency care facility 24 hours a day, 7 days a week (including services outside the usual service area).	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
2. Informing Providers of Emergency Medical Services CRA A.2.7.1.1 TSA 2.7.1.1 TCA 56-7-2356(a)(1)	There is evidence through a review of P&Ps and the Provider Manual that providers are informed that emergency medical services are available at any available emergency care facility 24 hours a day, 7 days a week (including services outside the usual service area).	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					

* *This column was submitted by the MCO with the pre-onsite documentation and the content has not been altered or corrected grammatically. This tool does not include any attachments provided with the MCO submission.*

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO***
			Value	**Score**	
Standards for Availability and Accessibility					
3. Maximum Members per Provider CRA Attachment IV TSA Attachment IV	The MCO has processes and procedures in place to ensure that ratios of non-dual-eligible members to providers remain below the following maximum limits: **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: 10,000 Orthopedic Surgery: 15,000 Otolaryngology: 30,000 Psychiatry (Adult): 25,000 Psychiatry (Child and Adolescent): 150,000 Urology: 30,000	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO***
			Value	**Score**	
Standards for Availability and Accessibility					
4. Appointment/Wait Times for PCPs CRA Attachment III TSA Attachment III	Through a review of plan documents, there is evidence that the MCO requires that providers offer adequate access to covered services. At a minimum, access standards must specify that 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	a. ☐ Met ☐ Not Met b. ☐ Met ☐ Not Met c. ☐ Met ☐ Not Met Variables a & b = .33 Variable c = .34	**1.0**	**0.0**	
Findings:					
Recommendations:					
5. Appointment/Wait Times for SCPs CRA Attachment III TSA Attachment III	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	a. ☐ Met ☐ Not Met b. ☐ Met ☐ Not Met c. ☐ Met ☐ Not Met Variables a & b = .33 Variable c = .34	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO***
			Value	**Score**	
Standards for Availability and Accessibility					
6. Appointment/Wait Times for Optometry CRA Attachment III TSA Attachment III	Through a review of plan documents, there is evidence that the MCO requires that providers offer adequate access to covered services. At a minimum, access standards must specify that optometry wait times: a. 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	a. ☐ Met ☐ Not Met b. ☐ Met ☐ Not Met c. ☐ Met ☐ Not Met Variables a & b = .33 Variable c = .34	**1.0**	**0.0**	
Findings:					
Recommendations:					
7. Timeliness Standards for Access to BH Services CRA Attachment V TSA Attachment V	The MCO has standards for timeliness of access to BH services. There is evidence in plan documents that the MCO continually monitors its compliance with these standards and takes corrective action as necessary.	☐ Met ☐ Not Met ☐ NA*	**1.0**	**0.0**	
Findings:					
Recommendations:					
8. Standards for Timely Access to Psychiatric Inpatient Hospital Services CRA Attachment V TSA Attachment V	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**	

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

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO***
			Value	**Score**	
Standards for Availability and Accessibility					
Findings:					
Recommendations:					
9. Standards for Timely Access to 24-Hour Psychiatric Residential Treatment CRA Attachment V TSA Attachment V	The BH standards include access standards for 24-hour psychiatric residential treatment within 30 calendar days.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
10. Standards for Timely Access to Outpatient (Non-Medical Doctor [MD]) and Intensive Outpatient Services CRA Attachment V TSA Attachment V	The BH standards include access standards for outpatient mental health services, including non-MD and intensive outpatient (may include day treatment [adult], intensive day treatment [children and adolescents] or partial hospitalization), within 10 business days, and within 48 hours if urgent.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
11. Standards for Timely Access to Inpatient Substance Abuse Services CRA Attachment V TSA Attachment V	The BH standards include access standards for inpatient substance abuse services: a. Within 2 calendar days for detoxification b. Within 4 hours in an emergency c. Within 24 hours for a nonemergency	a. ☐ Met ☐ Not Met b. ☐ Met ☐ Not Met c. ☐ Met ☐ Not Met Variables a & b = .33 Variable c = .34	**1.0**	**0.0**	

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by MCO*
			Value	Score	
Standards for Availability and Accessibility					
Findings:					
Recommendations:					
12. Access Standards for Timely Access to 24-Hour Residential Substance Abuse Services CRA Attachment V TSA Attachment V	The BH standards include access standards for 24-hour residential substance abuse services within 10 business days.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
13. Access Standards for Timely Access to Outpatient Substance Abuse Services CRA Attachment V TSA Attachment V	The BH standards include access standards for outpatient substance abuse treatment: a. Within 10 business days b. Within 24 hours for detoxification	a. ☐ Met ☐ Not Met b. ☐ Met ☐ Not Met Each Variable=.50	**1.0**	**0.0**	
Findings:					
Recommendations:					
14. Access Standards for Timely Access to Intensive Community-Based Treatment Services CRA Attachment V TSA Attachment V	The BH standards include access standards for intensive community-based treatment services within 7 calendar days.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO***
			Value	**Score**	
Standards for Availability and Accessibility					
15. Access Standards for Timely Access to Tennessee Health Link Services CRA Attachment V TSA Attachment V	The BH standards include access standards for Tennessee Health Link services within 30 calendar days.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
16. Access Standards for Timely Access to Psychosocial Rehabilitation CRA Attachment V TSA Attachment V	The BH standards include access standards for psychosocial rehabilitation within 10 business days.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
17. Access Standards for Timely Access to Supported Employment CRA Attachment V TSA Attachment V	The BH standards include access standards for supported employment within 10 business days.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
18. Access Standards for Timely Access to Peer Recovery Services or Family Support CRA Attachment V TSA Attachment V	The BH standards include access standards for peer support within 10 business days.	☐ Met ☐ Not Met	**1.0**	**0.0**	

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO***
			Value	**Score**	
Standards for Availability and Accessibility					
Findings:					
Recommendations:					
19. Access Standards for Timely Access to Illness Management and Recovery CRA Attachment V TSA Attachment V	The BH standards include access standards for illness management and recovery within 10 business days.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
20. Standards for Timely Access to Mobile Crisis Services CRA Attachment V TSA Attachment V	The BH standards include access standards for BH crisis services (mobile), which includes face-to-face contact: a. Within 2 hours for emergency situations b. Within 4 hours for urgent situations	a. ☐ Met ☐ Not Met b. ☐ Met ☐ Not Met Each Variable=.50	**1.0**	**0.0**	
Findings:					
Recommendations:					
21. Standards for Timely Access to Crisis Stabilization CRA Attachment V TSA Attachment V	The BH standards include access standards for crisis stabilization within 4 hours of the referral.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
22. Standards for Timely Access to Supported Housing CRA Attachment V TSA Attachment V	The BH standards include access standards for supported housing within 30 calendar days.	☐ Met ☐ Not Met	**1.0**	**0.0**	

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO***
			Value	**Score**	
Standards for Availability and Accessibility					
Findings:					
Recommendations:					
23. Geographic Access Requirements CRA Attachments III & V TSA Attachment III & V	The MCO has standards for geographic access to care. There is evidence in plan documents that the MCO continually monitors its compliance with these standards and takes corrective action as necessary.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
24. Geographic Access Requirements for Psychiatric Inpatient Hospital Services CRA Attachment V TSA Attachment V	The BH standards include access standards for psychiatric inpatient hospital services: Travel distance is equal to or less than 90 miles and 120 minutes travel time for all members.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
25. Geographic Access Requirements for Outpatient Non-MD BH Services CRA Attachment V TSA Attachment V	The BH standards include access standards for outpatient mental health services: Travel distance for non-MD services is equal to or less than 30 miles and 45 minutes travel time for at least 75% of members; and is equal to or less than 60 miles and 60 minutes travel time for all members	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO***
			Value	**Score**	
Standards for Availability and Accessibility					
26. Geographic Access Requirements for Intensive Outpatient BH Services CRA Attachment V TSA Attachment V	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 equal to or less than 90 miles and 90 minutes travel time for 75% of the members; and is equal to or less than 120 miles and 120 minutes travel time for all members.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
27. Geographic Access Requirements for Inpatient Substance Abuse Services CRA Attachment V TSA Attachment V	The BH standards include access standards for inpatient substance abuse services: Travel distance is equal to or less than 90 miles and 120 minutes travel time for all members.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
28. Geographic Access Requirements for Outpatient Treatment for Substance Abuse CRA Attachment V TSA Attachment V	The BH standards include access standards for outpatient treatment: Travel distance is equal to or less than 30 miles and 30 minutes travel time for 75% of the members; and equal to or less than 45 miles and 45 minutes travel time for all members.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO***
			Value	**Score**	
Standards for Availability and Accessibility					
29. Geographic Access Requirements for Opioid Use Disorder Treatment Providers CRA Attachment IV TSA Attachment IV	The BH standards include access standards for opioid use disorder treatment providers: Travel distance is equal to or less than 45 miles and 45 minutes travel time for 75% of the non-dual members; and equal to or less than 60 miles and 60 minutes travel time for all non-dual members.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
30. Monthly Provider Enrollment File CRA A.2.30.8.1 TSA 2.30.8.1	The MCO submits a monthly Provider Enrollment File.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
31. Quarterly Reporting Requirements CRA A.2.30.8.3 CRA A.2.30.8.6 CRA A.2.30.8.9–10 CRA A.2.30.14.1 TSA 2.30.8.3 TSA 2.30.8.6 TSA 2.30.14	The MCO submits the following required quarterly reports: a. PCP Assignment Report b. BH Appointment Timeliness Summary Report c. CHOICES HCBS and ECF CHOICES Provider Criminal Background Check and Registry Check Report d. CHOICES HCBS AND ECF CHOICES Member Complaints Reports (NA for TennCare*Select*) e. HCBS Settings Report (NA for TennCare*Select*)	a. ☐ Met ☐ Not Met b. ☐ Met ☐ Not Met c. ☐ Met ☐ Not Met ☐ NA d. ☐ Met ☐ Not Met ☐ NA e. ☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO***
			Value	**Score**	
Standards for Availability and Accessibility					
	f. TennCare*Select* Member Complaint Report (including CHOICES members) (TennCare*Select* only)	f. ☐ Met ☐ Not Met ☐ NA Variables a & b = .166 Variable c-f = .167			
Findings:					
Recommendations:					
32. Annual Reporting Requirements CRA A.2.30.8.2 CRA A.2.30.8.4-5 CRA A.2.30.8.7–8 TSA 30.8.2 TSA 2.30.8.4–5 TSA 2.30.8.7–8	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. CHOICES HCBS and ECF CHOICES Qualified Workforce Strategies Report (NA for TennCare*Select*) d. Federally Qualified Health Center (FQHC) Report by January 1 of each year e. Monitoring of Behavioral Health Appointment Timeliness	a. ☐ Met ☐ Not Met b. ☐ Met ☐ Not Met c. ☐ Met ☐ Not Met ☐ NA d. ☐ Met ☐ Not Met e. ☐ Met ☐ Not Met Each Variable=.20	**1.0**	**0.0**	
Findings:					
Recommendations:					
33. Annual Plan for Monitoring BH Appointment Timeliness CRA A.2.30.8.5 TSA 2.30.8.5	The MCO submits an Annual Plan for the Monitoring of BH Appointment Timeliness that includes the MCO's plan for monitoring BH providers to ensure that they comply with the timeliness of appointment standards.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO***
			Value	**Score**	
Standards for Availability and Accessibility					
34. Provider Satisfaction Survey Report: Medicaid CRA A.2.30.13.3 TSA 2.30.13.3	A Provider Satisfaction Survey Report that encompasses behavioral and physical health is submitted to TennCare by January 30 each year beginning.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
35. Provider Satisfaction Survey Report: CHOICES CRA A.2.30.13.4 TSA 2.30.13.4	A CHOICES Provider Satisfaction Survey Report addressing results for CHOICES long-term care providers is submitted to TennCare by January 30 each year.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
36. Appointments Scheduling CRA Attachment III TSA Attachment III	There is evidence through a review of plan documents that the MCO has a system in place to evaluate providers' compliance with appointment scheduling times (e.g., cold calling).	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
37. Exchange of Information CRA Attachment III TSA Attachment III	There is evidence that the MCO has a system in place to document the exchange of member information if a provider, other than the PCP, provides healthcare (e.g., a school-based clinic or health department clinic).	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by MCO***
			Value	**Score**	
Standards for Availability and Accessibility					
38. PCP Selection CRA A.2.11.2.6 TSA 2.11.2.7	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. The P&P for changing with good cause includes a definition of "good cause" and the procedure to request a change.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
Standard Score for Availability and Accessibility		**0%**	**38.0**	**0.0**	

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
1. Inpatient Hospital Services CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary Under age 21: Includes rehabilitation hospital facility Age 21 and older: Inpatient rehabilitation hospital facility services are not covered for adults unless determined to be a cost effective alternative.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	

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

† *This column was submitted by the MCO with the pre-onsite documentation and the content has not been altered or corrected grammatically. This tool does not include any attachments provided with the MCO submission.*

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	Criteria	Criteria Met*	Element		Documentation/Evidence as Provided by MCO†
			Value	Score	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
Findings:					
Recommendations:					
2. Outpatient Hospital Services CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
3. Physician Inpatient Services CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
4. Physician Outpatient Services/Community Health Clinic Services/ Other Clinic Services CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
5. Lab and X-Ray Services CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
6. Maternity/ Postpartum Services TCA 56-7-2350	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
7. Hospice Care CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary (must be provided by a Medicare-Certified Hospice)	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
8. Vision Services CRA A.2.6.1.3 TSA 2.6.1.3	Preventive, diagnostic, and treatment services (including eyeglasses) for members younger than 21 years of age as medically necessary in accordance with TennCare Kids requirements. One pair of cataract glasses or lenses following cataract surgery is covered for adults. Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye, is covered as medically necessary.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
9. Home Healthcare CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary for those younger or older than 21 years of age in accordance with the definition of home health care in the Tennessee rules	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
10. Durable Medical Equipment CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary and covered in accordance with TennCare rules and regulations	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
11. Medical Supplies CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary and covered in accordance with TennCare rules and regulations	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
12. Emergency Air and Ground Ambulance Transportation CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
13. Nonemergency Transportation, Including Nonemergency Ambulance Transportation CRA A.2.6.1.3 TSA 2.6.1.3	Nonemergency transportation services are provided in accordance with federal law and the Tennessee Division of TennCare's rules and P&Ps. Nonemergency transportation services are provided to convey members to and from TennCare covered services.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
14. Renal Dialysis Services CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
15. TennCare Kids Services CRA A.2.6.1.3 TSA 2.6.1.3	Services for members younger than 21 years of age: a. As medically necessary, except that screenings do not have to be medically necessary b. Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal and state requirements	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
16. Preventive Care Services CRA A.2.7.5.1 TSA 2.7.5	The MCO provides preventive services, which include, but are not limited to, initial and periodic evaluations, family planning services, prenatal care, laboratory services, and immunizations in accordance with TennCare rules and regulations.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
17. Occupational Therapy CRA A.2.6.1.3 TSA 2.6.1.3	**Occupational Therapy:** a. Age 21 and older, as medically necessary, when provided by a licensed occupational therapist to restore, improve, or stabilize impaired functions b. Younger than age 21, as medically necessary, in accordance with TennCare Kids requirements	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
18. Physical Therapy CRA A.2.6.1.3 TSA 2.6.1.3	**Physical Therapy:** a. Age 21 and older, as medically necessary, when provided by a licensed physical therapist to restore, improve, or stabilize impaired functions b. Younger than age 21, as medically necessary, in accordance with TennCare Kids requirements	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
19. Chiropractic Services CRA A.2.6.1.3 TSA 2.6.1.3	**Chiropractic Services:** a. Age 21 and older, covered when determined to be a cost-effective alternative by the MCO b. Younger than age 21, covered as medically necessary in accordance with TennCare Kids requirements	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
20. Private Duty Nursing CRA A.2.6.1.3 TSA 2.6.1.3	Private duty nursing is covered as medically necessary in accordance with the definition of private duty nursing in the Tennessee rules.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
21. Speech Therapy CRA A.2.6.1.3 TSA 2.6.1.3	**Speech Therapy:** a. Age 21 and older, as medically necessary, when provided by a licensed speech therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic, or personality disorder. b. Younger than age 21, as medically necessary in accordance with TennCare Kids requirements	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
22. Organ and Tissue Transplants and Donor Organ Procurement CRA A.2.6.1.3 TSA 2.6.1.3	**Organ and Tissue Transplants and Donor Organ Procurement:** a. Age 21 and older, all medically necessary and non-investigational/ experimental organ and tissue transplants, as covered by Medicare b. Younger than age 21, covered as medically necessary in accordance with TennCare Kids requirements	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
23. Reconstructive Breast Surgery CRA A.2.6.1.3 TSA 2.6.1.3	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, as well as any surgical procedure 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 will only be covered if the surgical procedure performed on a nondiseased breast occurs within five years of the date the reconstructive breast surgery was performed on a diseased breast.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
24. Mammography Screening TCA 56-7-2502	The MCO provides mammography screenings a minimum of once for ages 35–40, every two years or more frequently on physician recommendation for ages 40–50 and annually for ages 50 and older.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
25. Phenylketonuria (PKU) TCA 56-7-2505 2019 MCO Provider Network Adequacy and Benefit Delivery Review Questionnaire	The MCO provides coverage for the treatment of PKU, including licensed professional medical services and special dietary formulas.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
26. Diabetic Services TCA 56-7-2605 2019 MCO Provider Network Adequacy and Benefit Delivery Review Questionnaire	The MCO provides coverage for diabetic equipment, supplies, and outpatient self-management training and education, including medical nutrition counseling, when medically necessary.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
27. Chlamydia Screens TCA 56-7-2606 2019 MCO Provider Network Adequacy and Benefit Delivery Review Questionnaire	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.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
28. Psychiatric Inpatient Hospital Services (Including Physician Services) CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
29. Outpatient Mental Health Services (Including Physician Services) CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
30. Inpatient/Residential and Outpatient Substance Abuse Benefits CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
31. 24-Hour Psychiatric Residential Treatment CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
32. BH Crisis Services CRA A.2.6.1.4 TSA 2.6.1.4	As necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
33. BH Intensive Community Based Treatment CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
34. Psychiatric Rehabilitation Services CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
35. CHOICES: Nursing Facility Care CRA A.2.6.1.5.3 CRA A.2.6.1.6.4 TSA 2.6.1.5.3	As medically necessary: For CHOICES members in Group 1; on a short-term basis only (up to 90 days) for members in CHOICES Groups 2 and 3.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA*	**1.0**	**0.0**	
Findings:					
Recommendations:					

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

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	Criteria	Criteria Met*	Element		Documentation/Evidence as Provided by MCO†
			Value	Score	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
36. CHOICES: Community-Based Residential Alternatives CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary for CHOICES members in Group 2. For Group 3, specified services and levels of reimbursement only (i.e., assisted care living facility, community living supports(CLS1), and community living supports—family model (CLS-FM1).	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
37. CHOICES: Personal Care Visits CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to two visits per day at intervals of no less than four hours between visits) for CHOICES members in Groups 2 and 3.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
38. CHOICES: Attendant Care CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to 1,080 hours per calendar year; up to 1,400 hours per full calendar year only for persons who require covered assistance with household chores or errands in addition to hands-on assistance with self-care tasks) for CHOICES members in Groups 2 and 3.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
39. CHOICES: Home-Delivered Meals CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to one meal per day) for CHOICES members in Groups 2 and 3.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
40. CHOICES: PERS CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary for CHOICES members in Groups 2 and 3.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
41. CHOICES: Adult Day Care CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to 2,080 hours per calendar year) for CHOICES members in Groups 2 and 3.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
42. CHOICES: In-Home Respite Care CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to 216 hours per calendar year) for CHOICES members in Groups 2 and 3.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
43. CHOICES: Inpatient Respite Care CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to nine days per calendar year) for CHOICES members in Groups 2 and 3.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
44. CHOICES: Assistive Technology CRA A.2.6.1.5.3 CRA A.2.6.1.6.3 TSA 2.6.1.5.3	As medically necessary up to $900 per calendar year for CHOICES members in Group 2 and3; and up to $5,000 per calendar year for ECF Choices members in Groups 4, 5, and 6. (TennCare*Select* Groups 2 and 3 only)	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
45. CHOICES: Minor Home Modifications CRA A.2.6.1.5.3 CRA A.2.6.1.6.3 TSA 2.6.1.5.3	As medically necessary up to $6,000 per project, $10,000 per calendar year, and $20,000 per lifetime for CHOICES members in Groups 2, 3, 4, 5, and 6. (TennCare*Select* Groups 2 and 3 only)	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
46. CHOICES Pest Control CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to nine units per calendar year) for CHOICES members in Groups 2 and 3.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
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.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					

* *TennCareSelect does not provide services to the ECF CHOICES population*

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
Recommendations:					
48. ECF CHOICES: 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**	
Findings:					
Recommendations:					
49. ECF CHOICES: 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**	
Findings:					
Recommendations:					
50. ECF CHOICES: 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, and 6.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
51. ECF CHOICES: Community Transportation CRA A.2.6.1.6.3	As medically necessary for ECF CHOICES members in Groups 4, 5, and 6.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
52. ECF CHOICES: 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, and 6.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
53. ECF CHOICES: Community Support CRA A.2.6.1.6.3	As medically necessary for community support development, organization, and navigation for ECF CHOICES members in Group 4.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
54. ECF CHOICES: 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.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
55. ECF CHOICES: Family-to-Family Support 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**	
Findings:					
Recommendations:					
56. ECF CHOICES: Conservatorship CRA A.2.6.1.6.3	As medically necessary for conservatorship and alternatives to conservatorship counseling and assistance (up to $500 per lifetime) for ECF CHOICES members in Groups 4, 5, and 6.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	Criteria	Criteria Met*	Element		Documentation/Evidence as Provided by MCO†
			Value	Score	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
57. ECF CHOICES: 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 Group 4.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
58. ECF CHOICES: 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**	
Findings:					
Recommendations:					
59. ECF CHOICES: 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**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	Criteria	Criteria Met*	Element		Documentation/Evidence as Provided by MCO†
			Value	Score	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
60. ECF CHOICES: 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**	
Findings:					
Recommendations:					
61. ECF CHOICES: 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 and 6.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
62. ECF CHOICES: Peer-to-peer Person-centered Planning, Self-Direction, Employment, and Community Support and Navigation CRA A.2.6.1.6.3	As medically necessary for person-centered planning, self-direction, integrated employment/self-employment, and independent community living (up to $1,500 per lifetime) for ECF CHOICES members in Groups 5 and 6.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
63. ECF CHOICES: 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 and 6. For adults in Group 6, benefit group determined to have exceptional medical and/or behavioral support needs, specialized consultation services are limited to $10,000 per person per calendar year.	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
64. ECF CHOICES: 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, and 6. Group 4 benefits limited to adults age 21 and older	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
65. ECF CHOICES: 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, and 6: ♦ Supported employment: Individual employment support ♦ Exploration ♦ Benefits counseling ♦ Discovery ♦ Situational observation and assessment ♦ Job development plan or self-employment plan ♦ Job development or self-employment start up ♦ Job coaching for individualized, integrated employment, or self-employment ♦ Coworker supports ♦ Career advancement	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
66. Regulator Approval: Medicaid Handbook CRA A.2.18.6.13 TSA 2.18.6.13	The MCO's Medicaid Member Handbook was approved by TennCare. Date of Approval: Month Day, Year (Please be prepared to show proof of the approval during the onsite audit.)	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits, or another location described.)					
67. Regulator Approval: ECF Handbook CRA A.2.18.6.13	The MCO's ECF CHOICES Member Handbook was approved by TennCare. Date of Approval: Month Day, Year (Please be prepared to show proof of the approval during the onsite audit.)	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
Accessibility Benefits Review—Member		**0%**	**67.0**	**0.0**	

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
1. Inpatient Hospital Services CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary Under age 21: Includes rehabilitation hospital facility Age 21 and older: Inpatient rehabilitation hospital facility services are not covered for adults unless determined to be a cost effective alternative.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

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

† *This column was submitted by the MCO with the pre-onsite documentation and the content has not been altered or corrected grammatically. This tool does not include any attachments provided with the MCO submission.*

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
2. Outpatient Hospital Services CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
3. Physician Inpatient Services CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
4. Physician Outpatient Services/Community Health Clinic Services/ Other Clinic Services CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
5. Lab and X-Ray Services CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
6. Maternity/ Postpartum Services TCA 56-7-2350	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
7. Hospice Care CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary (must be provided by a Medicare-Certified Hospice)	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
8. Vision Services CRA A.2.6.1.3 TSA 2.6.1.3	Preventive, diagnostic, and treatment services (including eyeglasses) for members younger than 21 years of age as medically necessary in accordance with TennCare Kids requirements. One pair of cataract glasses or lenses following cataract surgery is covered for adults. Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye, is covered as medically necessary.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
9. Home Healthcare CRA A.2.6.1.3 TSA 2.6.1.3	Covered as medically necessary for those younger or older than 21 years of age in accordance with the definition of home healthcare in the Tennessee rules.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
Recommendations:					
10. Durable Medical Equipment CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary and covered in accordance with TennCare rules and regulations.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
11. Medical Supplies CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary and covered in accordance with TennCare rules and regulations.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
12. Emergency Air and Ground Ambulance Transportation CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
13. Nonemergency Transportation, Including Nonemergency Ambulance Transportation CRA A.2.6.1.3 TSA 2.6.1.3	Nonemergency transportation services are provided in accordance with federal law and the Tennessee Division of TennCare's rules and P&Ps. Nonemergency transportation services are provided to convey members to and from TennCare covered services.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
Findings:					
Recommendations:					
14. Renal Dialysis Services CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
15. TennCare Kids Services CRA A.2.6.1.3 TSA 2.6.1.3	Services for members younger than 21 years of age: a. As medically necessary, except that screenings do not have to be medically necessary b. Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal and state requirements	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
16. Preventive Care Services CRA A.2.7.1 TSA 2.7.5	The MCO provides preventive services, which include, but are not limited to, initial and periodic evaluations, family planning services, prenatal care, laboratory services, and immunizations in accordance with TennCare rules and regulations.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
17. Occupational Therapy CRA A.2.6.1.3 TSA 2.6.1.3	**Occupational Therapy:** a. Age 21 and older, as medically necessary, when provided by a licensed occupational therapist to restore, improve, or stabilize impaired functions b. Younger than age 21, as medically necessary, in accordance with TennCare Kids requirements	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
18. Physical Therapy CRA A.2.6.1.3 TSA 2.6.1.3	**Physical Therapy:** a. Age 21 and older, as medically necessary, when provided by a licensed physical therapist to restore, improve, or stabilize impaired functions b. Younger than age 21, as medically necessary, in accordance with TennCare Kids requirements	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
19. Chiropractic Services CRA A.2.6.1.3 TSA 2.6.1.3	**Chiropractic Services:** a. Age 21 and older, covered when determined to be a cost-effective alternative by the MCO b. Younger than age 21, covered as medically necessary in accordance with TennCare Kids requirements	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
20. Private Duty Nursing CRA A.2.6.1.3 TSA 2.6.1.3	Private duty nursing is covered as medically necessary in accordance with the definition of private duty nursing in the Tennessee rules.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
21. Speech Therapy CRA A.2.6.1.3 TSA 2.6.1.3	**Speech Therapy:** a. Age 21 and older, as medically necessary, when provided by a licensed speech therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic, or personality disorder. b. Younger than age 21, as medically necessary in accordance with TennCare Kids requirements	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
22. Organ and Tissue Transplants and Donor Organ Procurement CRA A.2.6.1.3 TSA 2.6.1.3	**Organ and Tissue Transplants and Donor Organ Procurement:** a. Age 21 and older, all medically necessary and non-investigational/ experimental organ and tissue transplants, as covered by Medicare b. Younger than age 21, covered as medically necessary in accordance with TennCare Kids requirements	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
Recommendations:					
23. Reconstructive Breast Surgery CRA A.2.6.1.3 TSA 2.6.1.3	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, as well as any surgical procedure 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 non-diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five years of the date the reconstructive breast surgery was performed on a diseased breast.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
24. Mammography Screening TCA 56-7-2502	The MCO provides mammography screenings a minimum of once for ages 35–40, every two years or more frequently on physician recommendation for ages 40–50 and annually for ages 50 and older.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
25. PKU TCA 56-7-2505 2019 MCO Provider Network Adequacy and Benefit Delivery Review Questionnaire	The MCO provides coverage for the treatment of PKU, including licensed professional medical services and special dietary formulas.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
Findings:					
Recommendations:					
26. Diabetic Services TCA 56-7-2605 2019 MCO Provider Network Adequacy and Benefit Delivery Review Questionnaire	The MCO provides coverage for diabetic equipment, supplies, and outpatient self-management training and education, including medical nutrition counseling, when medically necessary.	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
27. Chlamydia Screens TCA 56-7-2606 2019 MCO Provider Network Adequacy and Benefit Delivery Review Questionnaire	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**	
Findings:					
Recommendations:					
28. Psychiatric Inpatient Hospital Services (Including Physician Services) CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
29. Outpatient Mental Health Services, Including Physician Services CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
30. Inpatient/Residential and Outpatient Substance Abuse Benefits CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
31. 24-Hour Psychiatric Residential Treatment CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
32. BH Crisis Services CRA A.2.6.1.4 TSA 2.6.1.4	As necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
33. BH Intensive Community Based Treatment CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
34. Psychiatric Rehabilitation Services CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
35. CHOICES: Nursing Facility Care CRA A.2.6.1.5.3 CRA A.2.6.1.6.4 TSA 2.6.1.5.3	As medically necessary: For CHOICES members in Group 1; on a short-term basis only (up to 90 days) for members in CHOICES Groups 2 and 3.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA*	**1.0**	**0.0**	
Findings:					
Recommendations:					

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

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
36. CHOICES: Community-Based Residential Alternatives CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary for CHOICES members in Group 2. For Group 3, specified services and levels of reimbursement only (i.e., assisted care living facility, community living supports(CLS1), and community living supports—family model (CLS-FM1).	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
37. CHOICES: Personal Care Visits CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to two visits per day at intervals of no less than four hours between visits) for CHOICES members in Groups 2 and 3.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
38. CHOICES: Attendant Care CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to 1,080 hours per calendar year; up to 1,400 hours per full calendar year only for persons who require covered assistance with household chores or errands in addition to hands-on assistance with self-care tasks) for CHOICES members in Groups 2 and 3.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
39. CHOICES: Home-Delivered Meals CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to one meal per day) for CHOICES HCBS members in Groups 2 and 3.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
40. CHOICES: PERS CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary for CHOICES members in Groups 2 and 3.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
41. CHOICES: Adult Day Care CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to 2,080 hours per calendar year) for CHOICES members in Groups 2 and 3.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
42. CHOICES: In-Home Respite Care CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to 216 hours per calendar year) for CHOICES members in Groups 2 and 3.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
Recommendations:					
43. CHOICES: Inpatient Respite Care CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to nine days per calendar year) for CHOICES members in Groups 2 and 3.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
44. CHOICES: Assistive Technology CRA A.2.6.1.5.3 CRA A.2.6.1.6.3 TSA 2.6.1.5.3	As medically necessary up to $900 per calendar year for CHOICES members in Group 2 and3; and up to $5,000 per calendar year for ECF Choices members in Groups 4, 5, and 6. (TennCare*Select* Groups 2 and 3 only)	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
45. CHOICES: Minor Home Modifications CRA A.2.6.1.5.3 CRA A.2.6.1.6.3 TSA 2.6.1.5.3	As medically necessary up to $6,000 per project, $10,000 per calendar year, and $20,000 per lifetime for CHOICES members in Groups 2, 3, 4, 5, and 6. (TennCare*Select* Groups 2 and 3 only)	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
46. CHOICES: Pest Control CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to nine units per calendar year) for CHOICES members in Groups 2 and 3.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
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**	
Findings:					
Recommendations:					
48. ECF CHOICES: 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**	
Findings:					
Recommendations:					

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

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
49. ECF CHOICES: 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 ECF month for adults age 18 and older) for ECF CHOICES members in Group 4.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
50. ECF CHOICES: 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, and 6.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
51. ECF CHOICES: Community Transportation CRA A.2.6.1.6.3	As medically necessary for ECF CHOICES members in Groups 4, 5, and 6.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
52. ECF CHOICES: 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, and 6.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	Criteria	Criteria Met*	Element		Documentation/Evidence as Provided by MCO†
			Value	Score	
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
Findings:					
Recommendations:					
53. ECF CHOICES: Community Support CRA A.2.6.1.6.3	As medically necessary for community support development, organization, and navigation for ECF CHOICES members in Group 4.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
54. ECF CHOICES: 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.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
55. ECF CHOICES: Family-to-Family Support 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**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
56. ECF CHOICES: Conservatorship CRA A.2.6.1.6.3	As medically necessary for conservatorship and alternatives to conservatorship counseling and assistance (up to $500 per lifetime) for ECF CHOICES members in Groups 4, 5, and 6.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
57. ECF CHOICES: 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 Group 4.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
58. ECF CHOICES: 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**	
Findings:					
Recommendations:					
59. ECF CHOICES: 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**	
Findings:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	Criteria	Criteria Met*	Element		Documentation/Evidence as Provided by MCO†
			Value	Score	
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
Recommendations:					
60. ECF CHOICES: 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**	
Findings:					
Recommendations:					
61. ECF CHOICES: 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 and 6.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
62. ECF CHOICES: Peer-to-peer Person-centered Planning, Self-Direction, Employment, and Community Support and Navigation CRA A.2.6.1.6.3	As medically necessary for person-centered planning, self-direction, integrated employment/self-employment, and independent community living (up to $1500 per lifetime) for ECF CHOICES members in Groups 5 and 6.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	Criteria	Criteria Met*	Element		Documentation/Evidence as Provided by MCO†
			Value	Score	
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
63. ECF CHOICES: 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 and 6. For adults in Group 6, benefit group determined to have exceptional medical and/or behavioral support needs, specialized consultation services are limited to $10,000 per person per calendar year.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
64. ECF CHOICES: Adult Dental Services CRA A.2.6.1.6.3	As medically (up to $5,000 per calendar year; up to $7,500 across three consecutive calendar years) for ECF CHOICES members in Groups 4, 5, and 6. Group 4 benefits limited to adults age 21 and older.	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
65. ECF CHOICES: 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, and 6: ♦ Supported employment: Individual employment support ♦ Exploration ♦ Benefits counseling ♦ Discovery ♦ Situational observation and assessment	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA	**1.0**	**0.0**	

2019 Annual Network Adequacy Survey: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met***	**Element**		**Documentation/Evidence as Provided by MCO†**
			Value	**Score**	
Accessibility Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract, or another location described.)					
	♦ Job development plan or self-employment plan ♦ Job development or self-employment start up ♦ Job coaching for individualized, integrated employment, or self-employment ♦ Co-worker supports ♦ Career advancement				
Findings:					
Recommendations:					
66. Regulator Approval: Provider Manual CRA A.2.18.6.11 TSA 2.18.6.13	The MCO's Provider Manual was approved by TennCare. Date of Approval: Month Day, Year (Please be prepared to show proof of the approval during the onsite audit.)	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
Accessibility Benefits Review—Provider		**0%**	**66.0**	**0.0**	

DBM

2019 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM***
			Value	**Score**	
Standards for Availability and Accessibility					
1. Statewide Network TDC A. 18.	The DBM has a statewide provider network, including general dentists and dental specialists.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
2. Standards for Access TDC A.19.	Through a review of plan documents there is evidence that the DBM has established standards for access such as routine, urgent, and emergency care. Performance concerning access is assessed against these standards.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
3. Emergency Services TDC A.19.	The DBM is responsible for the provision of treatment for emergency medical conditions 24-hours a day, seven days a week.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
4. Access to Care TDC A.19. TDC A.20.	Through a review of provider contracts and plan documents, there is evidence that the DBM requires that its contracted providers offer adequate access to covered services. At a minimum, the DBM must maintain a network of dental providers with a sufficient number of providers who accept new TennCare members in accordance with the required standards:	a. ☐ Met ☐ Not Met b. ☐ Met ☐ Not Met Each Variable = 0.50	**1.0**	**0.0**	

* *This column was submitted by the DBM with the pre-onsite documentation and the content has not been altered or corrected grammatically. This tool does not include any attachments provided with the DBM submission.*

2019 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM***
			Value	**Score**	
Standards for Availability and Accessibility					
	a. Appointment wait times do not exceed three weeks for regular appointments b. Appointment wait times do not exceed 48 hours for urgent care				
Findings:					
Recommendations:					
5. Hours of Operation 68. TDC A.19.	The network providers must offer hours of operation that are no less than the hours of operation offered to commercial members.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
6. Transport Distance TDC A.20.	Through a review of plan documents, there is evidence that transportation time to dental providers, including ECF CHOICES dental providers, will be the usual and customary, not to exceed an average of 30 miles, except in rural areas, where community standards, as defined by TennCare, will apply. Exceptions must be justified and documented.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
7. Office Wait Time TDC A.21.	Through a review of plan documents, there is evidence that the office wait time does not exceed 45 minutes.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM***
			Value	**Score**	
Standards for Availability and Accessibility					
8. Provider Choice TDC A.22.	Through a review of plan documents, there is evidence that each member is permitted to obtain covered services from any general or pediatric dentist in the DBM's network who is accepting new patients.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
9. Access for Urgent Services 69. TDC A.36.	Through a review of plan documents, there is evidence that the DBM ensures access to services for urgent dental and oral conditions or injuries based on the professional judgment of the member's treating dentist, other dental professional, primary care provider, or triage nurse who is trained in dental care and oral healthcare.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
10. Out-of-Network Providers 70. TDC A.23.	If the DBM is unable to provide necessary medical services covered under the contract, the DBM must adequately and timely cover the services out-of-network for the member for as long as the DBM is unable to provide the services.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
11. Limited English Proficiency/ Cultural Competence 71. TDC A.24.	The DBM participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.	☐ Met ☐ Not Met	**1.0**	**0.0**	

2019 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by DBM*
			Value	Score	
Standards for Availability and Accessibility					
Findings:					
Recommendations:					
12. Non-Discrimination 72. TDC A.56. 73. TDC A.119. 74.	The DBM develops written P&Ps that demonstrate: a. Non-discrimination in the provision of services to members b. Non-discrimination in the selection and/or retention of providers specializing in conditions that require costly treatment	a. ☐ Met ☐ Not Met b. ☐ Met ☐ Not Met Each Variable = 0.50	**1.0**	**0.0**	
Findings:					
Recommendations:					
13. Dental Referrals 75. TDC A.38. 76.	The general dentist or pediatric dentist: a. Must refer members to a dental specialist (e.g., endodontists, oral surgeons, orthodontists, periodontists, or prosthodontists) for the initial visit for services requiring specialized expertise b. Does not need to provide separate referrals for subsequent visits to the same specialist in a course of treatment.	a. ☐ Met ☐ Not Met c. ☐ Met ☐ Not Met Each Variable = 0.50	**1.0**	**0.0**	
Findings:					
Recommendations:					
14. Second Opinions TDC A.38.a.	The DBM provides for a second opinion from a qualified healthcare professional within the network or arranges for the member to obtain a second opinion outside the network at no cost to the member.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM***
			Value	**Score**	
Standards for Availability and Accessibility					
15. Non-Discrimination TDC A.38.b.	The DBM has a mechanism to allow special needs members and members who require an ongoing course of treatment direct access to specialists, as appropriate.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
16. Dental Referrals TDC A.4.d.	The DBM implements a program that allows non-traditional providers (such as PCPs, pediatricians, physician assistants, nurse practitioners, and public health nurses) to conduct dental screenings and apply fluoride varnish to the teeth of TennCare members two through four years of age.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
Standard Score for Availability and Accessibility		**0%**	**16.0**	**0.0**	

2019 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by DBM*
			Value	Score	
Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)					
1. Member Education TDC A.98.	Education concerning measures to promote a member's oral health and prevent oral disease as required by EPSDT requirements	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
2. Oral Health Assessments TDC A.5.	Oral health assessments	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
3. Examinations of Teeth and Oral Cavity TDC A.5.	Examinations of the teeth and oral cavity	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

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2019 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM***
			Value	**Score**	
Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)					
4. Topical Fluoride TDC A.5.	Topical Fluoride	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
5. Application of Dental Sealants TDC A.5.	Application of dental sealants	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
6. Dental Prophylaxis Services TDC A.5.	Dental prophylaxis services	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by DBM*
			Value	Score	
Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)					
7. Diagnostic Services TDC A.4.a.	Radiographic, laboratory and other diagnostic services	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
8. Restorative Services TDC A.5.	Restorative services to include amalgams, resin and crowns	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
9. Orthodontic Services TDC A.4.b., A.38., A.43.a., A.44.	Orthodontic services	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM***
			Value	**Score**	
Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)					
10. Endodontic Services TDC A.38.	Endodontic Services	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
11. Oral Surgery TDC A.38.	Oral Surgery	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
12. Periodontic Services TDC A.38.	Periodontic Services	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM***
			Value	**Score**	
Benefits Review—Member (Evidence of benefits located in the Member Handbook, explanation of benefits or another location described.)					
13. Oral Pathology Services TDC A.55.j.	Oral Pathology Services	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
14. Anesthesia Services TDC A.40.	Anesthesia Services	☐ Member Handbook ☐ Explanation of Benefits ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
15. Member Handbook Approval TDC A.9.	The Member Handbooks were approved by TennCare prior to distribution. Date of Approval: Month Day, Year (Please be prepared to show proof of the approval during the onsite audit.)	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
Standard Score for Benefit Review—Member		**0%**	**15.0**	**0.0**	

2019 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by DBM*
			Value	Score	
Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)					
1. Member Education TDC A.98.	Education concerning measures to promote a member's oral health and prevent oral disease as required by EPSDT requirements	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
2. Oral Health Assessments TDC A.5.	Oral health assessments	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
3. Examinations of Teeth and Oral Cavity TDC A.5.	Examinations of the teeth and oral cavity	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
4. Topical Fluoride TDC A.5.	Topical Fluoride	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

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2019 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM***
			Value	**Score**	
Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)					
5. Application of Dental Sealants TDC A.5.	Application of dental sealants	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
6. Dental Prophylaxis Services TDC A.5.	Dental prophylaxis services	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
7. Diagnostic Services TDC A.4.a.	Radiographic, laboratory and other diagnostic services	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
8. Restorative Services TDC A.5.	Restorative services to include amalgams, resin and crowns	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by DBM*
			Value	Score	
Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)					
9. Orthodontic Services TDC A.4.b., A.38., A.43.a., A.44.	Orthodontic services	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
10. Endodontic Services TDC A.38.	Endodontic Services	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
11. Oral Surgery TDC A.38.	Oral Surgery	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
12. Periodontic Services TDC A.38.	Periodontic Services	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM***
			Value	**Score**	
Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)					
13. Oral Pathology Services TDC A.55.j.	Oral Pathology Services	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
14. Anesthesia Services TDC A.40.	Anesthesia Services	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
15. ECF CHOICES: Preventive Services TDC A.190.	ECF CHOICES Services: Preventive Dental Services	☐ Provider Manual ☐ Contract ☐ Other (Describe) ☐ NA††	**1.0**	**0.0**	
Findings:					
Recommendations:					
16. ECF CHOICES: Fillings TDC A.190.	ECF CHOICES Services: Fillings	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					

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

2019 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by DBM*
			Value	Score	
Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)					
17. ECF CHOICES: Root Canals TDC A.190.	ECF CHOICES Services: Root Canals	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
18. ECF CHOICES: Extractions TDC A.190.	ECF CHOICES Services: Extractions	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
19. ECF CHOICES: Periodontics TDC A.190.	ECF CHOICES Services: Periodontics	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
20. ECF CHOICES: Dentures TDC A.190.	ECF CHOICES Services: Dentures	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
21. ECF CHOICES: Sedation Services TDC A.190.	ECF CHOICES Services: Sedation Services—may include medically necessary and appropriate deep sedation or general anesthesia	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	

2019 Annual Quality Survey—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by DBM*
			Value	Score	
Benefits Review—Provider (Evidence of benefits located in the Provider Manual, contract or another location described.)					
Findings:					
Recommendations:					
22. ECF CHOICES: Benefit Maximums TDC A.192.	ECF CHOICES Services: Benefit maximum of $5,000 per member per calendar year and $7,500 per member across three consecutive calendar years	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
23. ECF CHOICES: Provider Training TDC A.201.	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**	
Findings:					
Recommendations:					
24. Approval of Provider Manual TDC A.44.	Any revisions to the Provider Manual are submitted to TennCare and TDCI for review and approval prior to distribution Date of Approval: Month Day, Year (Please be prepared to show proof of the approval during the onsite audit.)	☐ Provider Manual ☐ Contract ☐ Other (Describe)	**1.0**	**0.0**	
Findings:					
Recommendations:					
Standard Score for Benefit Review—Provider		**0%**	**24.0**	**0.0**	

File Review Tools

MCO Primary Care Providers (PCPs)

MCO: <MCO>	Reviewer:												Date of Review: x/xx/2019												# 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 this Contract/Agreement and the TennCare rules and regulations. CRA A.2.12.9.8 TSA 2.12.9.8																														

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

† *A–O are derived from CRA 2-12 and deal specifically with the quality and adequacy of the provider network.*

MCO: <MCO>	Reviewer:												Date of Review: x/xx/2019												# of Files: ##					
File #	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement *	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
D. Provide that emergency services be rendered without the requirement of prior authorization of any kind. CRA A.2.12.9.9 TSA 2.12.9.9																														
E. If the provider performs laboratory services, require the provider to meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988. CRA A.2.12.9.12 TSA 2.12.9.12																														
F. Specify that the Contractor shall monitor the quality of services delivered under the provider agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical, behavioral health, or long-term-care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TennCare. CRA A.2.12.9.22 TSA 2.12.9.22																														
G. Require that the provider comply with corrective action plans initiated by the Contractor. CRA A.2.12.9.23 TSA 2.12.9.23																														
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																														

MCO: <MCO>	Reviewer:												Date of Review: x/xx/2019												# 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**
contain language that references the TennCare Kids requirements. CRA A.2.12.9.62 TSA 2.12.9.62																														
I. Include a provision which states that providers are not permitted to encourage or suggest, in any way, that TennCare children be placed into state custody in order to receive medical, behavioral, or long-term-care services covered by TennCare. CRA A.2.12.9.63 TSA 2.12.9.63																														
J. Provide for the participation and cooperation in any internal and external quality management/quality improvement, monitoring, utilization review, peer review and/or appeal procedures established by the Contractor and/or TennCare. CRA A.2.12.9.20 TSA 2.12.9.20																														
K. Provide that TennCare, the U.S. Department of Health and Human Services Office of the Inspector General (DHHS OIG), Office of the Comptroller of the Treasury, OIG, Tennessee Bureau of Investigation Medical Fraud Control Unit, and the Department of Justice, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this Contract/Agreement including, but not limited to medical records, billing records, financial records,																														

MCO: <MCO>	Reviewer:												Date of Review: x/xx/2019												# 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**
and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. CRA A.2.12.9.18 TSA 2.12.9.18																														
L. Require safeguarding of information about enrollees according to applicable state and federal laws and regulations and as described in CRA Sections A.2.27 and E.6 and in TSA Sections 2.27 and 5.33 of the Agreement. CRA A.2.12.9.55 TSA 2.12.9.55																														
M. Specify that unreasonable delay in providing care to a pregnant member seeking prenatal care shall be considered a material breach of the provider's agreement with the Contractor and include the definition of unreasonable delay as described in Section A.2.7.5.2.3 of this Contract/Agreement. 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																														

MCO: <MCO>	Reviewer:												Date of Review: x/xx/2019												# 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**
O. Specify that the provider have written procedures for the provision of language assistance services to members and/or the member's representative. Language assistance services include interpretation and translation services and effective communication assistance in alternative formats for any member and/or the member's representative who needs such services, including but not limited to, members with Limited English Proficiency and individuals with disabilities. CRA A.2.12.9.65.2 Specify that the provider have written procedures for the provision of language interpretation and translation services for any members who needs such services, including but not limited to members with Limited English Proficiency. TSA 2.12.9.65.2																														
P. Require compliance with applicable access requirements, including but not limited to appointment and wait times as referenced in Section A.2.11 of the Contractor's Contract with TennCare. CRA A.2.12.9.10 TSA 2.12.9.10																														
Q. Require the provider to conduct criminal background checks and registry checks in accordance with state law and TennCare policy. CRA A.2.12.9.41 Require the provider to conduct background checks in accordance with state law and TennCare policy. TSA 2.12.9.41																														

MCO: <MCO>	Reviewer:												Date of Review: x/xx/2019												# 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**
R. Require providers to screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. The provider shall be required to immediately report to the Contractor any exclusion information discovered. The provider shall be informed by the Contractor that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare members. CRA A.2.12.9.39 TSA 2.12.9.39																														
S. 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																														
T. 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																														
U. Require that the provider comply with the Affordable Care Act and TennCare P&Ps regarding recovery of overpayments, including written notification to the																														

MCO: <MCO>	Reviewer:												Date of Review: x/xx/2019												# 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**
Contractor and TennCare Office of Program Integrity (OPI) of overpayments identified by the provider and, when applicable, returning the overpayment to the Contractor within sixty (60) days from the date the overpayment is identified. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may be a violation of state or federal law. CRA A.2.12.9.36 TSA 2.12.9.36																														
V. 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 identification of provider-preventable conditions as a condition of payment. At a minimum, this shall mean non-payment of provider-preventable conditions as well as appropriate reporting as required by the Contractor and TennCare. CRA A.2.12.9.56 TSA 2.12.9.56																														
Total Number of Points																														
Maximum Number of Points																														
Score																														

MCO Abbrev Contract File Review Totals for All Reviewed PCPs				
File	**Points Awarded**	**Total Points**	**Maximum Points**	**Score**
1				
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MCO Specialty Care Providers (SCPs)

MCO: <MCO>	**Reviewer:**												**Date of Review: x/xx/2019**												**# 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																														

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

† *A–O are derived from CRA A.2-12 and deal specifically with the quality and adequacy of the provider network.*

MCO: <MCO>	Reviewer:												Date of Review: x/xx/2019												# 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**
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 this Contract/Agreement and the TennCare rules and regulations. CRA A.2.12.9.8 TSA 2.12.9.8																														
D. Provide that emergency services be rendered without the requirement of prior authorization of any kind. CRA A.2.12.9.9 TSA 2.12.9.9																														
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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																														

MCO: <MCO>	Reviewer:												Date of Review: x/xx/2019												# 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**
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																														
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																														

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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**
review, peer review and/or appeal procedures established by the Contractor and/or TennCare. CRA A.2.12.9.20 TSA 2.12.9.20																														
K. Provide that TennCare, the DHHS OIG, Office of the Comptroller of the Treasury, OIG, Tennessee Bureau of Investigation Medical Fraud Control Unit, and the Department of Justice, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this Contract/ Agreement including, but not limited to medical records, billing records, financial records, and/or any records related to																														
L. Require safeguarding of information about enrollees according to applicable state and federal laws and regulations and as described in CRA Sections A.2.27 and E.6 and in TSA Sections 2.27 and 5.33 of the Agreement. CRA A.2.12.9.55 TSA 2.12.9.55																														
M. Specify that unreasonable delay in providing care to a pregnant member seeking prenatal care shall be considered a material breach of the provider's agreement with the Contractor and include the definition of unreasonable delay as described in Section A.2.7.5.2.3 of this Contract/Agreement. CRA A.2.12.9.11 TSA 2.12.9.11																														

MCO: <MCO>	Reviewer:												Date of Review: x/xx/2019												# of Files: ##					
File #	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement *	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
N. Provide for monitoring, whether announced or unannounced, of services rendered to members. CRA A.2.12.9.19 TSA 2.12.9.19																														
O. Specify that the provider have written procedures for the provision of language assistance services to members and/or the member's representative. Language assistance services include interpretation and translation services and effective communication assistance in alternative formats for any member and/or the member's representative who needs such services, including but not limited to, members with Limited English Proficiency and individuals with disabilities. CRA A.2.12.9.65.2 Specify that the provider have written procedures for the provision of language interpretation and translation services for any members who needs such services, including but not limited to members with Limited English Proficiency. TSA 2.12.9.65.2																														
P. Require compliance with applicable access requirements, including but not limited to appointment and wait times as referenced in Section A.2.11 of the Contractor's Contract with TennCare. CRA A.2.12.9.10 TSA 2.12.9.10																														

MCO: <MCO>	Reviewer:												Date of Review: x/xx/2019												# 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**
Q. Require the provider to conduct criminal background checks and registry checks in accordance with state law and TennCare policy. CRA A.2.12.9.41 Require the provider to conduct background checks in accordance with state law and TennCare policy. TSA 2.12.9.41																														
R. Require providers to screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. The provider shall be required to immediately report to the Contractor any exclusion information discovered. The provider shall be informed by the Contractor that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare members. CRA A.2.12.9.39 TSA 2.12.9.39																														
S. 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																														

MCO: <MCO>	Reviewer:												Date of Review: x/xx/2019												# 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**
T. 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																														
U. 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 overpayments to the Contractor within sixty (60) days from the date the overpayment is identified. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may be a violation of state or federal law. CRA A.2.12.9.36 TSA 2.12.9.36																														
V. 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 identification 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																														

MCO: <MCO>	Reviewer:												Date of Review: x/xx/2019												# of Files: ##					
File #	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement *	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
Total Number of Points																														
Maximum Number of Points																														
Score																														

MCO Abbrev Contract File Review Totals for All Reviewed SCPs				
File	**Points Awarded**	**Total Points**	**Maximum Points**	**Score**
1				
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DBM General Dental Practitioner (GDP)

DBM: <DBM>	Reviewer:												Date of Review: x/xx/2019												# 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 TennCare member under this contract for nonmedical reasons, including, but not limited to, failure to pay applicable cost-sharing responsibilities. The contractor specifies that a member who is subject to a copayment requirement be requested to pay applicable TennCare cost-sharing responsibilities prior to receiving nonemergency services. However, the provider is not to be 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.55.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 or her professional/technical practice. TDC A.55.g.																														
C. Specify the amount, duration, and scope of services to be provided by the provider. TDC A.55.h.																														
D. Provide that emergency services for eligible members under age 21 be rendered without the requirement of prior authorization. However, the required documentation must be submitted post-																														

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

DBM: <DBM>	Reviewer:												Date of Review: x/xx/2019												# 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**
treatment for retro authorizations in order for the dentist to receive payment. TDC A.55.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.55.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 recognized as acceptable professional practice in the respective community in which the provider practices and/or in accordance with the standards established by TennCare. TDC A.55.p.																														
G. Require that the provider comply with corrective action plans initiated by the contractor or be subject to recoupment of funds, termination or other penalties determined by TennCare. TDC A.55.p.2.																														
H. Ensure that all provider agreements include language that informs providers of the package of benefits that EPSDT offers and the periodicity schedule from which those benefits must be provided. All provider agreements must contain language that references the EPSDT benefit package and periodicity schedule. TDC A.55.kk.																														

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File #	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Item in Signed Agreement *	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
I. Ensure that all provider agreements include a provision stating that providers are not permitted to encourage or suggest, in writing or verbally, that TennCare children be placed into state custody to receive medical or behavioral services covered by TennCare. TDC A.55.ll.																														
J. Whether announced or unannounced, provide for the participation in and cooperation with any internal and external quality management/ improvement, utilization review, peer review and appeal procedures established by the contractor and/or TennCare. TDC A.55.o.																														
K. Provide that TennCare, the U.S. Department of Health and Human Services, the Tennessee State Board of Dentistry, the Tennessee Bureau of Investigation (TBI) State auditors, and other agencies designated by TennCare, have the right to evaluate through inspection, whether announced or unannounced, or by other means any records pertinent to this contract including quality, appropriateness and timeliness of services. Such evaluation, when performed, must be with the cooperation of the dental provider. Upon request, the dental provider assists in such reviews including the provision of complete copies of records, reports or any other media, whether electronic or hard copy. TDC A.55.m.																														

DBM: <DBM>	Reviewer:												Date of Review: x/xx/2019												# 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**
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. TDC A.55.r.																														
Total Number of Points																														
Maximum Number of Points																														
Score																														

DBM Abbrev Contract File Review Totals for All Reviewed GDPs				
File	**Points Awarded**	**Total Points**	**Maximum Points**	**Score**
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DBM Specialty Dental Providers (SDPs)

DBM: <DBM>	Reviewer:												Date of Review: x/xx/2019												# 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 TennCare member under this contract for nonmedical 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 TennCare cost-sharing responsibilities prior to receiving nonemergency services. However, the provider is not to be 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.55.f.																														
B. Specify the functions and/or services to be provided by the provider and ensure that the functions and/or services are within the scope of his or her professional/technical practice. TDC A.55.g.																														
C. Specify the amount, duration and scope of services to be provided by the provider. TDC A.55.h.																														
D. Provide that emergency services for eligible members younger than 21 years of age be rendered without the requirement of prior authorization. However, the required documentation																														

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

DBM: <DBM>	Reviewer:												Date of Review: x/xx/2019												# 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**
must be submitted post-treatment for retro authorizations in order for the dentist to receive payment. TDC A.55.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.55.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 recognized as acceptable professional practice in the respective community in which the provider practices and/or in accordance with the standards established by TennCare. TDC A.55.p.																														
G. Require that the provider comply with corrective action plans initiated by the contractor or be subject to recoupment of funds, termination or other penalties determined by TennCare. TDC A.55.p.2.																														
H. Ensure that all provider agreements include language that informs providers of the package of benefits that EPSDT offers and the periodicity schedule from which those benefits must be provided. All provider agreements must contain language that references the EPSDT benefit package and periodicity schedule. TDC A.55.kk.																														

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Item in Signed Agreement *	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**	**Y**	**N**	**P**
I. Ensure that all provider agreements include a provision stating that providers are not permitted to encourage or suggest, in writing or verbally, that TennCare children be placed into state custody to receive medical or behavioral services covered by TennCare. TDC A.55.ll.																														
J. Whether announced or unannounced, provide for the participation in and cooperation with any internal and external quality management/ improvement, utilization review, peer review and appeal procedures established by the contractor and/or TennCare. TDC A.55.o.																														
K. Provide that TennCare, the U.S. Department of Health and Human Services, the Tennessee State Board of Dentistry, the Tennessee Bureau of Investigation (TBI) State auditors, and other agencies designated by TennCare, have the right to evaluate through inspection, whether announced or unannounced, or by other means any records pertinent to this contract related to quality, appropriateness and timeliness of services. Such evaluation, when performed, must be with the cooperation of the dental provider. Upon request, the dental provider assists in such reviews including the provision of complete copies of records, reports or any other media, whether electronic or hard copy. TDC A.55.m.																														

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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**
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. TDC A.55.r.																														
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File	**Points Awarded**	**Total Points**	**Maximum Points**	**Score**
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AQS

The following assessment tools were used for the AQS evaluation of MCCs:

- 2019 AQS QP Standards Survey Tools (MCO and DBM)
- MCC Complaints File Review Tool (DBM)
- MCC UM Denials File Review Tool
- Appeals File Review Tool (MCO)
- Appeals File Review Tool (DBM)
- EPSDT Information System Tracking File Review Tool (MCO)
- CHOICES Annual Level of Care Assessment File Review Tool (MCO)
- Transition of CHOICES Members Between MCOs File Review Tool (MCO)
- Credentialing/Recredentialing P&Ps (MCO and DBM)
- CHOICES Credentialing File Review Tools (not applicable to **TCS** or **DQ**)
- CHOICES Recredentialing File Review Tools (not applicable to **TCS** or **DQ**)

QP Standards Tools

MCO

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Network: Contracting, Availability, Access, and Documentation					
1. Specialist Termination CRA and TSA § 2.11.10.1.4*	The MCO provides written timely notification (no less than 30 days prior when possible) to its members affected by the termination of a specialist and/or entire specialty group.	☐ Yes ☐ No	**0.250** **0.000**	**0.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Notice of Provider Termination* CRA and TSA § 2.11.10.1.2	If a primary care provider (PCP) ceases participation in the MCO, the MCO immediately provides written notice—no less than 30 calendar days prior to the effective date of the termination and no more than 15 calendar days after receipt or issues of the termination notice—to each member who has chosen the provider as his or her PCP. The requirement to provide notice thirty (30) calendar days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide thirty (30) calendar days advance notice to the MCO, the provider moves from the service area and fails to notify the MCO, or a provider fails credentialing, and instead shall be made immediately upon the MCO becoming aware of the circumstances.	☐ Yes ☐ No	**0.250** **0.000**	**0.250**	**0.000**
Findings **Strength** **AON**					

* *The element/criterion will be considered deemed if the MCO provides documentation that it scored 100% on that element/criterion during NCQA accreditation.*

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Network: Contracting, Availability, Access, and Documentation					
Suggestion					
3. Second Opinion** CFR 438.206.b.3	The MCO facilitates a second opinion from a network provider or arranges for the member to obtain one outside the network at no cost to the member.	☐ ☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
4. Subcontractor Audits CFR 438.230.c.3-.3.iv	The MCO's contract with a subcontractor includes the right for TennCare or CMS to audit the subcontractor's records and systems at any time through 10 years after the final date of the contract period or the last audit, whichever is later.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
5. Marketing Activities CFR 438.104.b.1.i; .iv-.v	The MCO does not engage in cold-call marketing, distribute marketing materials without TennCare approval, or seek to influence enrollment in conjunction with offering private insurance.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Network: Contracting, Availability, Access, and Documentation					
6. Prohibited Affiliations CFR 438.610.a-.a.1	The MCO does not knowingly have a relationship with an individual who is a. debarred, suspended, or otherwise excluded from participating under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549; b. an affiliate, as defined in the Federal Acquisition Regulation, of a person described above; or c. excluded from participation in any federal healthcare program.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Network: Contracting, Availability, Access, and Documentation Score	**0.0%**	**4.500**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
QI Activities					
1. Coordination Between Physical and Behavioral Health CRA and TSA § 2.9.9.1; 2.9.9.3.2	The MCO maintains policies and procedures (P&Ps) for and ensures continuity and coordination between physical health and behavioral health services by including key elements to the right.	☐ a. Screening for behavioral health needs	**0.500**	**6.000**	**0.000**
		☐ b. Referral to physical health and behavioral health providers	**0.500**		
		☐ c. Screening for long-term care needs	**0.500**		
		☐ d. Exchange of information**	**0.500**		
		☐ e. Confidentiality	**0.500**		
		☐ f. Assessment	**0.500**		
		☐ g. Treatment plan development**	**0.500**		
		☐ h. Collaboration**	**0.500**		
		☐ i. Care/support coordination and population health	**0.500**		
		☐ j. Provider training	**0.500**		
		☐ k. Encourages PCPs and other providers to use TennCare-approved behavioral health screening tool	**0.500**		
		☐ l. Monitoring implementation and outcomes	**0.500**		
Findings					
Strength					
AON					
Suggestion					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
QI Activities					
2. Discharge Planning and Follow-Up CRA and TSA § 2.7.2.6.5.2; CFR 438.208.b–b.2.i	The MCO has care delivery procedures that coordinate services between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays and behavioral health follow-up services.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Integrated Population Health CRA and TSA § 2.8.1; 2.8.2.1; 2.8.2.1.2; 2.8.2.1.5; 2.8.2.2.1; 2.8.3.4; 2.8.4.2.2	The MCO has an integrated Population Health Program based on risk stratification of its members. Each month new members are systematically stratified using predictive modeling and enrolled into specific programs based on risk rather than disease-specific categories. The predictive modeling uses a combination of claims data, pharmacy data, and laboratory results, supplemented by referrals, utilization management (UM) data, and/or health risk assessment results. The risk levels range from 0–2. ♦ Risk Level 0: Wellness Program ♦ Risk Level 1: Low Risk Maternity, Health Risk Management, and Care Coordination Program ♦ Risk Level 2: Chronic Care Management, High-Risk Pregnancy, and Complex Case Management (voluntary programs) For members to be stratified into Level 0, there must be no identified health risks, chronic care conditions, indication of pregnancy, or claims history. Pregnant members are stratified into low- or high-risk pregnancy programs based on the MCO's obstetrical assessment. The MCO transitions low-risk pregnancy program members into the high-risk pregnancy program when ongoing member monitoring identifies an increased health risk.	☐ a. Process in place to identify members ☐ b. Staff demonstrated knowledge of the member stratification process ☐ c. Ongoing assessment for low-risk pregnancy program members ☐ d. High-risk pregnancy members included those with history of tobacco and substance abuse or other high-risk indicators	**0.500** **0.500** **0.500** **0.500**	**2.000**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
QI Activities					
Findings					
Strength					
AON					
Suggestion					
4. Outreach to Members Stratified for Chronic Care and Complex Case Management CRA and TSA § 2.8.4.5.2; 2.8.4.7.2	The MCO makes three outreach attempts to each newly identified member eligible for chronic care and/or complex case management to offer enrollment into the program(s). Outreach attempts must occur within three months of the member's identification. If the MCO is unable to contact the member after three outreach attempts and the member appears on the refreshed list, the MCO is not obligated to make another attempt for 180 days.	☐ Three attempts made to enroll ☐ Attempts made within required time	**0.500** **0.500**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
5. Screening for Risk Factors in High-Risk Pregnancy CRA and TSA § 2.8.4.6.1	The MCO provides screening for risk factors, which includes screening for mental health and substance abuse.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
QI Activities					
6. Face-to-Face Visit for High-Risk Members CRA and TSA § 2.8.3.4	For members identified as potential participants in voluntary Level 2 Population Health Programs (Chronic Care Management, Complex Case Management, or High-Risk Maternity Programs), assessment includes whether a member needs a face-to-face visit. In cases where a need is identified, the visit is conducted following consent of the member.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
7. Transitioning of Members into Higher/Lower Levels of Care CRA and TSA § 2.8.4.5.6-.7; 2.8.4.7.5	After enrollment into one of the voluntary programs, the MCO will continue to provide ongoing member assessment for transition into higher- or lower-risk classification or to Chronic Care Management Programs for services.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
8. Implementation of Population Health CRA and TSA § 2.8.2.1.1	The MCO makes reasonable attempts to assess each member's health risks by utilizing an approved common mini health survey approved by TennCare and Population Health Program staff, or a comprehensive health risk assessment.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
QI Activities					
9. Enrollment of CHOICES and ECF CHOICES Members in Population Health Programs CRA § 2.8.11-.1; TSA § 2.8.10-.1	The MCO has a systematic process in place to identify and enroll eligible members in each Population Health Program, including CHOICES, ECF CHOICES, and dual-eligible CHOICES and ECF CHOICES members. The process integrates members' information with other activities to ensure programs are linked for care coordination.	☐ a. Process in place to identify and enroll CHOICES and ECF CHOICES members ☐ b. Process in place to identify and enroll dual-eligible members ☐ c. Process in place to ensure programs are linked	**0.500** **0.500** **0.500**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
10. Population Health Treatment Plans for CHOICES and ECF CHOICES Members CRA and TSA § 2.8.4.3.1; CRA § 2.8.11.3.6; TSA § 2.8.10.3.6	Health coaching or other interventions for health risk management emphasize self-management strategies addressing healthy behaviors (i.e., weight management and tobacco cessation), self-monitoring, co-morbidities, cultural beliefs, depression screening, and appropriate communication with providers. The MCO ensures that the member's care/support coordinator is responsible for coordinating with the member's providers regarding the development and implementation of an individualized treatment plan which is integrated into the member's plan of care or person-centered support plan (PCSP), as applicable, and includes monitoring the member's condition, helping to ensure compliance with treatment protocols, and to the extent appropriate, lifestyle changes which help to better ensure management of the member's condition.	☐ Elements of treatment plans were individualized and integrated into the CHOICES or ECF CHOICES plan of care or PCSP. ☐ Treatment plans included monitoring conditions, ensuring compliance with treatment protocols, and making lifestyle changes.	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
QI Activities					
11. Integration of Population Health Program into CHOICES and ECF CHOICES Members' Plans of Care CRA § 2.8.11.3; 2.8.11.3.2; 2.8.11.3.5; TSA § 2.8.10.3; 2.8.10.3.2; 2.8.10.3.5	The Population Health Program Description (PHPD) addresses how the MCO will ensure that the care/support coordinator integrates aspects of the Population Health Program that will enhance management of the member's condition into their PCSP.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
12. Stratification of CHOICES and ECF CHOICES Members in Population Health Programs CRA § 2.8.11.4; TSA § 2.8.10.4	In addition to stratifying Population Health Program members by risk level or by clinical- or member-provided information, the MCO also stratifies CHOICES and ECF CHOICES members by the type of setting where long-term care services are delivered (e.g., nursing facility, home- or community-based residential alternative, or home-based). The MCO's interventions are based on the risk level and setting in which the CHOICES or ECF CHOICES member resides.	☐ Stratification included risk level, clinical- and member-provided information, and service setting. ☐ Interventions were based on stratification and service setting.	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
QI Activities					
13. Population Health and CHOICES and ECF CHOICES Care Coordination CRA § 2.8.11.2; TSA § 2.8.10.2	The PHPD addresses how the MCO ensures that population health activities are integrated with CHOICES and ECF CHOICES care coordination processes and functions and how it confirms that the member's care/support coordinator has primary responsibility for coordination of all the member's physical health, behavioral health, and long-term care services, including appropriate management of chronic conditions.	☐ a. PHPD addressed the integration of CHOICES care coordination processes and functions. ☐ b. CHOICES program description indicated that the care coordinator has primary responsibility. ☐ c. PHPD addressed the integration of ECF CHOICES care coordination processes and functions. ☐ d. ECF CHOICES program description indicated that the support coordinator has primary responsibility.	**0.250** **0.250** **0.250** **0.250**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
14. Care/Support Coordinator Responsibilities for CHOICES and ECF CHOICES Members CRA § 2.8.11.3.6; TSA § 2.8.10.3.6	The PHPD addresses how the MCO will ensure that the care/support coordinator is responsible for coordinating with the member's providers regarding the development and implementation of an individualized treatment plan. The treatment plan is integrated into the member's plan of care or PCSP, if applicable, and includes the following: ♦ Monitoring of the member's condition ♦ Ensuring compliance with treatment protocols ♦ Lifestyle changes	☐ a. Care/support coordinator and providers involved in development and implementation of treatment plan ☐ b. Treatment plan integrated into plan of care or PCSP ☐ c. Treatment plan included condition monitoring ☐ d. Treatment plan included compliance with protocols ☐ e. Treatment plan included lifestyle changes	**0.300** **0.300** **0.300** **0.300** **0.300**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
QI Activities					
15. Keeping Care/Support Coordinator Informed CRA § 2.8.11.3-.3.3; TSA § 2.8.10.3-.3.3	The PHPD addresses how the member's care/support coordinator will receive the following: a. Notification of the member's participation in a Population Health Program b. Information collected about the member through a Population Health Program c. Educational materials given to the member through a Population Health Program	☐ a. Participation notification sent ☐ b. Information collected ☐ c. Educational materials given	**0.250** **0.250** **0.250**	**0.750**	**0.000**
Findings **Strength** **AON** **Suggestion**					
16. Care/Support Coordinator Review CRA § 2.8.11.3; 2.8.11.3.4; TSA § 2.8.10.3; 2.8.10.3.4	The PHPD ensures that the care/support coordinator completes the following: ♦ Verbal reviews of the educational materials with the member and the member's caregiver and/or representative ♦ Coordination of necessary follow-up regarding the Population Health Program, such as scheduling screenings or appointments	☐ Educational materials verbally reviewed ☐ Follow-up coordinated	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
QI Activities					
17. Identification of Increase in Member Needs During Transition CRA and TSA § 2.9.2.1.4.3; 2.9.3.5	If the MCO becomes aware of an increase in the member's needs prior to conducting a comprehensive needs assessment for CHOICES members in or transitioning to Group 2 or 3, the following occurs: a. A comprehensive needs assessment is immediately conducted. b. The plan of care or PCSP is updated. c. The changes in services are implemented within 10 days of the MCO becoming aware of the change in needs.	☐ a. Comprehensive needs assessment conducted ☐ b. Plan of care or PCSP updated ☐ c. Service changes implemented within 10 days of MCO's knowledge of change in needs	**0.250** **0.250** **0.250**	**0.750**	**0.000**
Findings **Strength** **AON** **Suggestion**					
18. Transition of CHOICES Group 2 Members in Community-Based Residential Alternative Settings CRA and TSA § 2.9.6.2.5.2	For members in CHOICES Group 2, who upon CHOICES enrollment are receiving services in a community-based residential alternative setting, within 10 business days of notice of the member's enrollment in CHOICES the care coordinator conducts a face-to-face visit with the member, performs a comprehensive needs assessment, develops a plan of care, and authorizes and initiates additional CHOICES HCBS specified in the PCSP (i.e., assistive technology).	☐ a. Face-to-face visit with member ☐ b. Comprehensive needs assessment ☐ c. PCSP development ☐ d. Additional CHOICES HCBS specified in the plan of care (i.e., assistive technology)	**0.250** **0.250** **0.250** **0.250**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
QI Activities					
19. Nursing Facility-to-Community Transition CRA and TSA § 2.9.6.8.6-.7; .11-.12	If the member wishes to pursue transition to the community (within the required timeframe), the care coordinator or support coordinator conducts an in-facility assessment of the member's ability and/or desire to transition using tools and protocols specified or prior approved in writing by TennCare. As part of the transition assessment, the care coordinator or support coordinator conducts a risk assessment in accordance with protocols developed by TennCare. Prior to the member's physical move to the community, the care coordinator or support coordinator visits the residence where the member will live to conduct an onsite evaluation of the physical residence and meet with the member's family or other caregiver who will be residing with the member (as appropriate). The transition plan includes at a minimum member needs related to housing, transportation, availability of caregivers, and other transition needs and supports.	☐ a. In-facility risk assessment ☐ b. Risk assessment in accordance with protocols developed by TennCare ☐ c. Onsite evaluation conducted ☐ d. Transition plan includes necessary details	**0.250** **0.250** **0.250** **0.250**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
20. Transition of CHOICES and ECF CHOICES Members from Nursing Facilities CRA and TSA § 2.9.6.8.21	When member transitions from a nursing facility to a community-based residential alternative or to live with a relative or other caregiver, the care coordinator or support coordinator makes contact with the member within the first 24 hours of transition and visits the member in his or her new residence within seven days of transition. During the initial 90 days post-transition period, the care coordinator or support coordinator contacts the member at least monthly by telephone to ensure the plan of care or PCSP is being followed, member needs are met, and transition to the community has been successful. Additional face-to-face assessments are conducted when additional needs are identified and to confirm member needs are met.	☐ a. Contacted member within the first 24 hours ☐ b. Visited residence within seven days ☐ c. Made or attempted at least monthly telephone contact within the initial 90 days post-transition ☐ d. Performed face-to-face assessments as needed	**0.250** **0.250** **0.250** **0.250**	**1.000**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
QI Activities					
Findings					
Strength					
AON					
Suggestion					
21. Telephonic Screening for CHOICES and ECF CHOICES Referrals CRA § 2.9.6.3.4-.4.1; TSA § 2.9.6.3.3-.3.1	If the MCO uses a telephone screening process for members referred to CHOICES or ECF CHOICES, the following process is in place and documented: ♦ Three attempts are made to contact a member by telephone over a period of no less than three days. ♦ If telephone attempts are unsuccessful, a letter with CHOICES or ECF CHOICES information on how to obtain a screening for CHOICES or ECF CHOICES is sent to the member's most recently reported address.	☐ Three attempts by telephone per timeline criteria ☐ Letter sent after unsuccessful telephone attempts	**0.500** **0.500**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
22. CHOICES and ECF CHOICES Level of Care (LOC) Reassessment CRA and TSA § 2.9.6.10.3.1.1	The MCO conducts a LOC reassessment at least annually and within five business days of awareness of a change in a member's functional or medical status that could potentially affect LOC eligibility.	☐ Reassessment conducted annually ☐ Reassessment conducted within five business days as applicable	**0.500** **0.500**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
QI Activities					
23. High Utilization of Services CRA and TSA § 2.9.6.10.3.4; TSA § 2.7.2.8.4.1	The MCO monitors and evaluates member emergency department and behavioral health crisis service utilization to determine the reasons for these visits. The care/support coordinator takes appropriate action to address physical and behavioral health needs and facilitates appropriate utilization of these services, e.g., communicating with the member's providers, educating the member, conducting a needs reassessment, updating the member's plan of care or PCSP, and to better manage the member's condition(s) and/or for persons in ECF CHOICES, referral for Behavioral Crisis Prevention, Intervention, and Stabilization Services if medically necessary. For any member with intellectual or developmental disabilities (I/DD) receiving such services in the System of Support (SOS) model, the support coordinator participates as a member of the SOS team and ensures that the Crisis Prevention, Intervention, and Stabilization Plan developed in the SOS model is incorporated into the PCSP, as appropriate.	☐ a. Member emergency department and behavioral health crisis service utilization monitored and evaluated ☐ b. Appropriate action taken to address member needs ☐ c. Support coordinator participated as SOS team member for members receiving such services ☐ d. Crisis Prevention, Intervention, and Stabilization Plan developed in the SOS model was incorporated into the PCSP, as appropriate	**0.500** **0.500** **0.500** **0.500**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
24. Member Advisory Committee CFR 438.110	The MCO supports a Member Advisory Committee that includes a representative sample of CHOICES and ECF CHOICES members.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
QI Activities					
25. Health Information System CFR 438.242.a	The MCO maintains a health information system that collects, analyzes, integrates, and reports data including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for reasons other than loss of Medicaid eligibility.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
26. Compliance Program CFR 438.608.a-.a.1	The MCO (and subcontractor, if applicable) maintains a compliance program and procedures that detect and prevent fraud, waste, and abuse.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
		QI Activities Score	**0.0%**	**33.000**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Clinical Criteria for Utilization Management (UM) Decisions					
1. Availability of Criteria CRA § 2.18.5.2; 2.18.5.2.8 and .18; TSA § 2.18.5.3; 2.18.5.3.8 and .18	The MCO includes the following information in its Provider Handbooks: ♦ Medical necessity standards and clinical practice guidelines ♦ Prior authorization, referral, and other UM requirements and procedures	☐ Medical necessity standards and clinical practice guidelines included ☐ Prior authorization, referral, and other UM requirements included	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Transition to Other Care CRA and TSA § 2.9.5.1-.1.2	The MCO assists members in transitioning to another provider when a provider currently treating their condition or providing prenatal services terminates participation with the MCO. Assistance is provided to members with the following conditions: ♦ Chronic or acute medical conditions ♦ Behavioral health conditions ♦ Currently receiving long-term care services ♦ Pregnancy For members in their second or third trimester of pregnancy, the MCO allows continued access to the prenatal care provider and to any provider treating the member's chronic or acute medical or behavioral health condition through the postpartum period. For all other members, continuation of care is provided up to 90 calendar days or until the member may be reasonably transferred to another provider without disruption of care, whichever is less.	☐ a. Assistance provided to specific members ☐ b. Continuation of current prenatal provider through postpartum period ☐ c. Continuation of care up to 90 calendar days or until transfer without disruption of care for all other members ☐ d. Staff able to demonstrate knowledge of transition requirements and provide examples	**0.500** **0.500** **0.500** **0.500**	**2.000**	**0.000**
Findings **Strength**					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Clinical Criteria for Utilization Management (UM) Decisions					
AON					
Suggestion					
3. Practice Guidelines CFR 438.236.b-.c	Practice guidelines comply with TennCare medical necessity rule, are based on valid and reasonable evidence or consensus of healthcare professionals in a particular field, consider the needs of members, and are developed, reviewed, and updated by providers.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Clinical Criteria for Utilization Management (UM) Decisions Score	**0.0%**	**4.000**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
1. Member Handbook Development and Distribution CRA and TSA § 2.17.4.1-.2 and .4; CFR 438.10.d	The Member Handbook is developed and updated annually based on TennCare-provided templates. It is distributed to the following: ♦ Members within 30 calendar days of receiving notice of enrollment in the MCO ♦ All contracted providers upon initial credentialing ♦ All members and providers annually and as updates occur ♦ All potential members upon request	☐ a. Developed/updated using TennCare templates ☐ b. Sent to members within 30 calendar days of enrollment ☐ c. Sent to providers upon credentialing ☐ d. Redistributed annually ☐ e. Redistributed as updated ☐ f. Potential members upon request	**0.200** **0.200** **0.200** **0.200** **0.200** **0.200**	**1.200**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
2. Communication of Rights and Responsibilities in Member Handbook CRA § 2.17.4.6; 2.17.4.6.23-.24; .28-.30; .32; .35-.38; TSA § 2.17.4.7; 2.17.4.7.22-.23; .27-.29; .33-.37	The Member Handbook informs members of the following: a. Grievance and appeal procedures b. Right to request reassessment of eligibility-related decisions directly to TennCare c. Requirement to notify the MCO and TennCare of each change of address d. Right to request to change MCOs at any time during the 45 calendar day period immediately following their initial enrollment in an MCO e. Right to change MCOs at the next choice period and has a 45 calendar day period immediately following the enrollment, as requested during said choice period, in a new MCO to request to change MCOs f. Right to terminate participation in the TennCare program at any time with instructions to contact TennCare for termination forms and additional information on termination g. Necessary steps to amend their data in accordance with HIPAA regulations and state law** h. Instructions on how to request and obtain information regarding the "structure and operation of the MCO" and "physician incentive plans" i. Right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand j. Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation	☐ a. Grievance and appeal procedures ☐ b. Right to request reassessment ☐ c. Requirement to notify MCO and TennCare of address changes ☐ d. Right to request to change MCOs at any time during the 45 calendar day period immediately following initial enrollment ☐ e. Right to change MCOs at the next choice period ☐ f. Right to terminate participation in the TennCare program ☐ g. Steps to amend their data** ☐ h. Instructions on how to request and obtain information regarding the "structure and operation of the MCO" and "physician incentive plans" ☐ i. Right to receive information on available treatment options and alternatives ☐ j. Right to be free from any form of restraint or seclusion	**0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
3. Member Handbook Inclusions CRA § 2.17.4.6.3-.5; .8-.11; .16-.17; .22; .26-.27; .33; .41; TSA § 2.17.4.7.3-.5; .8-.11; .15-.16; .21; .25-.26; .32; .40	The Member Handbook includes, at a minimum, the following: a. Explanation on how members will be notified of member-specific information, such as the effective date of enrollment b. Explanation of how members can change PCPs c. Description of services provided, including benefit limits, exclusions, and use of non-contract providers d. Financial responsibilities of member and explanation that a provider may take steps to collect any copays the member may owe e. Indications that members may not be billed for covered services except for the amounts of the specified TennCare cost-share responsibilities and indications of their right to appeal in the event that they are billed f. Information about preventive services for adults and children, including TennCare Kids for Medicaid-eligible members, listing of preventive services, and notice that preventive services are at no cost and without cost-share responsibilities g. Procedures for obtaining required services, including procedures for obtaining referrals to network specialists and providers outside of the plan h. Information advising members that if they need a service that is not available within the plan, they will be referred to a provider outside of the plan, and any copayment requirements would be the same as if this provider were in the plan i. Information for CHOICES and ECF CHOICES members on the Care Coordination Program j. Explanation of emergency services and how to obtain them in and out of the MCO's service area, including but	☐ a. Member notification methods ☐ b. Information on how to change PCPs ☐ c. Service parameters ☐ d. Financial responsibilities of member, explanation regarding collection, and steps taken to collect any copays the member may owe ☐ e. Billing for covered services and appeal of billed services ☐ f. Preventive services information ☐ g. Obtaining services and referrals in- and out-of-plan ☐ h. Out-of-plan referral and copay requirements ☐ i. Information for CHOICES and ECF CHOICES members on the Care Coordination Program ☐ j. Emergency services access information ☐ k. PCP and nurse line 24/7 access ☐ l. Information about how to report suspected abuse, neglect, or exploitation ☐ m. Advance directives information	**0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200**	**3.200**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
	not limited to the use of 911 and locations of emergency settings and services k. Information on how to access the PCP on a 24-hour basis and the 24-hour nurse line l. Information about how to report suspected abuse, neglect, and exploitation of members who are adults and suspected brutality, abuse, or neglect of members who are children, including the telephone number to call to report suspected abuse m. Written information concerning advance directives n. Member notice indicating that enrollment in the MCO's plan invalidates any prior authorization for services granted by another plan but not utilized prior to enrollment in the new MCO and notice of continuation of an active treatment plan or pregnancy o. Member services toll-free telephone numbers, including the TennCare Hotline, the MCO's customer service line, and the MCO's 24/7 Nurse Triage Line with a statement indicating that the member may contact the plan or TennCare regarding questions about TennCare, as well as the service/information that may be obtained from each line p. Information on appropriate prescription drug usage	☐ n. Service continuation/discontinuations ☐ o. Required toll-free telephone numbers and notice that members may contact the MCO or TennCare with questions ☐ p. Information on appropriate prescription drug usage	**0.200** **0.200** **0.200**		
Findings **Strength** **AON** **Suggestion**					
4. Information about Civil Rights CRA and TSA § 2.17.2.4	All written materials include information about the civil rights laws as directed by TennCare, which includes, but is not limited to, the notice of non-discrimination, taglines, and the discrimination complaint forms.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
Strength **AON** **Suggestion**					
5. Notification of Changes to Written Materials CRA and TSA § 2.17.2.9	The MCO provides written notice to members of any changes in policies or procedures described in written materials previously sent to members at least 30 days before the effective date of change.	☐ Written notice to members ☐ Members notified at least 30 days before effective date of change	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
6. Communication Assistance Services CRA § 2.17.4.6; 2.17.4.6.34; TSA § 2.17.4.7; 2.17.4.7.33; CRA and TSA § 2.17.5.2.2; 2.18.2.1-.2; 2.28.2; 2.28.2.1; CFR 438.10.d	The MCO provides translation services for members and potential members as demonstrated by the following: a. Member Handbooks include information on how to obtain information in alternative formats or how to access interpretation services, as well as a statement indicating that interpretation and translation services are free. b. Quarterly newsletters include the procedure on how to obtain information in alternative formats or how to access interpretation services, as well as a statement indicating that interpretation and translation services are free. c. The MCO maintains TennCare-approved, written P&Ps for providing members and potential members with language assistance services, which includes, but is not limited to, interpretation and translation services and effective communication assistance in alternative formats, such as auxiliary aids to any member, potential member, and/or representative who needs such services. d. The MCO has proof/documentation that it provides language assistance services, including but not limited to interpreter and translation services and effective	☐ a. Information in Member Handbook ☐ b. Information in all quarterly newsletters ☐ c. Procedure for language interpretation and translation services ☐ d. Documentation of services provided** ☐ e. Non-Discrimination Compliance Coordinator provided required training	**0.200** **0.200** **0.200** **0.200** **0.200**	**1.000**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
	communication assistance in alternative formats, such as auxiliary aids free of charge to members and/or the member's representative.** e. The MCO's Non-Discrimination Compliance Coordinator provides language and cultural competence training for MCO staff, including but not limited to all providers and direct service subcontractors, which includes the potential impact of linguistic and cultural barriers on utilization, quality, and satisfaction with care and how and when to access interpreter services and to promote their appropriate use during the medical encounter.				
Findings **Strength** **AON** **Suggestion**					
7. Translated Vital Documents CRA and TSA § 2.17.2.6	All vital MCO documents and the Member Handbook are translated and available in Spanish. Within 90 calendar days of notification from TennCare, all vital MCO documents are translated and available to each limited English proficiency (LEP) group identified by TennCare that constitutes 5% of the TennCare population or 1,000 members, whichever is less.	☐ All vital documents translated ☐ Vital documents translated within 90 calendar days	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
8. Website CFR 438.10.c.3; .g; .h; .i	The MCO operates a website that includes all information from the Member Handbook, Provider Directory, and drug formulary.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength**					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
AON Suggestion					
9. Limitations/ Capitations/ Delays CRA and TSA § 2.6.3.2-.4; CFR 438.210.B-.C	The MCO demonstrates that it does not impose benefit limitations, duration/scope limitations, or monetary capitations upon EPSDT, long-term supports and services (LTSS), or family planning services unless they are excluded under TennCare rule. UM controls do not unreasonably delay the initial or continued receipt of services. Services are provided based on individual needs.	☐ a. No limits or capitations imposed unless excluded under TennCare rule ☐ b. UM controls did not delay services ☐ c. Services based on individual needs	**0.500** **0.500** **0.500**	**1.500**	**0.000**
Findings **Strength** **AON Suggestion**					
		Member Rights and Responsibilities Score	**0.0%**	**12.900**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
1. New Member Calls CRA and TSA § 2.7.6.2.2.1	The MCO conducts telephone calls to all new members under the age of 21 years to inform them of TennCare Kids services, including the availability of assistance with appointment scheduling and transportation. (This is not applicable if the MCO's TennCare Kids screening rate is above 90%, as determined in the most recent Centers for Medicare & Medicaid Services [CMS]-416 report.)	☐ Yes or Not Applicable (CMS-416 screening rate above 90%) ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Member Outreach Contacts CRA and TSA § 2.7.6.2.2; 2.7.6.2.2.2; 2.17.4.2	The MCO distributes six outreach contacts a year, which include the following: ♦ Member Handbook sent within 30 calendar days of enrollment (annually thereafter upon the member's anniversary date of enrollment, the MCO sends an updated handbook, a supplemental update to the handbook, or a reminder of EPSDT services) ♦ Four quarterly newsletters ♦ One reminder before screenings are due (with transportation and scheduling assistance offered) ♦ At least one of the six outreach attempts identified above advises members who are blind, deaf, illiterate, or LEP how to request and/or access such assistance and/or information	☐ a. Member Handbook sent within 30 calendar days of enrollment and annually thereafter ☐ b. Quarterly newsletters ☐ c. Screening due reminders ☐ d. Annual reminder of EPSDT services ☐ e. Annually informed regarding availability of information in alternative formats	**0.125** **0.125** **0.125** **0.125** **0.250**	**0.750**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
3. Documenting Outreach CRA and TSA § 2.7.6.2.4	The MCO has P&Ps in place as well as a process for following up with members who do not get their screenings timely. It includes provisions for documenting all outreach attempts with a mechanism for maintaining records of efforts to reach members who miss screening appointments or who have failed to receive regular check-ups. MCO staff demonstrates knowledge of the outreach efforts used for each quarter.	☐ Process in place ☐ Staff demonstrated knowledge	**0.750** **0.750**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
4. Re-Notification If No Services Used CRA and TSA § 2.7.6.2.5	The MCO maintains a process for determining whether someone eligible for EPSDT has used services within a year. The MCO follows up with two reasonable attempts in different formats to re-notify the member.	☐ Maintained process ☐ Two additional attempts	**0.250** **0.250**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
5. Accurate Provider Lists CRA and TSA § 2.7.6.2.6	The MCO makes available to families accurate lists of names and telephone numbers of contract providers who are currently accepting TennCare.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
6. Targeted Activities CRA and TSA § 2.7.4.1; 2.7.4.1.3; 2.7.6.2.2.1-.2; 2.7.6.2.5; 2.7.6.2.7	The MCO has established criteria for determining when to target specific informing activities for each of the following groups: ♦ Pregnant women ♦ Adolescents ♦ First-time eligible members ♦ Illiterate, blind, deaf, and LEP members ♦ Those not using the program within a year ♦ Families with newborns Pregnant women are informed about the availability of EPSDT for their children prior to the delivery date (provided the MCO is informed of the pregnancy) and are offered EPSDT services for the child when it is born.	☐ Criteria established for when to target informing activities for each of the specified groups ☐ Pregnant women informed about EPSDT services prior to delivery and offered services for children when born	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
7. Outreach to Individuals Who Need Alternative Communication Methods CRA and TSA § 2.7.6.2.2.2	The MCO customizes communication assistance methods to inform illiterate individuals or those with disabilities, such as visual or hearing impairments or LEP, about the availability of EPSDT services.	☐ Customized methods ☐ Items distributed to identified members	**0.250** **0.250**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
8. Prenatal Appointment Assistance CRA and TSA § 2.7.5.2.1; 2.11.4.2	The MCO has processes in place and provides information on covered services to prenatal members who enter TennCare through presumptive eligibility. On the day eligibility is determined, the MCO offers individual assistance in making a timely first prenatal appointment. For a woman past her first trimester, this appointment occurs within 15 calendar days.	☐ a. Process in place ☐ b. Provided information on covered services ☐ c. On the day eligibility was determined, offered appointment assistance ☐ d. For a woman past her first trimester, appointment occurred within 15 calendar days	**0.500** **0.500** **0.500** **0.500**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
9. Referrals from One Level of Screening to Another CRA and TSA § 2.7.6.1.3; 2.7.6.1.5; 2.7.6.1.5.2	The MCO has a P&P in place to ensure that providers make and document appropriate referrals from one level of screening or diagnosis to another, more sophisticated level. These referrals are made as needed to determine medically necessary services for the child's physical health, behavioral health, and developmental needs. This is done regardless of whether the required services are covered by the MCO.	☐ P&P in place ☐ Evidence ensuring provider compliance	**0.500** **0.750**	**1.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 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)					
10. Notify MCO If Unable to Make Referral CRA and TSA § 2.7.6.1.6	The MCO has procedures in place that direct providers to notify the MCO if a screening reveals the need for other healthcare and the provider is unable to make an appropriate referral. These procedures include the MCO's securing an appropriate referral and contacting the member to offer scheduling assistance and transportation.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
11. Medically Necessary Services CRA and TSA § 2.6.3.1; 2.6.3.5; 2.7.6.1.5; 2.7.6.1.5.3	The MCO has procedures in place to provide all medically necessary EPSDT services as required by law. The MCO has procedures to educate providers about the necessity of documenting all components of a screening with accurate coding and demonstrates that provider education has occurred.	☐ a. EPSDT services provided ☐ b. Procedures to educate providers in place ☐ c. Evidence of provider education	**0.500** **0.500** **0.500**	**1.500**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2019 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)					
12. Rehabilitative Services CRA and TSA § 2.7.6.1.1; 2.7.6.4.8; 2.7.6.4.8.3	Rehabilitative services include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts for "maximum reduction of physical or mental disability and restoration of a recipient to the best possible functional level." These services may be, where medically necessary to do so, delivered in conjunction with the services listed in the Service Chart (2.7.6.4.8) in the CRA. Covered services must be medically necessary and include treatment to correct or ameliorate, or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, regardless of whether the required service is a covered benefit.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
13. Medical Necessity CRA and TSA § 2.6.3.1 and .5	The MCO has a process in place concerning issues of medical necessity, which ensures that consistent decisions are rendered and that they are compliant with federal and state laws.	☐ a. Process in place ☐ b. Definition of medical necessity same as contract or no more restrictive ☐ c. Evidence of consistent decisions (e.g., inter-rater reliability [IRR] testing) ☐ d. Appropriate follow-up as applicable	**0.500** **0.500** **0.500** **0.500**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 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. Qualified UM Personnel CRA and TSA § 2.14.1.1 and .8	The MCO has a process in place guaranteeing that only appropriately licensed professionals with education, training, or experience in child and adolescent health are employed to make utilization review (UR) and prior authorization decisions for members ages 20 years and under. Personnel making UR and prior authorization decisions for members ages 20 years and under are trained or experienced as described above.	☐ Process in place ☐ Staff licensed/experienced	**0.500** **2.500**	**3.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
15. Services Without Prior Authorization CRA and TSA § 2.7.6.1.7	The MCO ensures that all covered medically necessary services (including continuation of services) are provided, whether the condition existed prior to any screening and regardless of whether the need for such services was identified by a provider whose services had received prior authorization from the MCO or via an in-network provider.	☐ Yes ☐ No	**1.250** **0.000**	**1.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					
16. Specialist List CRA and TSA § 2.14.3.5.1	The MCO demonstrates that it provides PCPs participating in EPSDT with a hard copy of an updated list of referral providers and behavioral health providers to whom referrals may be made for screens, lab tests, further diagnostic services, and corrective treatment. The list is supplemented and mailed quarterly to indicate additions and deletions. The MCO also maintains an updated electronic, web-accessible version of the referral provider listing.	☐ Yes ☐ No	**0.750** **0.000**	**0.750**	**0.000**
Findings					

2019 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					
17. Mental Health Case Management Services CRA and TSA § 2.7.2.1.2	Mental health case management services, for children whose behavioral health needs require these services, are provided to all TennCare children for whom they are medically necessary.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
18. Family Involvement and Accessible Services CRA and TSA § 2.6.1.1; 2.7.2.1.2; 2.11.1.1	Parents and family members are involved, to the greatest extent possible, in the determination of behavioral health services to be delivered to a particular child. The MCO provides access to behavioral health providers for the provision of covered services in accordance with the geographic, appointment, and wait times access standards.	☐ a. Parent/family involvement ☐ b. Comprehensive/appropriate scope ☐ c. Geographically accessible	**0.500** **0.500** **0.500**	**1.500**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2019 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)					
19. Follow-Up After Inpatient or Residential Treatment CRA and TSA § 2.9.10.3.2	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, his or her family, or other caregivers, clinicians, and social worker(s) have participated. This discharge plan includes an outpatient visit scheduled before discharge, which ensures access to proper provider/medication follow-up. Also, an appropriate placement or housing site is secured prior to discharge.	☐ a. Discharge plan completed ☐ b. Required persons participated ☐ c. Outpatient appointment scheduled ☐ d. Appropriate placement or housing secured	**0.500** **0.500** **0.500** **0.500**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
20. Screening Components Including Follow-Up CRA and TSA § 2.7.6.1.4	The MCO has procedures in place for ensuring that all TennCare Kids screens contain all required components, including follow-up components if all components of a screen cannot be completed in a single visit or whenever concerns or questions remain after the screening process.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
21. Interperiodic Screening CRA and TSA § 2.6.1.3; 2.7.6.1.7; 2.7.6.3.2	The MCO demonstrates that any encounter with a health professional practicing within the scope of his or her practice is considered an interperiodic screening and that any person who suspects a problem may refer a child for an interperiodic screening.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings					

2019 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**					
22. Prior Authorization Prohibited CRA and TSA § 2.7.6.1.7	The MCO does not impose prior authorization requirements on interperiodic screenings conducted by a PCP.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
23. Transportation CRA and TSA § 2.7.6.4.6 and Attachment XI: 1.2-.3; 4.1.1	The MCO has protocols and procedures for ensuring 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. The MCO has protocols for making referrals to TennCare transportation providers.	☐ a. Protocols and procedures in place ☐ b. No blanket restrictions ☐ c. Assistance was inclusive of identified components ☐ d. Transportation referral protocols	**0.500** **0.500** **0.500** **0.500**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
24. Program Coordination CRA and TSA § 2.7.6.1.3	The MCO has P&Ps that coordinate TennCare Kids outreach, screening, and treatment services with other children's health and education services and programs. Staff is able to describe and demonstrate coordination efforts by the MCO.	☐ P&Ps in place ☐ Coordination described and demonstrated	**0.500** **0.500**	**1.000**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
Findings					
Strength					
AON					
Suggestion					
25. Individual Education Plans (IEPs) CRA § 2.9.16.7.1 and .4-.4.3; TSA § 2.9.17.7.1 and .4-.4.3	The MCO is responsible for the delivery of medically necessary covered services to school-aged children. The MCO is also encouraged to work with school-based providers to manage the care of students with special needs. The Department of Education (DOE) and local education agencies are responsible for documenting a school-aged child's need for medical services in an IEP. When the child is enrolled in TennCare, the school is responsible for obtaining parental consent to share the IEP with the MCO and subsequently sending a copy of the parental consent and IEP to the MCO in the required manner. The MCO decides whether to receive the IEP and parental consent prior to providing and paying for medically necessary covered services or upon request during a post-payment audit. If the MCO requires the school to submit parental consent and the IEP prior to providing and paying for the services, the MCO completes the following after receiving the documentation: ♦ Either accepts the IEP as an indication of a medical problem and treats the IEP as a request for service to which the MCO responds within 14 days or assists in making an appointment to have the child appropriately evaluated within the timeframes specified in the TennCare Waiver Terms and Conditions for access to care ♦ Sends a copy of the IEP and related information to the PCP ♦ Notifies the designated school contact of the ultimate disposition of the request	☐ a. Accepted problem or had child evaluated ☐ b. Shared with PCP ☐ c. Notified school contact of disposition of request	**0.250** **0.250** **0.250**	**0.750**	**0.000**
Findings					
Strength					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
AON					
Suggestion					
26. IEP Services Provided Without Submission of the IEP CRA § 2.9.16.7.2-.3.1; TSA § 2.9.17.7.2-.3.1	The MCO may choose to provide the medically necessary covered services identified either within or outside the school setting. When the MCO does not require the DOE to submit parental consent and the IEP prior to providing and paying for services, the MCO conducts regular post-payment sample audits of the IEP and all other documentation that supports medical necessity of school-based services reimbursed by the MCO. When the MCO requests a copy of an IEP, the provider must also include a copy of the appropriate parental consent.	☐ Yes ☐ No	**0.250** **0.000**	**0.250**	**0.000**
Findings					
Strength					
AON					
Suggestion					
27. Tracking System CRA and TSA § 2.7.6.1.8; 2.7.6.2.3-.4	Tracking system data are used to take action to improve the EPSDT services. The tracking system information has been utilized to contact providers regarding the need to set appointments for the individual member. The tracking system information has been used to contact parents/guardians/members regarding the need to make an appointment and receive EPSDT services. (For more detailed information, refer to the EPSDT Information System Tracking Review Tool.)	☐ Contact providers ☐ Contact parents/guardians/members	**1.000** **1.000**	**2.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		☐ a. Comprehensive health history ☐ b. Comprehensive physical exam	**0.250** **0.250**	**2.000**	**0.000**

2019 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)					
28. EPSDT Language in Contracts CRA and TSA § 2.7.6.3.3-.5	All contracts with appropriate providers contain language requiring the following EPSDT elements: a. Comprehensive health and developmental history b. Comprehensive physical exam c. Immunizations d. Vision and hearing testing e. Laboratory testing f. Health education g. Dental assessment h. Referral to behavioral health services	☐ c. Immunizations ☐ d. Vision and hearing testing ☐ e. Laboratory testing ☐ f. Health education ☐ g. Dental assessment ☐ h. Behavioral health services referral	**0.250** **0.250** **0.250** **0.250** **0.250** **0.250**		
Findings **Strength** **AON** **Suggestion**					
29. EPSDT Contract Review CRA and TSA § 2.12.8; 2.12.9; 2.12.9.6	Review of contracts ensures that there are no provisions which would encourage violations of the EPSDT mandate.	☐ Yes (no provisions) ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
		Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Score	**0.0%**	**33.500**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
TennCare Medical Services Grievance and Appeal Process					
1. Appeals Unit CRA and TSA § 2.19.1.4	The MCO has sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to member appeals contesting MCO adverse benefit determinations.	☐ Yes ☐ No	**1.500** **0.000**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Appeals Procedures CRA and TSA § 2.19.1.2	In accordance with TennCare requirements, the MCO has internal grievance procedures in place for its assigned TennCare members. Further, the MCO has the contractually required procedures in place for handling its obligations related to the TennCare appeal process. Appeals staff demonstrates the procedures that ensure compliance with the appeals process.	☐ Internal procedures in place ☐ Procedures demonstrated	**1.000** **1.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
		TennCare Medical Services Grievance and Appeal Process Score	**0.0%**	**3.500**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Non-Discrimination Compliance					
1. Non-Discrimination Compliance Questionnaire CRA and TSA § 2.30.22.1	There is documentation of the MCO's submission of a completed Non-Discrimination Compliance Questionnaire to TennCare within 60 calendar days of receipt of the Questionnaire from TennCare. The completed Non-Discrimination Compliance Questionnaire and Assurance of Compliance signature dates are the same.	☐ Yes ☐ No	**0.250** **0.000**	**0.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Display of Non-Discrimination Information CRA § D.7; TSA § 5.32.3	The MCO ensures that no employee is subjected to discrimination based on handicap or disability, age, race, color, religion, sex, national origin, or any other classification protected by federal, state, or statutory law. The MCO provides proof of non-discrimination upon request and posts the information in conspicuous places that are accessible for all employees and applicants.	☐ Yes ☐ No	**0.250** **0.000**	**0.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Provision of Services CRA and TSA § 2.28.3	The MCO has written non-discrimination P&Ps on file that demonstrate that the provision of services to members are provided in a non-discriminatory manner.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**0.000**
Findings					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Non-Discrimination Compliance					
Strength					
AON					
Suggestion					
4. Complaint Resolution and Reporting CRA and TSA § 2.28.3; 2.28.6-.6.2; 2.30.22.3, .3.2, and .3.2.1	The MCO has a written P&P on file, approved by TennCare, for monitoring, assisting with initial investigations, and implementing TennCare's resolutions for discrimination complaints. The MCO has the written documentation that is required as part of the discrimination complaint process (e.g., proof that TennCare's resolution has been implemented by the MCO). The MCO submits a quarterly Non-Discrimination Compliance Report to TennCare. The report lists all complaints of alleged discrimination filed against the MCO by employees, members, providers, and subcontractors.	☐ a. Written P&P ☐ b. Approved by TennCare ☐ c. Complaints documented, investigated, and resolved ☐ d. Quarterly report submitted, including required information	**0.200** **0.200** **0.300** **0.300**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
5. Member Handbook Complaint Forms CRA and TSA § 2.28.7	The English and Spanish Member Handbooks include a copy of the Discrimination Complaint Forms.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Non-Discrimination Compliance					
6. Health Disparities Projects CRA and TSA § 2.30.22.4; 2.30.22.4.2	On an annual basis, the MCO documents that it assisted TennCare with its health disparities survey efforts and projects.	☐ Documentation for survey communication efforts ☐ Documentation for healthcare disparities projects	**0.250** **0.250**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
7. Provider and Subcontractor Compliance Education CRA and TSA § 2.28.2-.2.1.1	The MCO can document that its providers and subcontractors have been made aware of their obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the Americans with Disabilities Act of 1990, and the Age Discrimination Act of 1975.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
		Non-Discrimination Compliance Score	**0.0%**	**5.000**	**0.000**

DBM

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Written QMP Description					
1. Quality Monitoring Program (QMP) Description DBMC A.114; A.122	The DBM has a written QMP Description (QMPD) that clearly defines its quality improvement (QI) structures, processes, and related activities to pursue opportunities for improvement on an ongoing basis. The description also includes the staff responsible.	☐ a. Clearly defined ☐ b. QI structure ☐ c. Defined processes ☐ d. Staff responsible included	**0.250** **0.250** **0.250** **0.250**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. QMP Work Plan DBMC A.122.a; A.122.a.2 and .e	The DBM has an annual work plan that identifies QMP activities, yearly objectives, timeframes for completion, and staff responsible for oversight of QMP activities. The work plan is submitted annually to TennCare.	☐ Work plan with required components submitted annually to TennCare	**1.500**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. QMP Activities/ Service Delivery DBMC A.122; A.122.c–.d	The DBM uses the results of QMP activities to improve the quality of dental health with appropriate input from providers and members, and takes appropriate action to address service delivery including continuity and coordination of care, access to care, utilization of services, health education and emergency services; patient safety; provider; and other QMP issues as they are identified.	☐ Used the results of QMP activities to improve the quality of dental health ☐ Took appropriate action to address service delivery	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Written QMP Description					
4. Continuous Activity Performance and Tracking DBMC A.114; A.122	The written QMPD includes, and there is evidence of, continuous performance of the quality of care activities and tracking of issues over time.	☐ Continuous performance ☐ Tracking of issues over time	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
5. Peer Review DBMC A.117; A.117.a	The Peer Review Committee (PRC) meets at least quarterly to review processes, outcomes, and appropriateness of dental care provided to members for any participating provider. The PRC reviews and provides detailed written findings, recommendations, and appropriate corrective action for any participating dental provider who has provided inappropriate care.	☐ Meetings held at least quarterly ☐ Findings, recommendations, and appropriate corrective action provided	**0.750** **0.750**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
6. Feedback DBMC A.116.b	The QMP Committee analyzes and evaluates QMP activity results; recommends policy decisions; ensures that providers are involved in the QMP; institutes needed action; and ensures that appropriate follow-up occurs.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Written QMP Description					
7. Guideline Dissemination DBMC A.45.f	The practice guidelines are disseminated to all affected providers and, upon request, to members and potential members.	☐ To providers ☐ To members and potential members when requested	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
8. Delegation of QMP Activity ~	The QMP includes a written description of delegated activities, including accountability and reporting frequency. Written procedures for monitoring and evaluating implementation of delegated functions and for verifying the actual quality of care being provided are also included.	☐ Description of delegated activities ☐ Procedures for implementation review and quality verification	**1.000** **1.500**	**2.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
		Written QMP Description Score	**0.0%**	**10.500**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Systematic Process of Quality Assessment and Improvement					
1. Population Served DBMC A.122; A.123.c	The QMP has written guidelines for its performance improvement projects that specify that the monitoring and evaluation of care reflect the DBM's population in terms of age groups, disease categories, and special risk status. This includes ECF CHOICES members.	☐ a. Age groups ☐ b. Disease categories ☐ c. Special risk status	**0.250** **0.250** **0.250**	**0.750**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Practice Guidelines DBMC A.45.a–.e	Practice guidelines comply with TennCare medical necessity rule, are based on valid and reasonable evidence or consensus of healthcare professionals in a particular field, consider the needs of members, and are developed, reviewed, and updated by plan providers. The needs of ECF CHOICES members are also included.	☐ Yes ☐ No	**0.750** **0.000**	**0.750**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Updates Disseminated DBMC A.44; A.45.f	Practice guidelines are included in DBM Provider Manuals or are otherwise disseminated to providers (as they are adopted). The Provider Manuals include a supplement specific to providers participating in ECF CHOICES.	☐ Yes ☐ No	**0.250** **0.000**	**0.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Systematic Process of Quality Assessment and Improvement					
4. Address Preventive Health DBMC A.45; A.97; A.122	Practice guidelines address preventive dental services for all members, including ECF CHOICES members.	☐ Yes ☐ No	**0.250** **0.000**	**0.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					
5. Analysis of Clinical Care and Related Services DBMC A.117; A.122.b	Appropriate clinicians monitor and evaluate quality of care through the review of individual cases (where there are questions about care) and through studies analyzing patterns of clinical care and related services. For quality issues identified in the QMP's targeted clinical areas, the analysis includes quality indicators and uses practice guidelines to make determinations.	☐ a. Review of individual cases ☐ b. Review of studies analyzing patterns of clinical care and related services ☐ c. Analysis included quality indicators and used practice guidelines to make determinations	**0.250** **0.250** **0.250**	**0.750**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Systematic Process of Quality Assessment and Improvement					
6. Remedial/ Corrective Action Procedures DBMC A.122.b	The QMP includes written procedures for taking remedial/corrective action when, as determined by the QMP, inappropriate or substandard services are furnished, or when services that should have been furnished were not. Written remedial/corrective action procedures include the following: a. Specific types of problems requiring remedial/corrective action b. Specific person(s) or body responsible for making final determinations regarding quality problems c. Specific actions to be taken d. Provision of feedback to appropriate dental professionals and staff e. Schedule of corrective actions to be completed, due dates, and persons responsible for implementing corrective actions f. Methodology for modifying corrective actions if improvements do not occur g. Procedures for terminating DBM affiliation with a dental professional when warranted	☐ a. Specific types of problems requiring action ☐ b. Party responsible for final determinations ☐ c. Specific actions to take ☐ d. Provision of feedback to professionals and staff ☐ e. Schedule and persons responsible for implementing actions ☐ f. Method of modifying corrective actions if no improvements ☐ g. Procedures for terminating a dental professional	**0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.300**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
7. Corrective Action Follow-Up DBMC A.122.b	The DBM follows up on identified issues to ensure that actions for improvement have been effective.	☐ Yes ☐ No	**0.750** **0.000**	**0.750**	**0.000**
Findings **Strength**					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Systematic Process of Quality Assessment and Improvement					
AON					
Suggestion					
8. Annual Evaluation DBMC A.122.e	The DBM prepares an annual evaluation of the QMP that addresses: a. studies and other activities completed; b. trending of clinical and service indicators and other performance data; c. demonstrated improvements in quality; d. areas of deficiency and recommendations for corrective action; and e. an evaluation of the overall effectiveness of the QMP.	☐ a. Studies and other activities completed ☐ b. Trending of clinical and service indicators and other performance data ☐ c. Demonstrated improvements in quality ☐ d. Areas of deficiency and recommendations for corrective action ☐ e. Evaluation of the overall effectiveness of the QMP	**0.200** **0.200** **0.200** **0.200** **0.200**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
9. Subcontractor Audits CFR 438.230.c.3-.3.iv	The DBM's contract with a subcontractor includes the right for TennCare or CMS to audit the subcontractor's records and systems at any time through 10 years after the final date of the contract period or the last audit, whichever is later.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Systematic Process of Quality Assessment and Improvement					
10. Marketing Activities CFR 438.104.b.1.i; .iv-.v	The DBM does not engage in cold-call marketing, distribute marketing materials without TennCare approval, or seek to influence enrollment in conjunction with offering private insurance.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
11. Prohibited Affiliations CFR 438.610.a-.a.1	The DBM does not knowingly have a relationship with an individual who is a. debarred, suspended, or otherwise excluded from participating under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549; b. an affiliate, as defined in the Federal Acquisition Regulation, of a person described above; or c. excluded from participation in any federal healthcare program.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
		Systematic Process of Quality Assessment and Improvement Score	**0.0%**	**9.000**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Accountability to the Governing Body					
1. Governing Body DBMC A.116.d	The governing body that is accountable for the DBM's QMP is the Board of Directors or, where the Board's participation with the QMP is not direct, a designated committee of the DBM's senior management.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Oversight of QMP DBMC A.116.d.1	The governing body is accountable for monitoring, evaluating, and making improvements to care. There is documentation showing that the governing body approves the written QMP and annual work plan.	☐ Yes ☐ No	**1.750** **0.000**	**1.750**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. QMP Progress Reports DBMC A.116.d.2	The QMP Committee provides written reports to the governing body that describe actions taken, progress in meeting QM objectives, and improvements made.	☐ Yes ☐ No	**0.750** **0.000**	**0.750**	**0.000**
Findings **Strength** **AON** **Suggestion**					
4. Program Modification DBMC A.116.d.3	Following review of written QMP progress reports, the governing body takes action, as appropriate, and directs that the operational QMP be modified on an ongoing basis to accommodate review findings and issues of DBM concern.	☐ Yes ☐ No	**0.750** **0.000**	**0.750**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Accountability to the Governing Body					
Findings					
Strength					
AON					
Suggestion					
5. Follow-Up DBMC A.116.d.3	Governing body meeting minutes include documentation in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to QM/QI.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Accountability to the Governing Body Score	**0.0%**	**6.250**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Active Quality Monitoring Program Committee					
1. QMP Committee DBMC A.116.a	The written QMP establishes and defines a committee responsible for performing QM functions within the organization.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Meeting Frequency DBMC A.116.e	The QMP Committee has meetings no less than quarterly to oversee QMP activities. The frequency of meetings is sufficient to demonstrate committee follow-up.	☐ Meetings held at least quarterly ☐ Follow-up demonstrated on all findings and required actions	**0.750** **0.750**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Meeting Documentation DBMC A.116.f	The QMP Committee keeps written minutes of all meetings. The minutes are signed, dated, and available for review upon request and during the annual onsite EQRO review.	☐ Yes ☐ No	**1.500** **0.000**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Active Quality Monitoring Program Committee					
4. Membership DBMC A.116.a	There is active participation in the QMP Committee from DBM providers, who are representative of the composition of DBM providers. Membership also includes a TennCare senior executive representative responsible for program implementation and the DBM's Dental Director.	☐ Active TennCare provider participation ☐ TennCare senior executive and DBM Dental Director participation	**0.750** **0.750**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
5. Committee Approval of QMP DBMC A.116.c	The QMP Committee reviews and approves the written QMP and associated work plan prior to submission to TennCare.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
		Active Quality Monitoring Program Committee Score	**0.0%**	**7.500**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Monitoring Supervision					
1. Dental Director Involvement DBMC A.17.b	The DBM's Dental Director has substantial involvement in QM activities.	☐ Yes ☐ No	**3.000** **0.000**	**3.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. External Advisory Committee DBMC A.17.b	The DBM participates in the TennCare Dental Advisory Committee empowered to review and make recommendations to the DBM and TennCare concerning the dental program.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Compliance Program CFR 438.608.a-.a.1	The DBM (and subcontractor, if applicable) maintains a compliance program and procedures that detect and prevent fraud, waste, and abuse.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
		Quality Monitoring Supervision Score	**0.0%**	**5.000**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Adequate Resources					
1. Resources and Staffing DBMC A.122.a.3	The DBM has designated sufficient material resources and staff with the necessary education, experience, or training to effectively carry out QMP activities.	☐ Material resources ☐ Staff with necessary education, experience, or training, including transportation coordinator(s)	**5.000** **5.000**	**10.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Adequate Resources Score	**0.0%**	**10.000**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Provider Participation in the QMP					
1. Informed Providers DBMC A.122.f	The DBM makes all information about its QMP available to its providers. The DBM also includes language requiring cooperation with the QMP in all of its provider contracts and employment agreements with dentists and non-dentist providers.	☐ Yes ☐ No	**3.500** **0.000**	**3.500**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Provider Participation in the QMP Score	**0.0%**	**3.500**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
1. Policies and Procedures (P&Ps) on Member Rights DBMC A.124.a.1-.9; D.7	The DBM has established P&Ps to protect member rights and recognizes such rights to be: a. treated with respect, including recognition of his or her dignity and need for privacy; b. provided with information about the DBM, its services, the practitioners providing care, and members' rights and responsibilities; c. able to choose dentists within the limits of the plan network, including the right to refuse care from specific practitioners; d. a participant in decision-making regarding his or her dental care; e. free to voice complaints or appeals about the DBM or care provided; f. guaranteed the right to request and receive a copy of his or her records, and to request that they be amended or corrected as specified in the Code of Federal Regulations, Title 45 Part 164; g. free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; h. free to exercise his or her rights, and that the exercising of those rights does not adversely affect the way the DBM and its providers or TennCare treat the member; i. provided information on available treatment options and alternatives presented in a manner appropriate to the member's condition and ability to understand; and j. provided services without discrimination due to age, sex, race, color, religion, or national origin.	☐ a. Treated with respect, dignity, and privacy ☐ b. Provided with listed information ☐ c. Able to choose dentists and refuse care ☐ d. Participate in decision-making ☐ e. Voice complaints or appeals ☐ f. Request and receive a copy of records, and request that they be amended or corrected ☐ g. Free from any form of restraint or seclusion ☐ h. Exercise his or her rights ☐ i. Receive information on treatment options/alternatives in an appropriate and understandable manner ☐ j. Receive services without discrimination due to age, sex, race, color, religion, or national origin	**0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200**	**2.000**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Member Rights and Responsibilities					
Findings					
Strength					
AON					
Suggestion					
2. Member Responsibilities Policy DBMC A.124.b	The DBM has a written policy that addresses the member's responsibility for cooperating with those providing dental care services. The policy includes responsibility for providing, to the extent possible, information needed by professional staff in caring for the member and for following instructions and guidelines given by those providing dental care services.	☐ Addressed responsibility for providing needed information ☐ Addressed responsibility for following instructions and guidelines	**0.500** **0.500**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
3. Communication of Policies to Providers DBMC A.124.c	A copy of the DBM's policies on member rights and responsibilities is provided to all participating providers.	☐ Yes ☐ No	**0.750** **0.000**	**0.750**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
4. Communication of Policies to Members DBMC A.124.d.3–.6 and .8–.9	Members are provided a written statement upon enrollment that includes information on the following: a. Provisions for emergency coverage b. Policy on referrals for specialty care c. Policy on charges to members, if applicable, including (1) policy on payment of charges and (2) copayment and fees for which the member is responsible d. Procedures for notifying members affected by the termination of change to any benefits, services, or service delivery offices/sites e. Procedures for changing practitioners f. Procedures for voicing complaints/grievances and/or appeals	☐ a. Provisions for emergency coverage ☐ b. Policy on referrals for specialty care ☐ c. Policy on payment charges and copayment/fees ☐ d. Procedures for notifying members about changes for benefits, services, or service delivery offices/sites ☐ e. Procedures for changing practitioners ☐ f. Procedures for voicing complaints and/or appeals	**0.125** **0.125** **0.125** **0.125** **0.125** **0.125**	**0.750**	**0.000**
Findings **Strength** **AON** **Suggestion**					
5. Member Handbook DBMC A.9.a	The Member Handbook is distributed to members within 30 days of receipt of notice of enrollment in the DBM Plan.	☐ Yes ☐ No	**1.500** **0.000**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
6. Member Handbook Inclusions DBMC A.9.c	The Member Handbook includes the following: a. Table of contents b. Explanation on how members will be notified of member-specific information such as effective date of enrollment c. Description of services provided including limitations, exclusions, and out-of-plan use d. Financial responsibilities of the non-Medicaid eligible members, explaining collection and steps taken to collect any copays a member may owe e. Information about preventive services for children under age 21 years, including listing of such services and a notice that they are at no cost and without cost share responsibilities f. Procedures for obtaining required services, including procedures for obtaining referrals to specialists and to providers outside of the plan; the handbook should advise members that if they need a provider who is not available within the plan, they will be referred to a provider outside of the plan, and any copayment requirements would be the same as if this provider were in the plan g. An explanation that prior authorization is required for some services, including non-emergency services provided by a non-contract provider; such services will be covered and reimbursed only if such prior/service authorization is received before the service is provided; that all prior authorizations/service authorizations are null and void upon expiration of a member's TennCare eligibility; and that the member shall be responsible for payment for any services provided after the member's eligibility has expired h. An explanation of emergency services and procedures on how to obtain these services both in and out of the DBM's service area	☐ a. Table of contents ☐ b. Process for notifying members of their specific information ☐ c. Services provided including limitations, exclusions, and out-of-plan use ☐ d. Financial responsibilities of the non-Medicaid eligible members, explaining collection and steps taken to collect any copays a member may owe ☐ e. Preventive services for children under age 21 years ☐ f. Procedures for obtaining services, including referrals outside of plan ☐ g. Explanation of prior authorization ☐ h. Emergency services and how to obtain them in and out of the DBM service area ☐ i. Appeal procedures ☐ j. Right to request reassessment of eligibility-related decisions ☐ k. Policies on rights and responsibilities ☐ l. Written information concerning advance directives ☐ m. Notification by member when they move ☐ n. Toll-free telephone number for contacting TennCare	**0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200** **0.200**	**3.600**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Member Rights and Responsibilities					
	i. Appeal procedures j. Notice to the member that, in addition to the right to file an appeal for actions taken by the DBM, he or she shall have the right to request reassessment of eligibility-related decisions directly to the Tennessee Department of Human Services k. Written policies on member rights and responsibilities l. Written information concerning advance directives m. Notice that it is the member's responsibility to notify the DBM, TennCare, and Department of Human Services (or for Supplemental Security Income-eligible, the Social Security Administration) every time the member moves to a new address and that failure to notify could result in the member not receiving important eligibility and/or benefit information n. The toll-free telephone number for TennCare with a statement that the member may contact the DBM or TennCare regarding questions about TennCare o. Details on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free p. Information educating members on their rights and necessary steps to amend their data in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations q. Information on requirements for accessing services to which they are entitled under the contract, including factors such as physical access and non-English languages spoken r. Notice of right to file a complaint	☐ o. Ways to obtain information in alternative formats or access interpretation services and a statement such services are free ☐ p. Member rights and necessary steps to amend data in accordance with HIPAA regulations ☐ q. Requirements for accessing entitled services including special factors ☐ r. Notice of right to file a complaint	**0.200** **0.200** **0.200** **0.200**		
Findings					
Strength					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
AON					
Suggestion					
7. Complaint and Appeal System DBMC A.124.e	The DBM has system(s) linked to the QMP for resolving member complaints and appeals. The system includes: a. procedures for registering and responding to complaints and appeals in a timely fashion; b. documentation of the substance of complaints or appeals, and actions taken; c. procedures to ensure a resolution of the complaint or appeal; d. aggregation, analysis, and use of complaint and appeal data for QI; and e. an appeal process for adverse actions. DBM staff is able to demonstrate knowledge of complaint and appeal system and how it relates to QMP.	☐ a. System was in place ☐ b. Procedures for timely registration and response ☐ c. Documentation of complaints and appeals, and actions taken ☐ d. Procedures ensuring resolution ☐ e. Aggregation, analysis, and use of the data for QI ☐ f. Appeal process for adverse actions ☐ g. Staff demonstrated knowledge of complaint and appeal system	**0.250** **0.250** **0.250** **0.250** **0.250** **0.250** **0.250**	**1.750**	**0.000**
Findings					
Strength					
AON					
Suggestion					
8. Steps to Ensure Accessibility of Services DBMC A.124.f-.2	The DBM takes steps to promote accessibility of services offered to members. These steps include • identifying the points of access to dental services, specialty care, and hospital or ambulatory surgical center services and • providing information about obtaining services during regular hours of operation; emergency care; and the names, qualifications, and titles of the professionals providing and/or responsible for their care.	☐ Member points of access were identified ☐ Members were given information regarding services during regular business hours and emergency care, and information about their providers	**1.500** **0.750**	**2.250**	**0.000**
Findings					
Strength					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
AON					
Suggestion					
9. Written Information for Members DBMC A.12.a; A.124.g.1	Member information (e.g., subscriber brochures, announcements, handbooks) is written in prose that is readable and easily understood. All material is worded at a sixth-grade reading level unless TennCare approves otherwise.	☐ Yes, or approved by TennCare ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings					
Strength					
AON					
Suggestion					
10. Information for Limited English Proficiency (LEP) Groups DBMC A.9.c.16; A.12.e-.f; A.124.g.2	The DBM ensures the following: a. Information is included in the Member Handbook on how to obtain communications in alternate formats or how to access interpretation or translations services free of charge. b. All vital DBM documents, including the Member Handbook, are available in Spanish. c. All vital DBM documents are also available to LEP groups identified by TennCare that constitute 5% of the TennCare population, or 1,000 members, whichever is less. d. Written information is available as needed in the languages of the major population groups served. A major population group is one that represents at least 10% of the plan's population, or 3,000 members, whichever is less.	☐ a. Member Handbook explained how to obtain communications in alternate formats and access interpretive services ☐ b. Vital DBM documents available in Spanish ☐ c. Vital DBM documents available to LEP groups ☐ d. Written information available in the languages of the major population groups	**0.250** **0.250** **0.250** **0.250**	**1.000**	**0.000**
Findings					
Strength					
AON					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Member Rights and Responsibilities					
Suggestion					
11. Confidentiality/ HIPAA Compliance DBMC A.9.c.17; A.124.h	To ensure that the confidentiality of specified member information and records is protected, the DBM: a. educates members regarding their rights and the necessary steps to amend their data in accordance with HIPAA regulations; b. has established in writing and enforced P&Ps on confidentiality, including confidentiality of medical records; c. ensures patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the dental care organization; d. holds confidential all information obtained about members related to their examination, care, and treatment, and does not divulge it without member authorization, unless (1) it is required by law; (2) it is necessary to coordinate the member's care with physicians, hospitals, or other healthcare entities or to coordinate insurance or other matters pertaining to payment; or (3) it is necessary in compelling circumstances to protect the health or safety of an individual; e. reports to the member any release of information in response to a court order in a timely manner; and f. discloses records, whether authorized by the member, to qualified personnel for the purpose of conducting scientific research; these personnel may not identify, directly or indirectly, an individual participant in any report of the research or otherwise disclose a participant's identity in any manner.	☐ a. Members are educated on amending data. ☐ b. Confidentiality P&Ps are established and enforced. ☐ c. Offices had mechanisms against disclosure of confidential information. ☐ d. Member information is kept confidential unless (1) required by law; (2) used to coordinate care; or (3) needed in compelling circumstances. ☐ e. Court-ordered releases were reported timely. ☐ f. Information was de-identified in research reports.	**0.125** **0.125** **0.125** **0.125** **0.125** **0.125**	**0.750**	**0.000**

Findings

Strength

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Member Rights and Responsibilities					
AON					
Suggestion					
12. Member Satisfaction DBMC A.124.j and .1	The DBM conducts periodic surveys of member satisfaction with its services. The surveys include content on perceived problems in the quality, availability, and accessibility of care.	☐ Yes ☐ No	**0.250** **0.000**	**0.250**	**0.000**
Findings					
Strength					
AON					
Suggestion					
13. Second Opinion CFR 438.206.b.3	The DBM facilitates a second opinion from a network provider or arranges for the member to obtain one outside the network at no cost to the member.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
14. Cultural Competence CFR 438.206.c.2	The DBM shows evidence that it participates in TennCare's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency (LEP), disabilities, and/or diverse cultural and ethnic backgrounds and regardless of gender, sexual orientation, and gender identity.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Member Rights and Responsibilities					
Suggestion					
15. Website CFR 438.10.c.3; .g; .h; .i	The DBM operates a website that includes all information in the Member Handbook and Provider Directory.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Member Rights and Responsibilities Score	**0.0%**	**19.100**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Standards for Facilities					
1. DBM Standards DBMC A.120; E.7-.8	The DBM maintains standards for facilities (e.g., provider offices, surgery centers) in which patients receive care. Those standards include the following: a. Compliance with existing state and local laws regarding safety and accessibility b. Availability of emergency equipment (applicable to site) c. Storage of medications (including samples) d. Inventory control for expired medications e. Compliance with HIPAA regulations	☐ a. Compliance with state and local laws ☐ b. Availability of emergency equipment ☐ c. Medications storage ☐ d. Inventory control ☐ e. Compliance with HIPAA	**0.400** **0.400** **0.400** **0.400** **0.400**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
		Standards for Facilities Score	**0.0%**	**2.000**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Dental Records					
1. Appropriate Access to Records DBMC A.125.a.1	The DBM includes language in its contracts with providers that allows appropriate access to DBM member dental records for the purposes of quality reviews conducted by the Secretary (Department of Health and Human Services), TennCare agencies, or agencies thereof.	☐ Yes ☐ No	**1.250** **0.000**	**1.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Dental Records					
2. Dental Records Standards DBMC A.125.b-.1.o	The DBM has written standards for the maintenance of dental records in a legible, current, detailed, organized, and comprehensive manner that permits effective patient care and quality review. At a minimum, dental record standards include the following requirements: a. Each page includes the member's name or ID number. b. Member data include age, sex, address, employer, home and work telephone numbers, and marital status. c. All entries are dated. d. Every date of service includes written submission of treatment. e. All entries include the author's name. f. Records are legible to the reader. Any record determined by one reviewer to be illegible should be evaluated by a second reviewer. If still not legible, it is deficient. g. Any medication allergies and/or adverse reactions or absence of allergies (no known allergies) are noted in an easily recognizable location. h. The record contains an easily identified past medical history for patients seen three or more times. The history includes serious accidents, operations, and illnesses. i. For members ages 12 years and under, there is a completed immunization record or notation that immunizations are up to date. j. The record contains diagnostic information. k. The record contains current medication information. l. Information on current significant illnesses, medical conditions, and health maintenance concerns is documented. m. For members ages 12 years and older and seen three or more times, there is a notation concerning cigarette and/or alcohol use and/or substance abuse. n. There are notations of any referrals and results. o. Any emergency dental care rendered is noted.	☐ a. Member identification ☐ b. Personal/biographical data ☐ c. Entries dated ☐ d. Dated written submission of treatment ☐ e. Author identified ☐ f. Legible records ☐ g. Noted allergies ☐ h. Past medical history ☐ i. Immunization record ☐ j. Diagnostic information ☐ k. Medication information ☐ l. Current problems ☐ m. Substance use/abuse ☐ n. Referrals and results notations ☐ o. Emergency care	**0. 125** **0. 125** **0. 125** **0. 125** **0. 125** **0. 125** **0. 125** **0. 125** **0. 125** **0. 125** **0. 125** **0. 125** **0. 125** **0.125** **0.125**	**1.875**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Dental Records					
Findings **Strength** **AON** **Suggestion**					
3. Patient Visit Data DBMC A.125.b.2	Documentation of patient visits, at a minimum, includes: a. history and physical examination, including appropriate subjective and objective information for the presenting complaints; b. plan of treatment; c. diagnostic tests; d. therapies and other prescribed regimens; e. monitoring when in-office sedation is administered; f. charting of conditions and treatment; g. encounter forms or notes with a notation, when indicated, concerning follow-up care, calls, or visits. Specific time to call or return is noted as days, weeks, months, or as needed; h. unresolved concerns from previous visits are addressed in subsequent visits; i. Consultation, lab, and x-ray reports filed in the chart have the ordering dentist's/physician's initials or other documentation signifying review. Consultations and significantly abnormal lab and imaging study results specifically note follow-up plans. Consultations for speech/language pathology include supporting documentation that the condition must be non-responsive to speech therapy without orthodontic treatment; and j. all other aspects of patient care, including ancillary services.	☐ a. History and physical exam ☐ b. Plan of treatment ☐ c. Diagnostic tests ☐ d. Therapies and other prescribed regimens ☐ e. In-office sedation monitored ☐ f. Conditions and treatment charted ☐ g. Follow-up care noted ☐ h. Unresolved concerns from previous visits are addressed ☐ i. Evidence of consult notes and follow-up noted where required ☐ j. All other aspects of care	**0.250** **0.250** **0.250** **0.250** **0.250** **0.250** **0.250** **0.250** **0.250** **0.250**	**2.500**	**0.000**
Findings **Strength** **AON**					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Dental Records					
Suggestion					
4. Record Review Process DBMC A.125.c	The DBM has a written process for assessing dental records for legibility, organization, completion, and conformance to its standards.	☐ a. Legibility ☐ b. Organization ☐ c. Completion ☐ d. Conformance	**0.250** **0.250** **0.250** **0.250**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Dental Records Score	**0.0%**	**6.625**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Utilization Review					
1. Utilization Management (UM) P&Ps DBMC A.32-.a	The DBM has written UM P&Ps that minimally include a. procedures to evaluate medical necessity; b. the process used to review and approve the provision of dental services; and c. mechanisms to detect over- and under-utilization.	☐ a. Procedures to evaluate medical necessity ☐ b. Process to review and approve provision of dental services ☐ c. Mechanisms to detect over- and under-utilization	**0.500** **0.500** **0.500**	**1.500**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Utilization Review					
2. Coverage Limits DBMC A.32.b.1	For prior authorization or medical necessity review, the DBM does not employ or permit others acting on its behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individual determination of medical necessity based on the needs of the member and his or her history.	☐ Yes (does not) ☐ No	**0.750** **0.000**	**0.750**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Qualified Dental Professionals DBMC A.32.b.2–.3	Prior authorization and medical necessity review decisions are supervised by qualified dental professionals. Documented efforts are made to obtain all necessary information, including pertinent clinical information, and to consult with the treating dentists as appropriate. Staff is able to describe and demonstrate the authorization process.	☐ a. Decisions supervised appropriately ☐ b. Necessary information obtained ☐ c. Authorization process described and demonstrated	**1.000** **0.750** **0.750**	**2.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
4. Review Decisions DBMC A.32.b.4	Reasons for decisions regarding prior authorization and medical necessity review are clearly documented and available to the member.	☐ Clearly documented ☐ Made available to the member	**0.750** **0750**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Utilization Review					
5. Appeals Mechanisms DBMC A.32.b.5	There are well-publicized and readily available appeals mechanisms for both providers and members.	☐ Providers ☐ Members	**0.750** **0.750**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
6. Retrospective Utilization Review DBMC A.35	A retrospective treatment utilization review is conducted for members ages 21 years or under and ECF CHOICES members and includes basic provider profiling, test edits, and statistical process controls to flag potential under- and over-utilization. Cases identified as outliers are forwarded to the Peer Review Committee (PRC), which meets at least quarterly. Its reports include a summary of its investigation and actions taken based upon results.	☐ a. Profiling conducted ☐ b. Outliers sent for peer review ☐ c. Quarterly reports included summary of investigation ☐ d. Actions taken also reported	**0.250** **0.250** **0.250** **0.250**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
7. Mechanisms to Evaluate DBMC Attachment C	The mechanisms to evaluate the effects of the program include using data on member satisfaction, provider satisfaction, and other appropriate measures.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Utilization Review					
8. Health Information System CFR 438.242.a	The DBM maintains a health information system that collects, analyzes, integrates, and reports data including, but not limited to, utilization, claims, and grievances and appeals.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Utilization Review Score	**0.0%**	**10.750**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Coordination of QM Activity with Other Management Activity					
1. QM Findings Used in Recredentialing Activities DBMC A.119.f.4.a-.d	QM findings and conclusions are used in recredentialing, recontracting, and/or annual performance evaluations. Data reviewed include member complaints, quality review results, UM, and member satisfaction surveys.	☐ Yes ☐ No	**1.500** **0.000**	**1.500**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Coordination of QM Activity with Other Management Activity Score	**0.0%**	**1.500**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
1. Outreach Contacts DBMC A.9.a and .d; A.98.a.6	The DBM distributes six outreach contacts a year, which include the following: a. Member Handbook sent within 30 days of enrollment b. Four quarterly newsletters c. Annual notice informing members of their dental benefits and encouraging them to schedule an appointment	☐ a. Member Handbook ☐ b. Quarterly newsletters ☐ c. Annual reminder to schedule appointment	**0.250** **0.250** **0.250**	**0.750**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Re-Notification If No Services Used DBMC A.9.f	The DBM is responsible for distributing dental appointment notices annually to the heads of households for all TennCare members who have not had a dental service within the past year.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Accurate Provider List DBMC A.30	The DBM makes available to families accurate lists of the names and telephone numbers of contract providers who are currently accepting TennCare (sent within 30 days of enrollment, annually, and upon request). The DBM also provides a separate listing of providers participating in ECF CHOICES.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
4. Appointment Assistance DBMC A.29; CFR 441.56.a.2.iv; 441.59.a; 441.62.b	The DBM assists members in obtaining appointments for covered services, including facilitation of member contact with a participating dental provider who will establish an appointment. The DBM also tracks the number of requests for assistance to obtain an appointment, including the service area in which the member required assistance.	☐ Assisted members ☐ Tracked number of requests	**0.750** **0.750**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
5. Prior Authorization DBMC A.33	P&Ps clearly identify any services for which the DBM requires network providers to obtain authorization prior to the provision of the service as well as any additional submissions (such as radiographs) that may be required for approval of service. TennCare has 30 days to review and approve or request modification to the P&Ps. Dental management P&Ps are consistent with the following requirements: a. Requests for prior authorizations that are denied by the DBM must be denied in writing within 14 days of receipt. b. Prior authorizations are not required for referrals from the public health screening program, primary care physicians (PCPs), and for preventive services. c. UM activities may not be structured to provide incentives for the individual provider or DBM to deny, limit, or discontinue medically necessary services to any member.	☐ a. Denials in writing and within 14 days of receipt ☐ b. No referrals required for public health screening program, PCPs, or preventive services ☐ c. UM activities structured so no incentives were provided	**1.000** **1.000** **1.000**	**3.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
6. Referrals from One Level of Screening/ Diagnosis to Another DBMC A.32; A.38; A.125.b.1; A.125.b.1.n; A.125.b.2.h	The DBM has methods in place to ensure providers make and document appropriate referrals from one level of screening or diagnosis to another, more sophisticated level (e.g., general dentist to specialist) as needed to determine medical necessity. Notes from any consultations are also included in member records. This is done regardless of whether the required services are covered by the DBM.	☐ Methods in place ☐ Evidence ensuring provider compliance	**0.500** **0.750**	**1.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					
7. Medically Necessary Services DBMC A.3	The DBM has a process in place to provide all medically necessary EPSDT services as required by law.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
8. Provider Education DBMC A.43.a	The DBM holds at least two training sessions per year for each Grand Region in the state. Training, at a minimum, addresses • the extent and limits of TennCare dental and orthodontic treatment coverage rules and medical necessity rule and • federal EPSDT law, Children and Youth with Special Needs, and TennCare Rules.	☐ Yes ☐ No	**1.250** **0.000**	**1.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					
9. Medical Necessity DBMC A.91	The DBM has a process concerning issues of medical necessity, which ensures that consistent decisions are rendered and they are compliant with federal and state laws.	☐ a. Process in place ☐ b. Definition of medical necessity same as DBMC or no more restrictive ☐ c. Evidence of consistent decisions (e.g., inter-rater reliability) ☐ d. Appropriate follow-up as applicable	**0.500** **0.500** **0.500** **0.500**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
10. Limits/ Capitations/ Delays DBMC A.91	The DBM demonstrates that it does not impose benefit limitations, duration/scope limitations, or monetary capitations upon EPSDT services, unless they are excluded under TennCare rule. Services are provided based upon each child's individual needs. The DBM does not employ utilization control guidelines/limits unless supported by individualized determination of medical necessity based upon the member's medical history.	☐ a. No limits or capitations imposed unless excluded under TennCare rule ☐ b. Services based on individual needs ☐ c. No utilization control guidelines/limits unless supported by individual member's medical history	**0.500** **0.500** **0.500**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
11. Qualified UM Personnel DBMC A.92	The DBM has a process in place that guarantees only appropriately licensed professionals supervise all medical necessity decisions and specifies the type of personnel responsible for each level of UM decision-making. Personnel making such decisions are trained or experienced as described above.	☐ Process ☐ Staff appropriately licensed	**0.500** **2.500**	**3.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
12. Dentists Supervise TCA 63-5-108, Rules of Tennessee Board of Dentistry, Rule 0460-02–.11	All dental services are performed by or under the supervision of dentists.	☐ Yes ☐ No	**1.500** **0.000**	**1.500**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
Findings					
Strength					
AON					
Suggestion					
13. Compliance with Screening Obligation DBMC A.98.d; A.144	The DBM demonstrates that the annual EPSDT Dental Screening Percentage is met. The DBM's failure to meet this benchmark shall result in significant monetary sanctions and the DBM will be required to implement a corrective action plan. Also, if the DBM's Dental Screening Percentage is below 80%, the DBM shall conduct a new initiative, approved by TennCare, to increase participation of all children who have not received screenings.	☐ Yes ☐ No	**1.500** **0.000**	**1.500**	**0.000**
Findings					
Strength					
AON					
Suggestion					
14. Transportation DBMC A.40; A.95	It is the responsibility of the member's MCO to arrange transportation to covered services. The DBM has a process for coordinating with the MCOs to ensure that transportation to a dental service is provided if deemed necessary.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
15. Coordination with MCOs DBMC A.40.a–.b	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 observed	**1.000** **1.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
16. Coordination of Dental Services DBMC A.19; A.96	The DBM has a process ensuring that, when children with urgent dental needs or unmet dental treatment needs are identified through the Department of Health's School-Based Dental Prevention Program, the DBM arranges care according to access standards (urgent needs are scheduled within 48 hours and routine within three weeks).	☐ Process in place ☐ Evidence of coordination observed	**0.500** **0.750**	**1.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					
17. Tracking System DBMC A.41	The DBM has a process in place for tracking the current screening status, pending preventive services, screening due dates, referrals for corrective treatment, whether corrective treatment was provided, and dates of service for corrective treatment for each member.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)					
18. EPSDT Provisions DBMC A.55.kk	All contracts with dental providers contain language that informs providers of the EPSDT benefit package and periodicity schedule, including information as described in DBMC § A.97 and .98.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
19. Contract Review: Guidelines DBMC A.97	All contracts with dental providers contain language requiring providers to follow guidelines for preventive health services, including EPSDT, identified by TennCare.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Score	**0.0%**	**26.000**	**0.000**

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Non-Discrimination Compliance					
1. Non-Discrimination Compliance Plan DBMC A.163	The DBM answers the questions contained in the Non-Discrimination Compliance Plan Template provided by TennCare and submits the completed Plan to TennCare within 90 days of the end of the calendar year with any requested documentation, which includes the DBM's Assurance of Non-Discrimination.	☐ Yes ☐ No	**0.250** **0.000**	**0.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Assurance of Non-Discrimination DBMC A.163	The signature dates of the DBM's Non-Discrimination Compliance Plan and Assurance of Non-Discrimination are the same.	☐ Yes ☐ No	**0.250** **0.000**	**0.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Display of Non-Discrimination Information DBMC A.153; D.7	The DBM ensures that no employee is subjected to discrimination based on handicap or disability, age, race, color, religion, sex, national origin, or any other classification protected by federal, state, or statutory law. The MCO provides proof of non-discrimination upon request and posts the information in conspicuous places accessible to all employees and applicants.	☐ Yes ☐ No	**0.250** **0.000**	**0.250**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Non-Discrimination Compliance					
4. Non-Discrimination Written Materials DBMC A.12.e.–.g; A.162; CFR 438.10.d	All vital DBM documents and member materials are made available to members and potential members as noted below: a. All vital DBM documents and member materials are translated and available in Spanish. Within 90 calendar days of notification from TennCare, all vital DBM documents are translated and available to each LEP group identified by TennCare that constitutes 5% of the TennCare population or 1,000 members, whichever is less. b. All written materials notify members that auxiliary aids or services are available at no expense to the member or potential member and how to access them. c. All written materials are made available in alternative formats for persons with special needs, or appropriate interpretation/translation services are provided by the health plan at no cost to the member or potential member. d. The DBM can show proof of its capability to provide vital documents to members with impaired sensory skills (visually impaired) who require communication assistance.	☐ a. Documents translated as described ☐ b. Written materials notify members and potential members of auxiliary aids or services at no expense ☐ c. Written materials made available in alternative formats at no cost ☐ d. Vital documents provided to members and potential members	**0.250** **0.250** **0.250** **0.250**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Non-Discrimination Compliance					
5. Written P&P DBMC A.154-.155; CFR 438.10.d	The DBM has a written P&P on file for the provision of language interpretation and translation services for any member or potential member with LEP. The P&P also addresses the provision of language assistance for members and potential members who require communication assistance in alternative formats (e.g., members or potential members who are visually impaired, hearing impaired, and/or hearing/visually impaired). It has been approved by TennCare. The DBM shows that it • instructs its staff, including but not limited to, all providers and direct service subcontractors, regarding the P&P and • has available language/communication help-lines with specific numbers that are made known to its members, potential members, and subcontractors for the provision of member translation services and communication assistance in alternative formats.	☐ a. Language interpretation and translation services addressed ☐ b. Communication assistance in alternative formats addressed ☐ c. P&P approved by TennCare ☐ d. Staff, providers, and direct service subcontractors instructed ☐ e. Proof of available help-lines demonstrated ☐ f. Telephone numbers made known to members and subcontractors	**0.200** **0.200** **0.200** **0.200** **0.200** **0.200**	**1.200**	**0.000**
Findings **Strength** **AON** **Suggestion**					
6. Complaint Resolution and Reporting DBMC A.159; A.160; A.164.b	The DBM has on file a written P&P, approved by TennCare, for monitoring, assisting with the initial investigations, and implementing TennCare's resolutions for discrimination complaints. The DBM has the written documentation that is required as part of the discrimination complaint process (e.g., proof that TennCare's resolution has been implemented). The DBM submits a quarterly Non-Discrimination Compliance Report to TennCare. The report lists all complaints of alleged discrimination filed against the DBM by employees, members, providers, and subcontractors.	☐ a. Complaints documented, investigated, and resolved ☐ b. P&P approved by TennCare ☐ c. Proof TennCare's resolution has been implemented ☐ d. Quarterly Non-Discrimination Compliance Reports submitted to TennCare	**0.500** **0.500** **0.500** **0.500**	**2.000**	**0.000**
Findings **Strength**					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Non-Discrimination Compliance					
AON					
Suggestion					
7. Member Handbook Notification and Complaint Form DBMC A.9.c; A.9.c.19; A.160	The DBM has included a notice of the right to file a discrimination complaint and a copy of the Discrimination Notification and Complaint Form in its English and Spanish Member Handbooks.	☐ Notice of right placed in Member Handbooks ☐ Copy of form included in English and Spanish Member Handbooks	**0.250** **0.250**	**0.500**	**0.000**
Findings					
Strength					
AON					
Suggestion					
8. Quarterly Newsletter Notification DBMC A.9.d.3	Each quarterly newsletter sent by the DBM to members includes a notice to members of the right to file a complaint and a telephone number for doing so, as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972, and 42 U.S.C. § 18116. The notice is in English and Spanish.	☐ Notice of right and a telephone number for making a complaint ☐ Notice is in English and Spanish	**0.250** **0.250**	**0.500**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2019 Annual Quality Survey—Quality Process Standards: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Non-Discrimination Compliance					
9. Provider and Subcontractor Compliance Education DBMC A.153; A.154; D.7	The DBM can document that its providers and subcontractors have been made aware of their obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972, and 42 U.S.C. § 18116.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings					
Strength					
AON					
Suggestion					
10. Provision of Services CFR 438.214.c	The DBM has written non-discrimination P&Ps on file that demonstrate services are provided to members in a non-discriminatory manner.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
		Non-Discrimination Compliance Score	**0.0%**	**7.450**	**0.000**

PA File Review Tools

Complaints File Review Tool													
MCC: <DBM>													X/X/19
1	2	3	4		5		6	7	8	9		10	
File#	Case ID*	Complaint Rcvd. Date	Complaint Documented		Investigation of Complaint		Date Resolved	Number of Days to Resolve	Time Standard	Timeliness Standard Met		Notification of Resolution	
			Y	N	Y	N				Y	N	Y	N
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
Compliant Answers													
Applicable Answers													

Case IDs have been used to protect member information.

Total Compliant	
Total Applicable	
Percent Compliant	%

UM Denials File Review Tool

MCC: <MCO/DBM> **X/X/19**

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

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

Total Compliant	
Total Applicable	
Percent Compliant	%

Appeals File Review Tool

MCC: <MCO> **X/X/19**

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

**Case IDs have been used to protect member information.*
***Accelerated/Expedited/Standard*
**** Extension granted by TennCare*

Total Compliant	
Total Applicable	
Percent Compliant	**%**

Appeals File Review Tool

MCC: <DBM> **X/X/19**

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

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

Total Compliant	
Total Applicable	
Percent Compliant	

EPSDT Information System Tracking File Review Tool

MCC: **x/x/19**

1	2	3	4		5		6			7		8			9		
File #	Case ID*	Medical Record (MR) / Information System (IS)	Receipt of Screening		Diagnosis Documented		Treatment, Immunization, Lab Work Documented			Ability to Determine Screening Status		Actions Taken to Improve Member's Screenings by Contacting: Provider			Actions Taken to Improve Member's Screenings by Contacting: Parent/Guardian/ Member		
			Y	N	Y	N	Y	N	NA	Y	N	Y	N	NA	Y	N	NA
1		MR															
		IS															
2		MR															
		IS															
3		MR															
		IS															
4		MR															
		IS															
5		MR															
		IS															
6		MR															
		IS															
7		MR															
		IS															
8		MR															
		IS															
9		MR															
		IS															
10		MR															
		IS															
		Compliant Answers															
		Applicable Answers															

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

Total Compliant	
Total Applicable	
Percent Compliant	%

CHOICES Annual Level of Care Assessment File Review Tool

MCC: **X/X/19**

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

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

Total Compliant	
Total Applicable	
Percent Compliant	%

Transition of CHOICES Members Between MCOs: Criteria for Receiving MCO File Review Tool															
MCC:															X/X/19
Row #1		File #	1	2	3	4	5	6	7	8	9	10	Answers		
2	Case ID*												Compliant	Applicable	
3	CHOICES Group Category														
4	Date of CHOICES Enrollment with Receiving MCO														
5	Transition of Care Data Requested from Sending MCO	Y													
		N													
		NA													
6	Transition of Care Data from Sending MCO Reviewed	Y													
		N													
		NA													
7	For Group 2 or 3 Members, Svcs. Auth. by Sending MCO Cont'd for Min. 30 Days and Not Reduced until Needs Assessment, Plan of Care, and New Services Auth. and Implemented	Y													
		N													
		NA													
8	For Group 2 or 3 Members, F-to-F Visit, Plan of Care, and Auth. and Implement. of Services within 30 Days	Y													
		N													
		NA													
9	Svcs. Cont'd According to Level of Nursing Facility Svcs. and/or Reimbursement Approved by TennCare for Group 2 Members Rec. Short-Term Nursing (STN) Facility Care	Y													
		N													
		NA													
10	For Group 2 or 3 Members Rec. STN Facility Svcs. on Date of Enrollment, F-to-F Visit Occurred within 30 Days	Y													
		N													
		NA													

Transition of CHOICES Members Between MCOs: Criteria for Receiving MCO File Review Tool														
MCC:														X/X/19
Row #1		File #	1	2	3	4	5	6	7	8	9	10	Answers	
2	Case ID*												Compliant	Applicable
11	If Exp. Date for STN Facility Svcs. for Group 2 or 3 Members Occurs Prior to 30 Days Post Enrollment and MCO Is Unable to Conduct Visit, MCO Facilitates Discharge to Community or Enrollment in Group 1	Y												
		N												
		NA												
12	For Group 2 or 3 Members, If MCO Becomes Aware of Increase in Member Needs Prior to Comp. Needs Assessment, One Is Conducted Immediately and Member Plan of Care Is Updated and Change in Svcs. Initiated within 10 Business Days	Y												
		N												
		NA												
13	For Group 1 Members, Nursing Facility Svcs. Cont. in Accordance with Level of Nursing Facility Svcs. and/or Reimb. Approved by TennCare	Y												
		N												
		NA												
14	For Group 1 Members, F-to-F Visit Occurred within 30 Days of Enrollment and Needs Assess. Conducted as Necessary	Y												
		N												
		NA												
												Totals		
												Percent Compliant	%	

Case IDs have been used to protect member information.

Credentialing and Recredentialing Tools: P&Ps Evaluation

MCOs

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/ Evidence as Provided by MCO***
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
1. Written P&Ps for Credentialing: Contracted/ Employed Providers Contractor Risk Agreement (CRA) A.2.11.9.1.1† TennCare*Select* Agreement (TSA) 2.11.9.1.1	The MCO has written credentialing P&Ps that include the MCO's initial credentialing for all providers with whom the MCO contracts or employs and who fall within its scope of authority and action.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
2. Written P&Ps for Recredentialing: Contracted/ Employed Providers CRA A.2.11.9.1.1 TSA 2.11.9.1.1 NCQA CR4	The MCO has written recredentialing P&Ps that include the MCO's recredentialing of all providers with whom the MCO contracts or employs and who fall within its scope of authority and action.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
3. Credentialing Committee NCQA CR2	There is written documentation that a credentialing committee or other peer review body that includes the medical director or designated physician is designated by the MCO to	☐ Met ☐ Not Met	**1.0**	**0.0**	

* *This column was submitted by the MCO with the pre-onsite documentation and the content has not been altered or corrected grammatically. This tool does not include any attachments provided with the MCO submission.*

†*This tool was developed using the current MCO contract and the NCQA 2018 Health Plan Accreditation Standards and Guidelines for Credentialing.*

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/ Evidence as Provided by MCO***
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
	make recommendations regarding credentialing decisions.				
Findings:					
Recommendations:					
4. Credentialing Prior to Providing Services NCQA CR2	Credentialing documents include the statement that practitioners are credentialed prior to providing care to TennCare MCO members.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
5. Recredentialing Timeline NCQA CR4	Written recredentialing P&Ps include the statement that practitioners are recredentialed at least every 36 months.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
6. Provisional Credentialing NCQA CR1	The organization has a process for one-time provisional credentialing for practitioners applying to the organization for the first time.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
7. Length of Provisional Credentialing NCQA CR1	If the organization uses provisional credentialing, a practitioner may not be in provisional status for more than 60 calendar days.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	

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

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/ Evidence as Provided by MCO*
			Value	Score	
Credentialing/Recredentialing P&Ps					
Findings:					
Recommendations:					
8. Documents Required for Provisional Credentialing NCQA CR1	If the MCO uses provisional credentialing, the following documents are obtained prior to the MCO granting provisional credentialing privileges: a. Primary-source verification of a current, valid license to practice b. Primary-source verification of the past five years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank (NPDB) c. Current, signed application with the attestation d. The MCO follows the same process for presenting provisionally credentialed files to the credentialing committee or medical director as it does for its regular credentialing process.	a. ☐ Met ☐ Not Met ☐ NA b. ☐ Met ☐ Not Met ☐ NA c. ☐ Met ☐ Not Met ☐ NA d. ☐ Met ☐ Not Met ☐ NA Each Variable = .25	**1.0**	**0.0**	
Findings:					
Recommendations:					
9. Evaluation of Complaints and Adverse Events NCQA CR5	The organization evaluates the history of complaints and adverse events for all practitioners at least every six months.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/ Evidence as Provided by MCO***
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
10. Delegated Credentialing P&Ps NCQA CR8	If credentialing and recredentialing activities are delegated, the MCO has a delegation agreement describing the delegated credentialing activities.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
11. Delegated Credentialing Accountability NCQA CR8	If credentialing and recredentialing activities are delegated, the agreement specifies that reporting is at least semi-annual, and the information to be reported by the delegate about the delegated activities.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
12. Delegated Credentialing Reporting CRA A.2.26.1.4 TSA 2.26.1.4	If credentialing and recredentialing activities are delegated, there is evidence (through the review of MCO reports, P&Ps, and minutes) that the MCO monitors the subcontractor's performance on an ongoing basis and subjects it to formal review, on at least an annual basis, consistent with NCQA standards and state MCO laws and regulations.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
13. Nondelegated Credentialing Activities NCQA CR1	If the MCO does not delegate credentialing activities, the credentialing documents explicitly specify that the MCO does not delegate credentialing activities.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/ Evidence as Provided by MCO***
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
14. Nondiscrimination in Credentialing and Recredentialing NCQA CR1	Credentialing P&Ps concerning nondiscrimination explicitly specify that the organization does not base credentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) in which the practitioner specializes.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
15. Monitoring to Prevent Discrimination in Credentialing and Recredentialing NCQA CR1	Credentialing P&Ps concerning nondiscrimination explicitly specify the steps that the organization takes to annually monitor for and prevent discriminatory practices during the credentialing and recredentialing process.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
16. Interventions for Providers Concerning Poor Quality Care NCQA CR5	The organization implements interventions based on its P&Ps if there is evidence of poor quality that could affect the health and safety of its members.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
17. Reporting Quality Deficiencies CRA A.2.11.10.2.3.1 TSA 2.11.10.2.3.1	The MCO notifies appropriate State or other authorities when a practitioner's privileges are terminated.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/ Evidence as Provided by MCO***
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
Recommendations:					
18. Notification of Denial to TennCare CRA A.2.11.9.1.4 CRA A.2.20.2.14 TSA 2.11.9.1.4 TSA 2.20.2.14	Plan documents specify that when the MCO denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons, the MCO notifies TennCare.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
19. Confidentiality NCQA CR1	The MCO's credentialing P&Ps describe the organization's process for ensuring confidentiality of the information collected during the credentialing process.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
20. Provider Appeals Processes NCQA CR6	The MCO has written P&Ps for providers to appeal determinations that suspend or terminate a provider's privileges.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
21. Provider Notification NCQA CR6	When provider privileges are suspended or terminated, there is evidence of written notification to the provider that includes the reasons for the action (see letter to provider).	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/ Evidence as Provided by MCO***
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
22. Provider Appeal Rights NCQA CR6	When provider privileges are suspended or terminated, there is evidence of written notification to the provider that includes the appeal rights and process (see letter to provider).	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
23. Unlicensed BH Providers CRA A.2.11.9.3.2 TSA 2.11.9.3.2	When individuals providing behavioral health treatment services are not required to be licensed or certified, the MCO ensures, based on applicable State license rules and/or program standards, that the individuals are: a. Appropriately educated b. Trained c. Qualified d. Competent to perform their job responsibilities	a. ☐ Met ☐ Not Met b. ☐ Met ☐ Not Met c. ☐ Met ☐ Not Met d. ☐ Met ☐ Not Met Each Variable = .25	**1.0**	**0.0**	
Findings:					
Recommendations:					
24. Credentialing Timeline CRA A.2.11.9.1.2 TSA 2.11.9.1.2	The MCO completely processes credentialing applications within 30 calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. Completely processed means that the MCO has approved and loaded approved applicants into the provider files in its claims processing system or denied the application.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/ Evidence as Provided by MCO***
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
25. Credentialing Timeline for Delegated Vendors CRA A.2.11.9.1.3 TSA 2.11.9.1.3	The MCO ensures that all providers submitted to the MCO from the delegated credentialing agent are loaded to its provider files and into its claims processing system within 30 calendar days of receipt.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
26. Credentialing and Recredentialing CHOICES Providers CRA A.2.11.9.4.1.1 TSA 2.11.9.4.1.1*	The MCO developed policies that specify by CHOICES provider type the initial credentialing and recredentialing process including frequency, and ongoing provider monitoring activities.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
27. Frequency of Recredentialing for Ongoing CHOICES Providers CRA A.2.11.9.4.1.1.1 TSA 2.11.9.4.1.1.1	The MCO had P&Ps to ensure that the MCO recredentials the ongoing CHOICES providers at least annually.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					

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

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/ Evidence as Provided by MCO***
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
28. Frequency of Recredentialing for Non-Ongoing CHOICES Providers CRA A.2.11.9.4.1.1.2 TSA 2.11.9.4.1.1.2	All other CHOICES providers must be recredentialed, at a minimum, every three years. (Other CHOICES HCBS providers include in-home respite care, in-patient respite care, assistive technology, minor home modifications, and pest control.)	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
29. Background Checks Conducted by CHOICES Providers CRA A.2.11.9.4.1.2.4 TSA 2.11.9.4.1.2.4	The MCO had P&Ps to ensure that during credentialing of CHOICES providers, the MCO verified that the providers had P&Ps that described the requirement to conduct criminal background checks for prospective employees to include: a. Tennessee Abuse Registry b. Tennessee Felony Offender Registry (TennCare*Select* only) c. National and Tennessee Sexual Offender Registry d. List of Excluded Individuals/Entities (LEIE)	a. ☐ Met ☐ Not Met ☐ NA b. ☐ Met ☐ Not Met ☐ NA c. ☐ Met ☐ Not Met ☐ NA d. ☐ Met ☐ Not Met ☐ NA Each Variable = .25	**1.0**	**0.0**	
Findings:					
Recommendations:					

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/ Evidence as Provided by MCO***
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
30. Initial and Ongoing Education Conducted by CHOICES HCBS Providers CRA A.2.11.9.4.1.2.5 TSA 2.11.9.4.1.2.5	The MCO had P&Ps to ensure that during credentialing, the MCO verified that CHOICES providers had a process in place to conduct and document initial and ongoing education for employees who provided services to CHOICES members to include: a. Delivering person-centered services and supports b. Abuse and neglect prevention, identification, and reporting c. Critical incident reporting d. Documentation of service delivery e. Use of the Electronic Visit Verification (EVV) System f. Other training requirements specified by TennCare	a. ☐ Met ☐ Not Met ☐ NA b. ☐ Met ☐ Not Met ☐ NA c. ☐ Met ☐ Not Met ☐ NA d. ☐ Met ☐ Not Met ☐ NA e. ☐ Met ☐ Not Met ☐ NA f. ☐ Met ☐ Not Met ☐ NA Variables a – d = .167 Variables e & f = .166	**1.0**	**0.0**	

Findings:

Recommendations:

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/ Evidence as Provided by MCO***
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
31. Initial and Ongoing Education Conducted by CHOICES Providers CRA A.2.11.9.4.1.2.5	The MCO had a process to ensure that during credentialing, the MCO verified that CHOICES providers had a process in place to conduct and document initial and ongoing education for employees who provided services to CHOICES HCBS and ECF CHOICES members to include: a. Orientation to the population that the staff will support (e.g., elderly and adults with physical disabilities) b. Disability awareness and cultural competency training, including person-first language; etiquette when meeting and supporting a person with a disability; and working with individuals who use alternative forms of communication, such as sign language or non-verbal communication, or who may rely on assistive devices for communication or who may need auxiliary aids or services in order to effectively communicate c. Ethics and confidentiality training, including HIPAA and HI-TECH d. Federal HCBS setting requirements and the importance of the member's experience e. Supporting community integration and participation in the delivery of HCBS	a. ☐ Met ☐ Not Met ☐ NA b. ☐ Met ☐ Not Met ☐ NA c. ☐ Met ☐ Not Met ☐ NA d. ☐ Met ☐ Not Met ☐ NA e. ☐ Met ☐ Not Met ☐ NA Each Variable= .20	**1.0**	**0.0**	

Findings:

Recommendations:

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/ Evidence as Provided by MCO***
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
32. Initial and Ongoing Education Conducted by CHOICES Providers CRA A.2.11.9.4.1.2.5	The MCO had a process to ensure that during credentialing, the MCO verified that CHOICES providers had a process in place to conduct and document initial and ongoing education for employees who provided services to CHOICES HCBS and ECF CHOICES members to include: a. Facilitating individual choice and control b. Working with family members and/or conservators, while respecting individual choice c. An introduction to behavioral health, including behavior support challenges or other cognitive limitations (including Alzheimer's Disease, dementia, etc.) may face; understanding behavior as communication; potential causes of behavior, including physiological or environmental factors; and person-centered supports for individuals with challenging behaviors, including positive behavior supports d. The paid caregiver's responsibility in promoting healthy lifestyle choices and in supporting self-management of chronic health conditions	a. ☐ Met ☐ Not Met ☐ NA b. ☐ Met ☐ Not Met ☐ NA c. ☐ Met ☐ Not Met ☐ NA d. ☐ Met ☐ Not Met ☐ NA Each Variable= .25	**1.0**	**0.0**	
Findings:					
Recommendations:					
33. Provider Policies and Processes Concerning Critical Incident Reporting for CHOICES Providers CRA A.2.11.9.4.1.2.6 TSA 2.11.9.4.1.2.6	The MCO had P&Ps to confirm that during the credentialing, the MCO verified that the CHOICES providers had P&Ps to ensure that the providers complied with: a. The MCO's critical incident reporting and management process b. Appropriate use of the EVV system	a. ☐ Met ☐ Not Met ☐ NA b. ☐ Met ☐ Not Met ☐ NA Each Variable = .50	**1.0**	**0.0**	

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/ Evidence as Provided by MCO*
			Value	Score	
Credentialing/Recredentialing P&Ps					
Findings:					
Recommendations:					
34. Recredentialing Verifications for CHOICES Providers CRA A.2.11.9.4.1.4 TSA 2.11.9.4.1.3	The MCO had plan documents in place to ensure that the recredentialing of CHOICES providers included: a. Verification of licensure/certification b. Verification of background checks c. Verification of training requirements d. Verification of critical incident reporting and management e. Verification of reportable event reporting and management (CRA only) f. Verification of the use of the EVV	a. ☐ Met ☐ Not Met ☐ NA b. ☐ Met ☐ Not Met ☐ NA c. ☐ Met ☐ Not Met ☐ NA d. ☐ Met ☐ Not Met ☐ NA e. ☐ Met ☐ Not Met ☐ NA f. ☐ Met ☐ Not Met ☐ NA Variables a – d = .167 Variables e & f = .166	**1.0**	**0.0**	
Findings:					
Recommendations:					
35. Volunteers and employees hired after last credentialing visit CRA A.2.11.9.4.1.4.1	The MCO verifies that any persons required to have background checks, including registry checks, as applicable, who have been employed or have begun volunteering since the last credentialing visit have had criminal background checks, including registry checks, as applicable.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	

2019 Annual Quality Survey—Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/ Evidence as Provided by MCO*
			Value	Score	
Credentialing/Recredentialing P&Ps					
Findings:					
Recommendations:					
36. Site Visits for CHOICES Providers CRA A.2.11.9.4.1.5 TSA 2.11.9.4.1.4	The MCO had plan documents to ensure that the MCO conducted a site visit for CHOICES providers for both credentialing and recredentialing, unless the provider is located out of state. If the provider is located out of state, the site visit may be waived if documentation concerning the reason for not completing the site visit is included in the provider's file.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
37. Monthly Verification of CHOICES Providers CRA A.2.11.9.4.1.6 TSA 2.11.9.4.1.5	The MCO had P&Ps to ensure that the MCO conducted monthly checks to ensure that CHOICES providers had not been excluded from participation in Medicare, Medicaid, or the State Children's Health Insurance Program (SCHIP).	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
Standard Score for Credentialing/Recredentialing		**0%**	**37.0**	**0.0**	

DBM

2019 Annual Network Adequacy Survey: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Element**		**Documentation/Evidence as Provided by DBM***
			Value	**Score**	
Credentialing/Recredentialing P&Ps					
1. Initial Credentialing P&Ps TennCare Dental Benefit Manager Contract (TDC) A.119.b.	The DBM has written initial credentialing P&Ps.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
2. Recredentialing P&Ps TDC A.119.b.	The DBM has written recredentialing P&Ps.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
3. Oversight by Governing Body TDC A.119.c.	Credentialing P&Ps are reviewed and approved by the governing body or the group/individual formally delegated the credentialing process by the governing body.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
4. Credentialing Entity TDC A.17.b. TDC A.119.d.	A credentialing committee or other peer review body (to include the dental director) has been designated by the DBM to make recommendations regarding credentialing decisions.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					

* *This column was submitted by the DBM with the pre-onsite documentation, and the content has not been altered or corrected grammatically. This tool does not include any attachments provided with the DBM submission.*

2019 Annual Network Adequacy Survey: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by DBM*
			Value	Score	
Credentialing/Recredentialing P&Ps					
5. Credentialing Entity to Include ECF CHOICES Dental Providers TDC A.35.	A credentialing committee or other peer review body (to include the dental director) includes at least one ECF CHOICES participating dental provider.	☐ Met ☐ Not Met ☐ NA*	**1.0**	**0.0**	
Findings:					
Recommendations:					
6. Credentialing/ Timeline TDC A.119.f.1.	The DBM ensures that there is a process and procedure for the periodic reverification of clinical credentials (recredentialing, reappointment or recertification) and that the procedure is implemented at least every three years.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
7. Pre-Delegation Credentialing Activities TDC A.72.a.	If credentialing and recredentialing activities are delegated, the DBM evaluates the prospective subcontractor's ability to perform the activities to be delegated.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
8. Monitoring Delegated Credentialing Activities TDC A.72.b.c.	If credentialing and recredentialing activities are delegated, the DBM: a. Executes a written agreement that specifies the activities and report responsibilities delegated to the subcontractor b. Monitors and evaluates delegated credentialing activities on an ongoing basis	a. ☐ Met ☐ Not Met ☐ NA b. ☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	

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

2019 Annual Network Adequacy Survey: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by DBM*
			Value	Score	
Credentialing/Recredentialing P&Ps					
		Each Variable = 0.50			
Findings:					
Recommendations:					
9. Corrective Action Plans for Delegated Credentialing Activities TDC A.72.d.	If credentialing and recredentialing activities are delegated, the DBM identifies deficiencies or areas for improvement, and the DBM and subcontractors take corrective action as necessary.	☐ Met ☐ Not Met ☐ NA	**1.0**	**0.0**	
Findings:					
Recommendations:					
10. Reporting Quality Deficiencies TDC A.119.g.	Through the review of plan documents there is evidence that the DBM established a mechanism for reporting serious quality deficiencies resulting in suspension or termination of a practitioner, to the appropriate authorities.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
11. Denial of Provider Credentialing TDC A.119.e.4.	If credentialing is denied, the provider must be notified in writing and the reasons for the denial must be specified (view denial letter).	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
12. Appeals Process TDC A.119.h.	The DBM has a process for providers to appeal determinations that reduce, suspend or terminate a provider's privileges.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					

2019 Annual Network Adequacy Survey: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Element		Documentation/Evidence as Provided by DBM*
			Value	Score	
Credentialing/Recredentialing P&Ps					
Recommendations:					
13. Current Dental Licenses TDC A.119.	The DBM ensures that a copy of the current, valid license is maintained on file at the Contractor's location for every dental professional in the network since dental licenses are renewed every two years.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
14. Credentialing Site Visits TDC A.119.e.5.	A site review will be required for a dentist's office for which the DBM receives a complaint from a member.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
15. Credentialing Timeline TDC A.119.a.	The DBM has a process to ensure that the DBM completely processes credentialing applications within 30 calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement/contract.	☐ Met ☐ Not Met	**1.0**	**0.0**	
Findings:					
Recommendations:					
Standard Score for Credentialing/Recredentialing		**0%**	**15.0**	**0.0**	

Credentialing and Recredentialing Tools: CHOICES File Review

CHOICES Credentialing

MCO: <MCO>	Reviewer:									Date of Review: X/XX/2019											# 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			
	#2				#9				#16				#23				#30				#37			
CRA A.2.11.9.4.1.2.1	#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			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
CRA A.2.11.9.4.1.2.2	#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			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
CRA A.2.11.9.4.1.2.3	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							

MCO: <MCO>	Reviewer:									Date of Review: X/XX/2019											# of Files: ##			
Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA
The provider has obtained a Medicaid provider number from TennCare. CRA A.2.11.9.4.1.2.3	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
A site visit is conducted for all in-state providers. Requirement may be waived for out-of-state providers and the reason documented in the provider file. CRA A.2.11.9.4.1.5	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							

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

CHOICES Credentialing Record Quality Results		
Category	**%**	**#**
Valid license or certification		
Medicare/Medicaid participation verified		
National Provider Identifier		
Medicaid provider number obtained from TennCare		
Site visit conducted for in-state providers		
Quality Score	**%**	**X/X**

CHOICES Recredentialing

MCO: <MCO>	Reviewer:									Date of Review: X/XX/2019											# 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			
	#2				#9				#16				#23				#30				#37			
CRA A.2.11.9.4.1.2.1	#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			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
CRA A.2.11.9.4.1.2.2	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
A site visit is conducted for all in-state providers. Requirement may be waived for out-of-state providers and the reason documented in the provider file.	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
CRA A.2.11.9.4.1.5	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							

MCO: <MCO>	Reviewer:									Date of Review: X/XX/2019											# of Files: ##			
Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA
Ongoing (i.e., provide service on a regular basis) HCBS providers are recredentialed at least annually; all other HCBS providers must be recredentialed at least every three years.	#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							
CRA A.2.11.9.4.1.1.1	#7				#14				#21				#28				#35							
FINAL SCORE	**YES**					**NO**							**SCORE**					**PERCENTAGE**						
	<X>					**<X>**							**<XX/XX>**					**<XX%>**						

CHOICES Recredentialing Record Quality Results		
Category	**%**	**#**
Valid license or certification		
Medicare/Medicaid participation verified		
Site visit conducted for in-state providers		
Recredentialing occurred annually or every three years		
Quality Score	**%**	**X/X**

PMV

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

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

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

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

PIP Validation

The TennCare 2019 PIP Validation Tool was used to assess applicable MCC PIPs in accordance with CMS protocol.

2019 PIP Validation Tool—<MCC> <PIP Title>					
Activity I: Choose the Study Topic(s)					
Topics selected for the study should reflect the Medicaid-enrolled population in terms of demographic characteristics, prevalence of disease and the potential consequences (risks) of disease. Topics could also address the need for a specific service. The goal of the project should be to improve processes and outcomes of healthcare. The topic may be specified by the State Medicaid Agency or based on input from Medicaid members.					
Element #	**C***	**Study topic(s):**	**Met**	**Not Met**	**NA****
1	☐	Reflects high-volume or high-risk conditions	☐	☐	☐
2	☐	Is selected following collection and analysis of data	☐	☐	☐
3	☐	Addresses a broad spectrum of care and services	☐	☐	☐
4	☐	Includes all eligible populations that meet the study criteria	☐	☐	☐
5	☐	Does not exclude members with special healthcare needs	☐	☐	☐
6	☑	Has the potential to affect member health, functional status or satisfaction	☐	☐	☐
Activity I Results:		**Total**	**Met**	**Not Met**	**NA**
All Elements		6			
Critical Elements		1			
Comment:					
Strength:					
AON:					
Suggestion:					

2019 PIP Validation Tool—<MCC>

<PIP Title>

Activity II: Define the Study Question(s)

Stating the study question(s) helps to maintain the focus of the PIP and sets the framework for data collection, analysis and interpretation.

Element #	C*	The study question(s):	Met	Not Met	NA**
1	☑	States the problem to be studied in simple terms	☐	☐	☐
2	☑	Is answerable	☐	☐	☐

Activity II Results:	Total	Met	Not Met	NA
All Elements	2			
Critical Elements	2			

Comment:

Strength:

AON:

Suggestion:

2019 PIP Validation Tool—<MCC>

<PIP Title>

Activity III: Use a Representative and Generalizable Study Population

The selected topic should represent the entire eligible Medicaid-enrolled population, with systemwide measurement and improvement efforts to which the study indicators apply.

Element #	C*	The representative and generalizable study population:	Met	Not Met	NA**
1	☑	Is accurately and completely defined	☐	☐	☐
2	☐	Includes requirements for the length of a member's enrollment in the MCC	☐	☐	☐
3	☑	Captures all members to whom the study question applies	☐	☐	☐

Activity III Results:	Total	Met	Not Met	NA
All Elements	3			
Critical Elements	2			

Comment:

Strength:

AON:

Suggestion:

2019 PIP Validation Tool—<MCC>

<PIP Title>

Activity IV: Select the Study Indicators

A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event (e.g., an older adult has not received an influenza vaccination in the last 12 months) or a status (e.g., a member's blood pressure is or is not below a specified level) that is to be measured. The selected indicators should track performance or improvement over time. The indicators should be objective, clearly and unambiguously defined and be based on current clinical knowledge or health services research.

Element #	C*	Study indicators:	Met	Not Met	NA**
1	☑	Are well-defined, objective and measurable	☐	☐	☐
2	☐	Are based on current, evidence-based practice guidelines, pertinent peer-reviewed literature or consensus of expert panels	☐	☐	☐
3	☑	Allow for the study questions to be answered	☐	☐	☐
4	☐	Measure changes (outcomes) in health or functional status, member satisfaction or valid process alternatives	☐	☐	☐
5	☑	Have available data that can be collected on each indicator	☐	☐	☐
6	☐	Are nationally recognized measures, such as HEDIS Technical Specifications, when appropriate	☐	☐	☐
7	☐	Include the basis on which the indicators were adopted, if internally developed	☐	☐	☐

Activity IV Results:	Total	Met	Not Met	NA
All Elements	7			
Critical Elements	3			

Comment:

Strength:

AON:

Suggestion:

2019 PIP Validation Tool—<MCC>

<PIP Title>

Activity V: Use Sound Sampling Methods

(This activity is only scored if sampling is used.) If sampling is used to select members of the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. The true prevalence or incidence rate for the event in the population may not be known the first time a topic is studied.

Element #	C*	Sampling methods:	Met	Not Met	NA**
1	☐	Consider and specify the true or estimated frequency of occurrence	☐	☐	☐
2	☐	Identify the sample size	☐	☐	☐
3	☐	Specify the confidence level	☐	☐	☐
4	☐	Specify the acceptable margin of error	☐	☐	☐
5	☑	Ensure a representative sample of the eligible population	☐	☐	☐
6	☐	Are in accordance with generally accepted principles of research design and statistical analysis	☐	☐	☐

Activity V Results:	Total	Met	Not Met	NA
All Elements	6			
Critical Elements	1			

Comment:

Strength:

AON:

Suggestion:

2019 PIP Validation Tool—<MCC>

<PIP Title>

Activity VI: Use Valid and Reliable Data Collection Procedures

Data collection must ensure that the data collected on the study indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement.

Element #	C*	Data collection procedures include:	Met	Not Met	NA**
1	☐	The identification of data elements to be collected	☐	☐	☐
2	☐	The identification of specified sources of data	☐	☐	☐
3	☐	A defined and systematic process for collecting baseline and remeasurement data	☐	☐	☐
4	☐	A timeline for the collection of baseline and remeasurement data	☐	☐	☐
5	☐	Qualified staff and personnel to abstract manual data	☐	☐	☐
6	☑	A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications	☐	☐	☐
7	☐	A manual data collection tool that supports inter-rater reliability	☐	☐	☐
8	☐	Clear and concise written instructions for completing the manual data collection tool	☐	☐	☐
9	☐	An overview of the study in written instructions	☐	☐	☐
10	☐	Administrative data collection algorithms/flow charts that show activities in the production of indicators	☐	☐	☐
11	☐	An estimated degree of data completeness	☐	☐	☐

Activity VI Results:	Total	Met	Not Met	NA
All Elements	11			
Critical Elements	1			

Comment:

Strength:

AON:

Suggestion:

2019 PIP Validation Tool—<MCC>

<PIP Title>

Activity VII: Analyze Data and Interpret Study Results

Review the data analysis process for the selected clinical or non-clinical study indicators. Review appropriateness of and adherence to the statistical analysis techniques used.

Element #	C*	Study results:	Met	Not Met	NA**
1	☑	Are conducted according to the data analysis plan in the study design	☐	☐	☐
2	☑	Allow for the generalization of results to the study population if a sample was selected	☐	☐	☐
3	☐	Identify factors that threaten internal or external validity of findings.	☐	☐	☐
4	☐	Include an interpretation of findings	☐	☐	☐
5	☐	Are presented in a way that provides accurate, clear and easily understood information	☐	☐	☐
6	☐	Identify the initial measurement and remeasurement of study indicators	☐	☐	☐
7	☐	Identify statistical differences between the initial measurement and the remeasurement	☐	☐	☐
8	☐	Identify factors that affect the ability to compare the initial measurement with the remeasurement	☐	☐	☐
9	☐	Include an interpretation of the extent to which the study was successful	☐	☐	☐

Activity VII Results:	Total	Met	Not Met	NA
All Elements	9			
Critical Elements	2			

Comment:

Strength:

AON:

Suggestion:

2019 PIP Validation Tool—<MCC>

<PIP Title>

Activity VIII: Include Improvement Strategies

Real, sustained improvements in care result from a continuous cycle of measuring and analyzing performance, as well as developing and implementing systemwide improvements in care. Interventions are designed to change behavior at an institutional, practitioner or member level.

Element #	Element C*	Improvement strategies are:	Met	Not Met	NA**
1	☑	Related to causes/barriers identified through data analysis and quality improvement processes	☐	☐	☐
2	☐	System changes that are likely to induce permanent change	☐	☐	☐
3	☐	Revised if the original interventions were not successful	☐	☐	☐
4	☐	Standardized and monitored if interventions were successful	☐	☐	☐

Activity VIII Results:	Total	Met	Not Met	NA
All Elements	4			
Critical Elements	1			

Comment:

Strength:

AON:

Suggestion:

2019 PIP Validation Tool—<MCC>

<PIP Title>

Activity IX: Assess for Real Improvement

This step in the protocol assesses the likelihood that results are accurate and represent actual and meaningful change. If improvement occurs, repeated measurement of the quality indicators selected for the project should demonstrate statistically significant improvement in performance relative to the performance observed during baseline measurement. Assess for any random, year-to-year variations, population changes or sampling errors that may have occurred during the measurement process.

Element #	C*	Assessments for real improvement strategies indicate that:	Met	Not Met	NA**
1	☐	The remeasurement methodology is the same as the baseline methodology	☐	☐	☐
2	☐	If improvement occurred, it is documented, quantitative, and related to processes or outcomes of care	☐	☐	☐
3	☐	If improvement occurred, it appears to be the result of planned intervention(s)	☐	☐	☐
4	☐	Observed changes have been measured for statistical significance	☐	☐	☐

Activity IX Results:	Total	Met	Not Met	NA
All Elements	4			
Critical Elements	0			

Comment:

Strength:

AON:

Suggestion:

2019 PIP Validation Tool—<MCC>

<PIP Title>

Activity X: Assess for Sustained Improvement

This step in the protocol determines whether any real improvements are sustainable. Describe any consistent, statistically significant change demonstrated through repeated measurements over comparable time periods. Discuss random, year-to-year variations, population changes, sampling errors, and/or statistically significant declines that may have occurred during the remeasurement process.

Element #	C*	Sustained improvement strategies indicate that:	Met	Not Met	NA**
1	☐	Repeated measurements over comparable time periods demonstrate improvement. If declines or no significant changes are observed over time, results and causes are analyzed.	☐	☐	☐

Activity X Results:	Total	Met	Not Met	NA
All Elements	1			
Critical Elements	0			

Comment:

Strength:

AON:

Suggestion:

Overall Results for PIP Study

Overall Results:	Total	Met	Not Met	NA
All Elements	53			
Critical Elements	13			