2025 Tennessee External Quality Review Technical Report

March 2026

Table of Contents

List of Tables

Abbreviations and Acronyms

AHRQ	Agency for Healthcare Research and Quality
ANA	annual network adequacy
AON	area of noncompliance
AQS	Annual Quality Survey
BBA	Balanced Budget Act of 1997
BC	BlueCare
BESMART	Buprenorphine-Enhanced Supportive Medication-Assisted Recovery and Treatment
BH	behavioral health
BMI	body mass index
CAHPS®[1]	Consumer Assessment of Healthcare Providers and Systems
CAP	corrective action plan
CAQH	Council for Affordable Quality Healthcare
CCC	children with chronic conditions
CDT	Current Dental Terminology
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHOICES	A program providing Home and Community-Based Services to CHOICES members
CMS	Centers for Medicare & Medicaid Services
COE	Center of Excellence
COVID-19	coronavirus disease 2019
CPT	Current Procedural Terminology
CRA	contractor risk agreement
CSA	customer service associate
CSR	customer service representative
CSS	Center for the Study of Services
CY	calendar year
DBM	dental benefits manager
DBMC	Dental Benefits Manager Contract
DCS	Tennessee Department of Children's Services
DIDD	Tennessee Department of Intellectual & Developmental Disabilities
DNR	Do Not Report
DOH	Tennessee Department of Health
DQ	DentaQuest
DTS	Dunwoody Technology Services
ECDS	Electronic Clinical Data System
ECF CHOICES	A program providing Employment and Community First services to CHOICES members
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

EQR/EQRO ..... external quality review/EQR organization
FAR ..... final audit report
FCC ..... family-centered care
FFS ..... fee-for-service
FFY ..... federal fiscal year
GDP ..... general dental provider
HCBS ..... Home and Community-Based Services
HCPCS ..... Healthcare Common Procedure Coding System
HEDIS®[2] ..... Healthcare Effectiveness Data and Information Set
HIV/AIDS ..... human immunodeficiency virus/acquired immunodeficiency syndrome
HMO ..... health maintenance organization
HPV ..... human papillomavirus
HSAG ..... Health Services Advisory Group, Inc.
ICD-10-CM ..... International Classification of Diseases, Tenth Revision, Clinical Modification
ICF/IID ..... Intermediate Care Facility/Services for Individuals with Intellectual Disabilities
ID ..... identification
I/DD ..... intellectual/developmental disabilities
IDSS ..... Interactive Data Submission System
IRR ..... interrater reliability
IS ..... information system
ISCA ..... Information Systems Capabilities Assessment
ISCAT ..... Information Systems Capabilities Assessment Tool
LAI ..... long-acting injectable
LO ..... licensed organization
LOC ..... level of care
LTSS ..... long-term services and supports
MCC ..... managed care contractor
MCO ..... managed care organization
MOUD ..... medications for opioid use disorder
MRR ..... medical record review
MRRV ..... medical record review validation
MY ..... measurement year
NA ..... not applicable
NAV ..... network adequacy validation
NCPDP ..... National Council for Prescription Drug Programs
NCQA ..... National Committee for Quality Assurance
NPI ..... National Provider Identifier
OB/GYN ..... obstetrician/gynecologist
ORx ..... OptumRx

[2] HEDIS® is a registered trademark by the National Committee for Quality Assurance (NCQA).

OUD ..... opioid use disorder
PAHP ..... prepaid ambulatory health plan
PBM ..... pharmacy benefits manager
PBMC ..... Pharmacy Benefits Manager Contract
PCCM ..... Primary Care Case Management
PCMH ..... Patient-Centered Medical Home
PCP ..... primary care provider
PDP ..... primary dental provider
PDSA ..... Plan-Do-Study-Act
PDV ..... provider data validation
PEF ..... provider enrollment file
PHE ..... public health emergency
PIHP ..... prepaid inpatient health plan
PIP ..... performance improvement project
PMV ..... performance measure validation
PSV ..... primary source verification
QAPI ..... Quality Assessment and Performance Improvement
QAS ..... Quest Analytics Suite
QI ..... quality improvement
SAFE ..... Secure Access File Exchange
SCP ..... specialty care provider
SDP ..... specialty dental provider
SOP ..... standard operating procedure
TCA ..... Tennessee Code Annotated
TCI ..... Tennessee Carriers, Inc.
TCS ..... TennCare*Select*
TDCI ..... Tennessee Department of Commerce and Insurance
TennCare ..... State of Tennessee Division of TennCare
TOPS ..... TennCare Oversight Processing System
TPA ..... third-party administrator
TSA ..... TennCare*Select* Agreement
UHC ..... UnitedHealthcare
WLP ..... Wellpoint

1. Introduction

On January 1, 1994, Tennessee implemented a new Medicaid reform program under the authority of a Section 1115 demonstration. This new program, known as the State of Tennessee Division of TennCare (TennCare), moved almost the entirety of Tennessee's Medicaid program into managed care. The TennCare 1115 demonstration has been renewed continuously by the State and the Centers for Medicare & Medicaid Services (CMS) since 1994. During calendar year (CY) 2025, beneficiaries enrolled in the TennCare program received services through one of six managed care contractors (MCCs):

- Three managed care organizations (MCOs), including Volunteer State Health Plan, Inc., doing business as BlueCare (BC); UnitedHealthcare Community Plan, doing business as UnitedHealthcare (UHC); and Wellpoint, Inc., doing business as Wellpoint (WLP)
- One prepaid inpatient health plan (PIHP), Volunteer State Health Plan, Inc., doing business as TennCare*Select* (TCS)
- Two prepaid ambulatory health plans (PAHPs), including DentaQuest of Tennessee, LLC (called DentaQuest [DQ]), and OptumRx (ORx)

All six MCCs coordinate and manage their members' care through dedicated staff and a network of qualified providers. There were no MCCs considered exempt from the Tennessee external quality review (EQR) activities during CY 2025.

This report is a summative account of a wide variety of activities conducted by Health Services Advisory Group, Inc. (HSAG), Tennessee's external quality review organization (EQRO). Activities conducted to evaluate the individual MCCs included audits of each MCC's annual contract compliance (Annual Quality Survey [AQS]), performance improvement projects (PIPs), performance measure validation (PMV), network adequacy validation (NAV); annual network adequacy (ANA); provider data validation (PDV); Secret Shopper Survey; and the Buprenorphine-Enhanced Supportive Medication-Assisted Recovery and Treatment (BESMART) Provider Survey. During CY 2025, HSAG analyzed each MCC's health outcome and beneficiary experience of care data and compared the results to national performance measures in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and the Healthcare Effectiveness Data and Information Set (HEDIS).

The CY 2025 Tennessee External Quality Review Technical Report presents and compares the rates of the three Tennessee Medicaid MCOs (i.e., BC, UHC, and WLP) and the PIHP (TCS), and provides rates achieved by the two PAHPs: the dental benefits manager (DBM), DQ, and the pharmacy benefits manager (PBM), ORx. The report includes conclusions and recommendations for each MCC in the detailed findings section of this report. That section also contains an explanation of each task conducted in Tennessee and offers nationally recognized comparison rates, when appropriate. The next section of the report offers a summary of strengths and recommendations for improving the quality, timeliness, and accessibility of healthcare services provided by each health plan. An assessment of the TennCare 2023 Quality Assessment and Performance Improvement Strategy Update follows, and the report concludes with information concerning the MCCs' follow-up to the recommendations for improvement included in the CY 2024 EQR Technical Report.

Table 1-1 through Table 1-6 summarize the areas providing the greatest opportunities for improvement noted in the EQR tasks described in this report for BC, UHC, WLP, TCS, DQ, and ORx.

Table 1-1 contains a list of the opportunities for improvement for BC. Targeted improvement activities for BC should focus on measures that did not meet the standard during the activities conducted in 2025.

Table 1-1—Opportunities for Improvement for BC

EQR Activity	Measure Standard	BC's Results	Standard
PMV	HEDIS MY 2024 Information System (IS) Standards	For MY 2024, BC met the IS standards for Data Management and Reporting (R), Clinical and Care Delivery Data (C), Medical Record Review Processes (M), and Administrative Data (A).	MCO meets all HEDIS MY 2024 IS Standards.
NAV	Access to general optometry and hospitals within the TennCare required distance/time standards	>99.99%	100%
	Access to CHOICES providers (adult day care and pest control) within the TennCare required distance/time standards	94.68%	100%
ANA	BC must ensure that all counties have access to at least two CHOICES pest control service providers.	43.16%	100%
	BC must ensure that all members have access to adult day care providers within the TennCare required travel distance and travel time standards.	98.28%	100%
	BC must ensure that all members have access to hospitals within the TennCare required travel distance and travel time standards.	99.99%	100%
HEDIS	MY 2024 Quality Compass[3] national 25th percentile benchmark	**Medicaid:** No measures included in TennCare's Quality Strategy fell below the MY 2024 national 25th percentile benchmark.	MCO performs above the MY 2024 national 25th percentile benchmark on all measures in

[3] Quality Compass® is a registered trademark of the National Committee for Quality Assurance.

EQR Activity	Measure Standard	BC's Results	Standard
		CHIP: Four of five indicators for the **Immunizations for Adolescents (IMA)** measure fell below the MY 2024 national 25th percentile benchmark.	TennCare's Quality Strategy.
PDV	Active Contract Status, Provider Specialty/Behavioral Health (BH) Service Code, Provider Panel Status, Routine Care Services, Urgent Care Services, Services for Children, and Primary Care Services	Below 90.00%	100%
Secret Shopper	Response Rate	All rates ranged from 64.44% to 85.19%	At or above 90%
	Correct Address Location	Except 2025 Q2 for active providers, all rates ranged from 75.00% to 89.66%	At or above 90%
	Provides Requested Services	All rates ranged from 54.05% to 89.13%	At or above 90%
	Accepting Insurance (inactive providers only)	All rates ranged from 34.48% to 69.73%	At or above 90%
	Accepting New Patients	All rates ranged from 34.48% to 73.91%	At or above 90%
	Offered Appointment	All rates ranged from 11.35% to 69.57%	At or above 90%
	Appointments Compliant With Wait Time Standard (i.e., within 30 days)	Except 2025 Q2 for active providers, active provider rates ranged from 64.71% to 85.71% Inactive provider rates ranged from 55.56% to 71.43%	At or above 90%

Table 1-2 contains a list of the opportunities for improvement for UHC. Targeted improvement activities for UHC should focus on measures that did not meet the standard during the activities conducted in 2025.

Table 1-2—Opportunities for Improvement for UHC

EQR Activity	Measure Standard	UHC's Results	Standard
PMV	HEDIS MY 2024 Information System (IS) Standards	For MY 2024, UHC met the IS standards for Data Management and Reporting (R), Clinical and Care Delivery Data (C), Medical Record Review Processes (M), and Administrative Data (A).	MCO meets all HEDIS MY 2024 IS Standards.
NAV	Access to primary care providers (PCPs) within the TennCare required distance/time standards	99.99%	100%
	Access to general optometry and hospitals within the TennCare required distance/time standards	99.95%	100%
	Access to an obstetrician/ gynecologist (OB/GYN) for all female members older than 13 years of age within the TennCare required suburban/rural distance/time standards.	99.94%	100%
	Access to CHOICES providers (adult day care and pest control) within the TennCare required distance/time standards.	94.00%	100%
ANA	UHC must ensure that there is a valid contract for every provider on the network.	95.00%	100%
	UHC must ensure that all female members older than 13 years of age have access to an obstetrician/gynecologist (OB/GYN) within the TennCare required travel distance and travel time standards.	99.94%	100%
	UHC must ensure that all members have access to hospitals within the TennCare required travel distance and travel time standards.	99.89%	100%

EQR Activity	Measure Standard	UHC's Results	Standard
	UHC must ensure that all members have access to adult day care providers within the TennCare required travel distance and travel time standards.	98.23%	100%
	UHC must ensure that all counties have access to at least two CHOICES pest control service providers.	35.79%	100%
HEDIS	MY 2024 Quality Compass national 25th percentile benchmark	**Medicaid:** Seven of nine indicators for the measure **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)**, two of five indicators for the measure **Immunizations for Adolescents (IMA)**, and one of five indicators for the measure **Asthma Medication Ratio (AMR)** fell below the MY 2024 national 25th percentile benchmark. **CHIP:** Seven of nine indicators for the measure **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)** and all five indicators for the measure **Immunizations for Adolescents (IMA)** fell below the MY 2024 national 25th percentile benchmark.	MCO performs above the MY 2024 national 25th percentile benchmark on all measures in TennCare's Quality Strategy.
PDV	Provider Specialty/BH Service Code, Provider Panel Status, Routine Care Services, Urgent Care Services, and Services for Children	Below 90.00%	100%

EQR Activity	Measure Standard	UHC's Results	Standard
Secret Shopper	Response Rate	All rates ranged from 45.42% to 80.77%	At or above 90%
	Correct Address Location	Except 2025 Q2 for active providers, all rates ranged from 66.67% to 88.00%	At or above 90%
	Provides Requested Services	Except 2025 Q2 for active providers, all rates ranged from 40.63% to 80.00%	At or above 90%
	Accepting Insurance (inactive providers only)	All rates ranged from 31.25% to 57.89%	At or above 90%
	Accepting New Patients	Except 2025 Q2 for active providers, all rates ranged from 31.25% to 73.02%	At or above 90%
	Offered Appointment	Except 2025 Q2 for active providers, all rates ranged from 14.29% to 37.72%	At or above 90%
	Appointments Compliant With Wait Time Standard (i.e., within 30 days)	Active provider rates for 2025 Q1 (64.29%) and 2024 Q4 (83.33%) Inactive provider rates ranged from 37.50% to 85.71%	At or above 90%

Table 1-3 contains a list of the opportunities for improvement for WLP. Targeted improvement activities for WLP should focus on measures that did not meet the standard during the activities conducted in 2025.

Table 1-3—Opportunities for Improvement for WLP

EQR Activity	Measure Standard	WLP's Results	Standard
PMV	HEDIS MY 2024 Information System (IS) Standards	For MY 2024, WLP met the IS standards for Data Management and Reporting (R), Clinical and Care Delivery Data (C), Medical Record Review Processes (M), and Administrative Data (A).	MCO meets all HEDIS MY 2024 IS Standards.
NAV	Access to PCPs within the TennCare required distance/time standards	99.99%	100%
	Access to general optometry and hospitals within the TennCare required distance/time standards	99.97%	100%
	Access to an OB/GYN for all female members older than 13 years of age within the TennCare required suburban/rural distance/time standards.	99.92%	100%
ANA	WLP must ensure that all provider contracts contain the provider and MCO signatures and signature dates.	99.80%	100%
	WLP must ensure that all female members older than 13 years of age have access to an OB/GYN within the TennCare required travel distance and travel time standards.	99.92%	100%
	WLP must ensure that all members have access to hospitals within the TennCare required travel distance and travel time standards.	99.98%	100%
	WLP must ensure that all members have access to general optometry services within the TennCare required travel distance and travel time standards.	99.97%	100%

EQR Activity	Measure Standard	WLP's Results	Standard
	WLP must ensure that all counties have access to at least two CHOICES pest control service providers.	46.32%	100%
HEDIS	MY 2024 Quality Compass national 25th percentile benchmark	**Medicaid:** Three of five indicators for the measures **Immunizations for Adolescents (IMA)**, **Eye Exam for Patients With Diabetes (EED)**, and **Blood Pressure Control for Patients With Diabetes (BPD)**; two of eight indicators for the measure **Follow-Up After Hospitalization for Mental Illness (FUH)**; and the measure **Breast Cancer Screening (BCS-E)** fell below the MY 2024 national 25th percentile benchmark. **CHIP:** Four of five indicators for the measure **Immunizations for Adolescents (IMA)** fell below the MY 2024 national 25th percentile benchmark.	MCO performs above the MY 2024 national 25th percentile benchmark on all measures in TennCare's Quality Strategy.
PDV	Active Contract Status, Provider Specialty/BH Service Code, Provider Panel Status, Routine Care Services, Urgent Care Services, Services for Children, Services for Adults, and Primary Care Services	Below 90.00%	100%
Secret Shopper	Response Rate	All rates ranged from 65.37% to 78.26%	At or above 90%
	Correct Address Location	All rates ranged from 66.07% to 88.89%	At or above 90%
	Provides Requested Services	All rates ranged from 35.68% to 88.89%	At or above 90%
	Accepting Insurance (inactive providers only)	All rates ranged from 29.73% to 50.56%	At or above 90%
	Accepting New Patients	All rates ranged from 28.65% to 72.73%	At or above 90%

EQR Activity	Measure Standard	WLP's Results	Standard
	Offered Appointment	All rates ranged from 4.55% to 66.67%	At or above 90%
	Appointments Compliant with Wait Time Standard (i.e., within 30 days)	Active provider rates for 2025 Q1 (85.71%) and 2024 Q4 (72.73%) Except 2025 Q2, inactive provider rates ranged from 44.12% to 69.23%	At or above 90%

Table 1-4 contains a list of the opportunities for improvement for TCS. Targeted improvement activities for TCS should focus on measures that did not meet the standard during the activities conducted in 2025.

Table 1-4—Opportunities for Improvement for TCS

EQR Activity	Measure Standard	TCS's Results	Standard
PMV	HEDIS MY 2024 Information System (IS) Standards	For MY 2024, TCS met the IS standards for Data Management and Reporting (R), Clinical and Care Delivery Data (C), Medical Record Review Processes (M), and Administrative Data (A).	MCO meets all HEDIS MY 2024 IS Standards.
NAV	None noted. TCS achieved full compliance with the TennCare required distance/time standards.	NA	NA
ANA	TCS must ensure that provider files include the correct PCP designations since one file chosen for the primary care contract review was not a PCP file.	95.00%	100%
HEDIS	MY 2024 Quality Compass national 25th percentile benchmark	**Medicaid:** The TCS plan is administered by BC. TCS's HEDIS results are included in the statewide HEDIS results captured in BC's statewide Interactive Data Submission System (IDSS) report. **CHIP:** TCS did not manage healthcare benefits for the CHIP population.	MCO performs above the MY 2024 national 25th percentile benchmark on all measures in TennCare's Quality Strategy.
PDV	Active Contract Status, Provider Specialty/BH Service Code, Provider Panel Status, Routine Care Services, Urgent Care Services, Services for Children, and Primary Care Services	Below 90.00%	100%

Table 1-5 contains a list of the opportunities for improvement for DQ. Targeted improvement activities for DQ should focus on measures that did not meet the standard during the activities conducted in 2025.

Table 1-5—Opportunities for Improvement for DQ

EQR Activity	Measure Standard	DQ's Results	Standard
PMV	No opportunities for improvement for DQ. DQ's MY 2024 rates on the **Oral Evaluation, Dental Services (OEV-CH)** and **Sealant Receipt on Permanent First Molars (SFM-CH)** measures were reportable. DQ's performance on **SFM-CH** improved from MY 2023 to MY 2024.		
NAV	Access to oral surgery within the TennCare required distance/time standards for non-ECF CHOICES members under the age of 21 years.	>99.99%	100%
	Access to orthodontic services within the TennCare required distance/time standards for non-ECF CHOICES members under the age of 21 years.	>99.99%	100%
ANA	DQ must ensure that all members have access to general orthodontists within the TennCare required travel distance and travel time standards.	>99.99%	100%
	DQ must ensure that all members have access to oral surgeons within the TennCare required travel distance and travel time standards.	>99.99%	100%
PDV	Active Contract Status, Provider Specialty/BH Service Code, Routine Care Services, Urgent Care Services, and Services for Adults	Below 90.00%	100%

Table 1-6 contains a list of the opportunities for improvement for ORx. Targeted improvement activities for ORx should focus on measures that did not meet the standard during the activities conducted in 2025.

Table 1-6—Opportunities for Improvement for ORx

EQR Activity	Measure Standard	ORx's Results	Standard
AQS	Enrollment and Disenrollment: Requirements and Limitations	77.78%	100%
	Emergency and Poststabilization Services	83.33%	100%
	Practice Guidelines	87.50%	100%
	Quality Assessment and Performance Improvement (QAPI) Program	90.00%	100%
PMV	No opportunities for improvement for ORx. ORx's MY 2024 rates on the **Concurrent Use of Opioids and Benzodiazepines (COB-AD)** and **Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)** measures were reportable. ORx's performance on both measures was steady between MY 2023 and MY 2024.		
NAV	Access to pharmacy providers within the TennCare required distance/time standards for all members in urban areas	99.96%	100%
ANA	ORx must take corrective action if a pharmacy fails to comply with established access requirements.	0.50 points	1.0 points
	ORx must implement a mechanism to ensure that network pharmacies provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.	0.50 points	1.0 points
	ORx must ensure that members living in urban areas have access to pharmacies within the TennCare required travel distance and travel time standards.	99.96%	100%

2. Overview of the TennCare Program

Overview

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

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

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

In 2020, TennCare and the Department of Intellectual and Developmental Disabilities (DIDD) jointly announced that all Medicaid LTSS programs for people with I/DD, including the Section 1915(c) Home and Community Based Services (HCBS) waivers, the ECF CHOICES Program, and Intermediate Care Facility/Services for Individuals with Intellectual Disabilities (ICF/IID) will, for the first time, be aligned in the managed care program. The primary goal of this integration will be to achieve a single, seamless, person-centered system of service delivery system for people with I/DD that supports them to increase their independence, participate fully in their communities, and achieve their competitive, integrated employment goals. In early 2021, TennCare submitted waiver amendments to the 1115 waiver as well as the three 1915(c) waivers seeking to integrate I/DD services. The 1115 waiver amendment is still pending.[4]

On January 1, 2021, Tennessee transitioned its separate Children's Health Insurance Program (CHIP) program from fee-for-service (FFS) to managed care, leveraging the State's existing managed care contracts and infrastructure to ensure close coordination and strategic alignment between Medicaid and CHIP. Tennessee uses the same MCCs to provide care to both its Medicaid and CHIP beneficiaries.

[4] At the request of CMS, the 1915(c) waivers were temporarily withdrawn to align approval of IDD integration across Medicaid authorities.

As noted above, Tennessee's managed care program encompasses all of the State's Medicaid and CHIP beneficiaries, and virtually all covered services. The State's managed care system currently consists of six MCCs as listed in Table 2-1.

Table 2-1—TennCare Managed Care Contractor Information

Plan Name	MCC Type
BC	MCO
UHC	MCO
WLP	MCO
TCS	PIHP
DQ	PAHP
ORx	PAHP

3. Detailed Findings

Overview

The federal Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires state Medicaid agencies to "provide for an annual (as appropriate) external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract."[5] HSAG is currently the EQRO in 19 states and has contracted with TennCare to perform EQR activities for Tennessee since 2010.

The CY 2025 Tennessee EQR Technical Report for the MCC program complies with Title 42 of the Code of Federal Regulations (42 CFR) §438.364 which requires the EQRO to produce "an annual detailed technical report that summarizes findings on access and quality of care including a description of the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, or PAHP."[6] This report meets the requirements of 42 CFR §438.364 and does not disclose the identity or other protected health information of any beneficiary. The current report contains findings from the EQR activities conducted during CY 2025.

The following section of the report presents and compares the rates of the six Tennessee MCCs (i.e., BC, UHC, WLP, TCS, DQ, and ORx) and includes conclusions and recommendations for each MCC. The section also contains an explanation of each task conducted by the EQRO in Tennessee and offers nationally recognized comparison rates, when appropriate.

[5] U. S. Government Publishing Office. (1997). **Public Law 105-33** (p. 249). Available at: Public Law 105 - 33 - Balanced Budget Act of 1997 - Content Details. Accessed on: Feb 9, 2026.

[6] U. S. Government Publishing Office. (2024). **Electronic Code of Federal Regulations**. Available at: eCFR :: 42 CFR 438.364 -- External quality review results. Accessed on: Feb 9, 2026.

Health Plan Comparisons and Health Plan-Specific Conclusions and Recommendations

This section of the report provides information concerning the Tennessee EQR tasks conducted by HSAG during CY 2025. The tasks include MCC AQS compliance reviews, PIPs, PMV, NAV, ANA, CAHPS, HEDIS, PDV, Secret Shopper Survey, and the BESMART Provider Survey.

AQS Compliance Reviews

The purpose of the TennCare compliance reviews was to determine the MCCs' compliance with the federal Medicaid managed care standards as described in 42 CFR §438 and the related TennCare contract requirements.

HSAG conducted the reviews consistent with the CMS EQR **Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity**, February 2023 (CMS EQR Protocol 3).[7] HSAG reviewed the MCCs' written operating policies and procedures, program plans, meeting minutes, numerous written reports, and other data and documentation related to the MCCs' performance during the review period. Reviewers also conducted staff interviews related to each of the compliance standards to allow MCC staff members to elaborate on the written information that HSAG reviewed, to assess the consistency of staff responses given during the interviews against the written documentation, and to clarify any reviewer questions following the document review.

The primary objective of HSAG's review was to identify and provide meaningful information to TennCare about each of the MCC's performance strengths and any areas requiring corrective actions. The information included HSAG's report of its findings related to the extent to which the MCCs' performance complied with the applicable federal Medicaid managed care regulations and TennCare's associated contract.

TennCare required the MCOs to be accredited by NCQA and allowed deeming for the MCOs as stipulated in 42 CFR §438.360 (i.e., nonduplication of activities).[8] To be eligible for deeming, the MCO must have obtained a score of 100 percent during the most recent accreditation survey for the NCQA element that matched the associated requirement in the federal and State regulations. Elements deemed during the review received a **Met** score.

According to §438.358, a state or its EQRO must conduct a review within a three-year period to determine a Medicaid MCO's compliance with the federal standards. The TennCare AQS includes 16 standards for the MCOs, PIHP, and DBM. The PBM AQS includes 15 standards.

[7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. **Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity**, February 2023. Available at: Quality of Care External Quality Review | Medicaid. Accessed on: Feb 9, 2026.

[8] National Archives. Code of Federal Regulations. (2024). Available at: eCFR :: 42 CFR 438.360 -- Nonduplication of mandatory activities with Medicare or accreditation review. Accessed on: Feb 9, 2026.

This year TennCare elected to review one-third of the MCC standards and file reviews included in the complete compliance review tool. Table 3-1 displays a table showing the standards and file reviews included in the Year 1, Year 2, and Year 3 AQS compliance reviews for the MCCs.

Table 3-1 includes the three-year cycle of the compliance standards HSAG will review during the AQS compliance reviews. Year 1 begins with the 2025 AQS compliance review and includes the standards denoted with an "X" in the Year 1 column. Table 3-1 displays the standards and file reviews that will be conducted in each year of the three-year cycle.

Table 3-1—Distribution of MCC Standards and File Reviews for the Three-Year Cycle of AQS Compliance Reviews

CFR	CMS Standard	Standard in TennCare Compliance Tool	Year the Requirements Are to Be Reviewed in Tennessee		
			Year 1 2025 Review	Year 2 2026 Review	Year 3 2027 Review
§438.10	Information Requirements	Information Requirements (tool includes cultural competence elements)			X
§438.54 §438.56	Managed Care Enrollment Disenrollment: Requirements and Limitations	Enrollment and Disenrollment: Requirements and Limitations	X		
§438.100	Enrollee Rights	Member Rights Requirements			X
§438.114	Emergency and Poststabilization Services	Emergency and Poststabilization Services	X		
§438.206	Availability of Services	Availability of Services		X	
§438.207	Assurances of Adequate Capacity and Services	Assurances of Adequate Capacity and Services		X	
§438.208	Coordination and Continuity of Care	Coordination and Continuity of Care	X		
§438.210	Coverage and Authorization of Services	Coverage and Authorization of Services (with denials file review)		X	
§438.214	Provider Selection	Credentialing and Recredentialing Policies and Procedures			X
§438.224	Confidentiality	Confidentiality			X
§438.228	Grievance and Appeal Systems	Grievance and Appeal Systems		X	

CFR	CMS Standard	Standard in TennCare Compliance Tool	Year the Requirements Are to Be Reviewed in Tennessee		
			Year 1 2025 Review	Year 2 2026 Review	Year 3 2027 Review
§438.230	Subcontractual Relationships and Delegation	Subcontractual Relationships and Delegation			X
§438.236	Practice Guidelines	Practice Guidelines	X		
§438.242	Health Information Systems	Health Information Systems	X		
§438.330	Quality Assessment and Performance Improvement (QAPI) Program	QAPI Program	X		
Contractor Risk Agreement (CRA)	NA	BESMART Program*			X
§§441.50–441.61 CRA	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) of Individuals Under Age 21**	EPSDT	X		
File Reviews* **			**Year 1**	**Year 2**	**Year 3**
CRA	Transition of CHOICES Members Between MCOs****		X		
CRA	CHOICES Annual Level of Care (LOC) Assessment****		X		
§438.210	Utilization Management Denials			X	
§438.214	CHOICES Provider Credentialing and Recredentialing****				X
§438.228	Grievances and Appeals			X	

*BESMART standard is not applicable for the DBM and PBM
**EPSDT standard is not applicable for the PBM.
***The PBM does not undergo file reviews.
****These file reviews are not applicable for the DBM.

This report includes findings from the MCC Year 1 standards, which were previously evaluated during the 2024 AQS compliance review. The standards in the 2025 MCC review are listed below:

- Enrollment and Disenrollment: Requirements and Limitations
- Emergency and Poststabilization Services
- Coordination and Continuity of Care

- Practice Guidelines
- Health Information Systems
- QAPI Program
- EPSDT

During the 2025 AQS compliance review, HSAG also conducted the following two file reviews for the MCOs:

- Transition of CHOICES[9] Members Between MCOs
- CHOICES Annual LOC Assessment

The standards included requirements that affect the **quality of care**, **timeliness of care**, and **access to care** for the TennCare Medicaid beneficiaries. The review period covered CY 2024. To assess the MCCs' compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the MCCs, including, but not limited to, the following:

- Committee meeting agendas, minutes, and handouts
- Written policies, procedures, and other plan documents with creation or revision dates prior to the end of the review period (i.e., December 31, 2024)
- The Provider Manual, provider newsletters, and other MCO communication to providers/subcontractors
- The automated provider portal and directory
- Narrative and/or data reports across a broad range of performance and content areas
- Financial management policies and procedures
- MCC Questionnaire sent to the MCCs with the pre-site documents

HSAG scheduled six two-day compliance reviews during February and March 2025. TennCare allowed the MCCs the option to have on-site or virtual reviews. One MCO chose an on-site review, and the remaining MCCs chose a virtual review. HSAG conducted this year's virtual reviews using Microsoft Teams, which supported an end-to-end encryption that allowed HSAG and the MCCs to securely display documents and databases discussed during the review.

[9] CHOICES is a TennCare program providing Home and Community-Based Services to CHOICES members.

Table 3-2 displays the rates achieved by the MCCs for the 2025 AQS compliance review standards.

Table 3-2—Rates Achieved by the MCCs for the 2025 AQS Compliance Review

Standard	BC	UHC	WLP	TCS	DQ	ORx
	2025	2025	2025	2025	2025	2025
Coordination and Continuity of Care	100%	100%	100%	100%	100%	100%
Emergency and Poststabilization Services	100%	100%	100%	100%	100%	83.33%
Practice Guidelines	100%	100%	100%	100%	100%	87.50%
Health Information Systems	100%	100%	100%	100%	100%	100%
QAPI Program	100%	100%	100%	100%	100%	90.00%
Enrollment and Disenrollment: Requirements and Limitations	100%	100%	100%	100%	100%	77.78%
EPSDT	100%	100%	100%	100%	100%	NA*

*This standard did not apply to the PBM.

BC, UHC, WLP, TCS, and DQ achieved 100 percent compliance on all standards included in the 2025 AQS compliance review. ORx achieved 100 percent compliance on the Coordination and Continuity of Care and Health Information Systems standards. The two elements that did not meet compliance in the Enrollment and Disenrollment: Requirements and Limitations standard required the PBM to understand the reasons a member may not be disenrolled and the circumstances that represent cause for disenrollment. The two elements that did not meet compliance in the Emergency and Poststabilization Services standard required the PBM to conduct oversight and enforcement of the pharmacy provider network and ensure that network providers offer a 72-hour emergency supply of medication, when appropriate, and to take appropriate corrective actions for pharmacies that fail to comply with the 72-hour emergency supply rule. The one element that did not meet compliance in the Practice Guidelines standard required the PBM to periodically review and update practice guidelines as appropriate. The one element that did not meet compliance in the QAPI Program standard required the PBM to establish and implement an ongoing comprehensive QAPI Program for the services furnished to members.

The AQS represented an opportunity for the MCCs to receive technical assistance from TennCare or HSAG while developing a corrective action plan (CAP) for all areas requiring improvement. TennCare required that the MCCs submit a CAP for any standard or file review component that received a score of less than 100 percent. HSAG included any element that did not receive a score of **Met** in a CAP document distributed to each MCC. Prior to the completion of the CAP process, which was approved by TennCare, the MCCs submitted information to bring all elements scoring less than a **Met** rating into compliance with the State contract requirements and federal regulations. CAPs are considered on-request reports, meaning that TennCare may request them at its discretion and not solely based on compliance outcomes. All CAPs were designed to improve performance in areas of noncompliance

(AONs) within the current CY. HSAG coordinated with TennCare and the PBM to ensure CAP completion and follow-up.

BC, UHC, and WLP achieved 100 percent compliance for the file reviews conducted during the 2025 AQS compliance review. Table 3-3 displays the AQS file review performance for the MCCs.

Table 3-3—AQS MCC File Review Scores

Performance Activity	BC	UHC	WLP	TCS	DQ
	2025	2025	2025	2025	2025
CHOICES Annual LOC Assessment*	100%	100%	100%	NA*	NA**
Transition of CHOICES Members Between MCOs*	100%	100%	100%	NA*	NA**

The PBM does not undergo file reviews.
*NA for 2024 as TCS did not have a sufficient number of CHOICES members to undergo this file review.
**NA for DQ since the dental plan is not involved in those activities.

For additional information concerning HSAG's methodology for conducting AQS compliance reviews, see Appendix A. Methodologies for Conducting EQR Activities, AQS Compliance Review.

PIPs

For CY 2025, the MCCs continued their clinical and nonclinical PIP topics as outlined in Table 3-4 below.

Table 3-4—PIP Topics by MCC

2024 PIP Topics by MCC	
BC	**Long-Term Services and Supports (LTSS) Reassessment/Care Plan Update After Inpatient Discharge (RAC)**
	Improving Glycemic Status Assessment for Patients with Diabetes (GSD) <8.0%
UHC	**Follow-Up After Emergency Department (ED) Visit for Mental Illness 7-Day (FUM)**
	LTSS HEDIS Process Improvement for Reassessment and Care Plan Update Within 30 Days After Inpatient Discharge
WLP	**Improve Human Papillomavirus (HPV) Vaccination of Adolescents by Their 13th Birthday—EPSDT**
	Improve Diabetic Retinal Eye Exam Screenings in the Patient-Centered Medical Home (PCMH) Clinical Setting
	Improve Timeliness of Reassessment and Care Plan Update for LTSS Members
TCS	**Improving Follow-Up After Hospitalization for Mental Illness 7-Day (FUH)**
	Improving Psychotropic Medication Management
	Improving Early and Periodic Screening, Diagnostic, & Treatment (EPSDT)
DQ	**Oral Health Disparities**
	Pregnant & Postpartum Dental Utilization
ORx	**Schizophrenia Medication Compliance Improvement Plan**
	Reducing Rejected Claims

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. The topics addressed CMS' requirements related to quality outcomes—specifically, the quality, timeliness, and accessibility of care and services.

For this year's validation, HSAG used the CMS EQR **Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity**, February 2023 (CMS EQR Protocol 1).[10]

[10] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: CMS External Quality Review (EQR) Protocols. Accessed on: Feb 9, 2026.

HSAG's validation of PIPs includes two key components of the quality improvement (QI) process:

1. Evaluation of the technical structure of the PIP to ensure that the MCCs design, conduct, and report the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., Aim statement, population, performance indicator(s), sampling methods, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. Evaluation of the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the MCC improves rates through the implementation of effective processes (i.e., evaluation of outcomes, barrier analyses, and interventions). The goal of HSAG's PIP validation is to ensure that TennCare and key stakeholders can have confidence that any reported improvement in outcomes is related to a given PIP.

The goal of HSAG's PIP validation is to ensure that TennCare and key stakeholders can have confidence that the MCC executed a methodologically sound improvement project, and any reported improvement is related to, and can be reasonably linked to, the QI strategies and activities the MCC conducted during the PIP.

In alignment with the CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. One validation rating reflects HSAG's confidence that the MCC adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. This validation rating is based on the scores for applicable evaluation elements in Steps 1 through 8 of the PIP Validation Tool. HSAG only assigns the second validation rating for PIPs that have progressed to the Outcomes stage (Step 9), which reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP Validation Tool. For each applicable validation rating, HSAG reports the percentage of applicable evaluation elements that received a **Met** validation score and the corresponding confidence level: **High Confidence**, **Moderate Confidence**, **Low Confidence**, or **No Confidence**. The confidence level definitions for each validation rating are as follows:

1. **Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)**
   - **High Confidence**: High confidence in reported PIP results. The MCO achieved a **Met** score on all critical evaluation elements, and on 90 percent to 100 percent of all evaluation elements across all steps.
   - **Moderate Confidence**: Moderate confidence in reported PIP results. The MCO achieved a **Met** score on all critical evaluation elements, and on 80 percent to 89 percent of all evaluation elements across all steps.

- **Low Confidence**: Low confidence in reported PIP results. The MCO achieved a **Met** score on 65 percent to 79 percent of all evaluation elements across all steps or achieved a **Partially Met** score on one or more critical evaluation elements.
- **No Confidence**: No confidence in reported PIP results. The MCO achieved a **Met** score on less than 65 percent of all evaluation elements across all steps or scored **Not Met** on one or more critical evaluation elements.

2. **Overall Confidence That the PIP Achieved Significant Improvement (Step 9)**
   - **High Confidence**: All performance indicators demonstrated **statistically significant** improvement over the baseline.
   - **Moderate Confidence**: One of the three scenarios below occurred:
     – All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated **statistically significant** improvement over the baseline.
     – All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated **statistically significant** improvement over the baseline.
     – Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated **statistically significant** improvement over baseline.
   - **Low Confidence**: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator, **or** some but not all performance indicators demonstrated **improvement** over the baseline and none of the performance indicators demonstrated **statistically significant** improvement over the baseline.
   - **No Confidence**: The remeasurement methodology was not the same as the baseline methodology for all performance indicators, **or** none of the performance indicators demonstrated improvement over the baseline.

The confidence levels for each MCC's PIP activities in CY 2025 are displayed in Table 3-5.

Table 3-5—MCC's PIP Topics and Confidence Levels

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements Met[1]	Percentage Score of Critical Elements Met[2]	Confidence Level[3]	Percentage Score of Evaluation Elements Met[1]	Percentage Score of Critical Elements Met[2]	Confidence Level[3]
BC						
LTSS Reassessment/Care Plan Update After Inpatient Discharge (RAC)	100%	100%	**High Confidence**	33%	100%	**Low Confidence**
Improving Glycemic Status Assessment for Patients with Diabetes (GSD) <8.0%	100%	100%	**High Confidence**	**Not Assessed[4]**		
UHC						
Follow-Up After ED Visit for Mental Illness 7-Day (FUM)	100%	100%	**High Confidence**	67%	100%	**Moderate Confidence**
LTSS HEDIS Process Improvement for Reassessment and Care Plan Update Within 30 Days After Inpatient Discharge	100%	100%	**High Confidence**	100%	100%	**High Confidence**
WLP						
Improve HPV Vaccination of Adolescents by Their 13th Birthday—EPSDT	100%	100%	**High Confidence**	100%	100%	**High Confidence**
Improve Diabetic Retinal Eye Exam Screenings in the PCMH Clinical Setting	100%	100%	**High Confidence**	**Not Assessed[4]**		
Improve Timeliness of Reassessment and Care Plan Update for LTSS Members	100%	100%	**High Confidence**	100%	100%	**High Confidence**

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements Met[1]	Percentage Score of Critical Elements Met[2]	Confidence Level[3]	Percentage Score of Evaluation Elements Met[1]	Percentage Score of Critical Elements Met[2]	Confidence Level[3]
TCS						
Improving Follow-Up After Hospitalization for Mental Illness 7-Day (FUH)	100%	100%	**High Confidence**	**Not Assessed[4]**		
Improving Psychotropic Medication Management	100%	100%	**High Confidence**	**Not Assessed[4]**		
Improving EPSDT	100%	100%	**High Confidence**	100%	100%	**High Confidence**
DQ						
Oral Health Disparities	100%	100%	**High Confidence**	100%	100%	**High Confidence**
Pregnant & Postpartum Dental Utilization	100%	100%	**High Confidence**	100%	100%	**High Confidence**
ORx						
Schizophrenia Medication Compliance Improvement Plan	100%	100%	**High Confidence**	50%	100%	**Moderate Confidence**
Reducing Rejected Claims	100%	100%	**High Confidence**	**Not Assessed[4]**		

[1] **Percentage Score of Evaluation Elements Met**—HSAG calculated the percentage score by dividing the total elements **Met** (critical and non-critical) by the sum of the total elements of all categories (**Met**, **Partially Met**, and **Not Met**).

[2] **Percentage Score of Critical Elements Met**—HSAG calculated the percentage score of critical elements **Met** by dividing the total critical elements **Met** by the sum of the critical elements **Met**, **Partially Met**, and **Not Met.**

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[4] **Not Assessed**—HSAG did not assess Step 9 for those MCCs that only reported baseline data.

Performance Indicator Results

Table 3-6 through Table 3-11 display performance indicator results for each PIP topic per MCC.

Table 3-6—Performance Indicator Results for BC

PIP Topic	Performance Indicator	Baseline Rate	R1 Rate	R2 Rate	R3 Rate
LTSS Reassessment/ Care Plan Update After Inpatient Discharge (RAC)	The percentage of discharges from inpatient facilities for LTSS CHOICES and ECF CHOICES BC members 18 years of age and older for whom LTSS reassessment occurred within 30 days of discharge.	**East Region**			
		62.96%	56.52%	67.74%	70.73%
		Middle Region			
		42.11%	60.71%	60.71%	64.06%
		West Region			
		51.61%	57.14%	56.76%	49.38%
	The percentage of discharges from inpatient facilities for LTSS CHOICES and ECF CHOICES BC members 18 years of age and older resulting in an LTSS reassessment and care plan update within 30 days of discharge.	**East Region**			
		55.56%	56.52%	61.29%	65.04%
		Middle Region			
		42.11%	60.71%	60.71%	60.94%
		West Region			
		45.16%	57.14%	56.76%	43.75%
Improving Glycemic Status Assessment for Patients with Diabetes (GSD) <8.0%	The percentage of members 18–75 years of age with diabetes (type 1 and 2) whose most recent glycemic status (hemoglobin A1c or glucose management indicator) was <8.0% during the measurement year (MY).	53.3%			

R = Remeasurement.
Gray shading represents PIPs that have not yet progressed to a certain remeasurement period.

Table 3-7—Performance Indicator Results for UHC

PIP Topic	Performance Indicator	Baseline Rate	R1 Rate	R2 Rate	R3 Rate
Follow-Up After ED Visit for Mental Illness 7-Day (FUM)	**Follow-Up After ED Visit for Mental Illness (FUM-7 Day)** HEDIS measure	32.05%	30.86%	33.53%	
LTSS HEDIS Process Improvement for Reassessment and Care Plan Update Within 30 Days After Inpatient Discharge	LTSS reassessments within 30 days of inpatient discharge.	12.50%	18.75%	26.04%	51.58%
	LTSS reassessments and care plan updates within 30 days after inpatient discharge.	11.46%	8.33%	23.96%	49.15%

R = Remeasurement.
Gray shading represents PIPs that have not yet progressed to a certain remeasurement period.

Table 3-8—Performance Indicator Results for WLP

PIP Topic	Performance Indicator	Baseline Rate	R1 Rate	R2 Rate	R3 Rate
Improve HPV Vaccination of Adolescents by Their 13th Birthday—EPSDT	The percentage of adolescents 13 years of age who have completed the HPV vaccine series by their 13th birthday.	31.39%	33.01%		
Improve Diabetic Retinal Eye Exam Screening Rates in the PCMH Clinical Setting	The percentage of members 18–75 years of age with diabetes (types 1 and 2) in the PCMH Adult and Family provider quality core metric populations who had a retinal eye exam by an eye care professional (optometrist or ophthalmologist) in the MY or a negative retinal or dilated eye exam (negative for retinopathy) in the year prior to the MY.	43.01%			
Improve Timeliness of Reassessment and Care Plan Update for LTSS Members	The percentage of discharges from inpatient facilities for LTSS organization members 18 years of age and older in Groups 2 through 8 resulting in an LTSS reassessment and care plan updates within 30 days of discharge between January 1 and December 1 of the MY.	51.04%	76.04%	70.83%	69.34%

R = Remeasurement.
Gray shading represents PIPs that have not yet progressed to a certain remeasurement period.

Table 3-9—Performance Indicator Results for TCS

PIP Topic	Performance Indicator	Baseline Rate	R1 Rate	R2 Rate
Improving Follow-Up After Hospitalization for Mental Illness 7-Day (FUH)	The percentage of discharges for TCS Tennessee Department of Children's Services (DCS) members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 7 days after discharge during the MY.	25.98%		
Improving Psychotropic Medication Management	The percentage of TCS DCS children and adolescents 20 years of age or younger during the measurement period who were prescribed at least one psychotropic medication.	34.55%		

PIP Topic	Performance Indicator	Baseline Rate	R1 Rate	R2 Rate
Improving EPSDT	The number of EPSDT screenings completed on TCS members under the age of 21 based on the periodicity schedule.	58.87%	68.85%	

R = Remeasurement.
Gray shading represents PIPs that have not yet progressed to a certain remeasurement period.

Table 3-10—Performance Indicator Results for DQ

PIP Topic	Performance Indicator	Baseline Rate	R1 Rate
Oral Health Disparities	The percentage of Black, non-Hispanic children ages 6–9 by December 31 of the measurement period, who have been continuously enrolled for 90 days during the MY and received at least one preventive dental service by or under the supervision of a dentist as defined by Current Dental Terminology (CDT) codes D1000–D1999.	50.83%	52.07%
Pregnant & Postpartum Dental Utilization	The percentage of adult pregnant and postpartum women over the age of 20, who have been continuously enrolled for 90 days and received at least one dental service by or under the supervision of a dentist as defined by CDT codes D0001–D9999.	9.63%	11.54%

R = Remeasurement
CDT = Current Dental Terminology

Table 3-11—Performance Indicator Results for ORx

PIP Topic	Performance Indicator	Baseline Rate	R1 Rate	R2 Rate
Schizophrenia Medication Compliance Improvement Plan	Number of inpatient psychiatric facility days and ER visits per patient	33.20 days per patient	18.49 days per patient	22.53 days per patient
	Schizophrenia inpatient medical spend per patient	$6,715.03 per patient	$8,739.64 per patient	$10,848.40 per patient
Reducing Rejected Claims	The percentage of rejected claims calculated by number of rejected claims/total claims for covered products or their equivalent from the TennCare Over the Counter list.			

R = Remeasurement.
Gray shading represents PIPs that have not yet progressed to a certain remeasurement period.

Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate, active interventions to address these barriers are necessary steps to improve outcomes. The MCC's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the MCC's overall success in achieving the desired PIP outcomes.

The tables below display the interventions implemented to address the barriers identified by each MCC using QI and causal/barrier analysis processes for each PIP topic.

Each MCC used different methods (i.e., workgroup discussion, the Plan-Do-Study-Act (PDSA) process and/or fishbone diagram) to identify barriers and interventions to improve performance indicator results.

Table 3-12—Intervention Descriptions for BC

BlueCare
LTSS Reassessment/Care Plan Update After Inpatient Discharge (LTSS–RAC)
Created Admission Discharge Transfer feeds/notifications in the documentation platform to autogenerate task alerts for care/support coordinators
Utilized a web-based application, AutoAudit, in combination with an LTSS quality monitoring dashboard to better assist the plan with identifying components of HEDIS LTSS measures
Improving Glycemic Status Assessment for Patients with Diabetes (GSD) <8.0%
Created the Diabetes Care Program for High-Risk Members With Diabetes to help with member communication and education

Table 3-13—Intervention Descriptions for UHC

UnitedHealthcare
Follow-Up After Emergency Department (ED) Visit for Mental Illness 7-Day (FUM)
Peer recovery telephonic outreach
LTSS HEDIS Process Improvement for Reassessment and Care Plan Update Within 30 Days After Inpatient Discharge
Reported actual discharge date to coordination staff to improve compliance for post-inpatient stay assessment and care planning

Table 3-14—Intervention Descriptions for WLP

Wellpoint
Improve HPV Vaccination of Adolescents by Their 13th Birthday—EPSDT
Added a monetary incentive for providers for MY 2025 based on Current Procedural Terminology (CPT) code use for HPV administration

Wellpoint
Enhanced member use of the plan's Healthy Rewards Incentive for HPV vaccination involves offering a monetary incentive to adolescents ages 9 to 13 years who complete the HPV series
Improve Diabetic Retinal Eye Exam Screenings in the PCMH Clinical Setting
Implemented an enhanced incentive program for providers focusing on the use of Category II codes for administration of the diabetic retinal eye exam
Provided direct telephonic provider education on appropriate coding of **EED** results with a request for resubmission of claims to close gap-in-care for **EED** HEDIS measure for all PCMH adult providers
Improve Timeliness of Reassessment and Care Plan Update for LTSS Members
Enhanced training program to prepare staff to implement LTSS HEDIS measures with an emphasis on post-discharge reassessment and care plan updates Staff will be trained to promptly document and update the Person-Centered Support Plan and improve care coordination after discharge

Table 3-15—Intervention Descriptions for TCS

TennCare*Select*
Improving Follow-Up After Hospitalization for Mental Illness 7-Day (FUH)
Created the Behavioral Health Care Transitions Initiative to coordinate member BH needs by addressing barriers to discharge from inpatient care and assisting with connection to post-discharge outpatient care with an appropriate provider within 7 days
Improving Psychotropic Medication Management
Provided support and consultation on psychotropic medication prescribing practices for children in State custody through partnership with the Vanderbilt Center of Excellence (COE)
Developed the Behavioral Healthcare in Pediatrics training program with various partners
EPSDT
Provided training and technical support to providers with low EPSDT rates with a focus on rural Middle and West Tennessee through a partnership with the Tennessee Chapter of the American Academy of Pediatrics

Table 3-16—Intervention Descriptions for DQ

DentaQuest
Oral Health Disparities
Targeted text message including information about why preventive dental care is important to overall health
Pregnant & Postpartum Dental Utilization
Targeted text message including information about why dental care is important during pregnancy, encouraging members to visit their Dental Home, and how to access transportation services

Table 3-17—Intervention Descriptions for ORx

OptumRx
Schizophrenia Medication Compliance Improvement Plan
Outreached to prescribers on benefits of switching to a long-acting injectable (LAI) to improve compliance for schizophrenic patients to utilize
Reducing Rejected Claims
This PIP has not progressed to reporting interventions.

Conclusions and Recommendations for Improvement

BC

The performance of the PIPs suggests a thorough application of the PIP Design and Implementation stages (Steps 1 through 8). By creating a sound PIP design, BC had the foundation to progress to subsequent PIP stages—collecting data and implementing interventions that have the potential to impact performance indicator results and the desired outcomes for each project. In the Implementation stage (Steps 7 and 8), BC accurately reported performance indicator data for each PIP. BC also reported methodologically sound improvement strategies.

- For the **LTSS Reassessment/Care Plan Update After Inpatient Discharge (RAC)** PIP, BC did not achieve improvement or statistically significant improvement over baseline for all indicators. BC should retire the PIP since baseline was CY 2021 and ongoing performance is compared to baseline. If BC wishes to continue to focus efforts on the same topic, HSAG recommends restarting the PIP with CY 2025 as the baseline and developing new interventions based on the causal/barrier analysis results. BC also should conduct a causal/barrier analysis for each region to better determine the unique barriers and possibly develop interventions that are specific to one or more lower-performing regions
- BC should continue the process to evaluate the effectiveness of each individual intervention. Decisions to continue, revise, or discontinue an intervention must be data driven.
- BC should revisit the causal/barrier analysis tools used at least annually to ensure that the PIP remains on track and that the identified barriers and opportunities for improvement are still relevant and applicable.
- BC should seek technical assistance from HSAG throughout the PIP process to address any questions or concerns.

UHC

The performance of the PIPs suggests a thorough application of the PIP Design and Implementation stages (Steps 1 through 8). By creating a sound PIP design, UHC has the foundation to progress to subsequent PIP stages—collecting data and implementing interventions that have the potential to impact performance indicator results and the desired outcomes for each project. In the Implementation stage

(Steps 7 and 8), UHC accurately reported performance indicator data for the PIP. UHC also reported methodologically sound improvement strategies.

- UHC should revisit its causal/barrier analysis processes frequently to ensure that the PIP remains on track and the identified barriers and opportunities for improvement are still relevant and applicable.
- UHC should consider testing more than one intervention over the duration of a PIP.
- UHC should test interventions long enough to generate sufficient data to decide to adopt, adapt, abandon, or continue testing the intervention. Small-scale testing will allow the MCO to determine whether the intervention is having the desired results or if mid-course corrections are necessary.

WLP

The performance of the PIPs suggests a thorough application of the PIP Design and Implementation stages (Steps 1 through 8). By creating a methodologically sound PIP design, WLP has the foundation to progress to subsequent PIP stages—collecting data and implementing interventions that have the potential to impact performance indicator results and the desired outcomes for each project. In the Implementation stage (Steps 7 and 8), WLP accurately reported performance indicator data for the PIP. WLP also reported methodologically sound improvement strategies.

- WLP should test interventions long enough to generate sufficient data to decide to adopt, adapt, abandon, or continue testing the intervention. Small-scale testing will allow WLP to determine whether the intervention is having the desired results or if mid-course corrections are necessary.
- WLP should revisit its causal/barrier analysis processes frequently to ensure that the PIP remains on track and that the identified barriers and opportunities for improvement are still relevant and applicable.

TCS

The performance of the PIPs suggests a thorough application of the PIP Design and Implementation stages (Steps 1 through 8). By creating a sound PIP design, TCS had the foundation to progress to subsequent PIP stages—collecting data and implementing interventions that have the potential to impact performance indicator results and the desired outcomes for each project. In the Implementation stage (Steps 7 and 8), TCS accurately reported performance indicator data for the PIP. TCS also reported methodologically sound improvement strategies.

- TCS should continue the process to evaluate the effectiveness of each individual intervention. Decisions to continue, revise, or discontinue an intervention must be data driven.
- TCS should revisit the causal/barrier analysis tools used at least annually to ensure that the PIP remains on track and that the identified barriers and opportunities for improvement are still relevant and applicable.
- TCS should seek technical assistance from HSAG throughout the PIP process to address any questions or concerns.

DQ

The performance of the PIPs suggests a thorough application of the PIP Design and Implementation stages (Steps 1 through 8). By creating a sound PIP design, DQ had the foundation to progress to subsequent PIP stages—collecting data and implementing interventions that have the potential to impact performance indicator results and the desired outcomes for each project. In the Implementation stage (Steps 7 and 8), DQ accurately reported performance indicator data for the PIPs. DQ also reported methodologically sound improvement strategies.

- DQ should utilize evidence-based QI strategies to improve member outcomes and optimize systems/processes.

ORx

The performance of the PIPs suggests a thorough application of the PIP Design stage (Steps 1 through 6). By creating a sound PIP design, ORx has the foundation to progress to subsequent PIP stages—collecting data and implementing interventions that have the potential to impact performance indicator results and the desired outcomes for each project. In the Implementation stage (Steps 7 and 8) for the **Schizophrenia Medication Compliance Improvement Plan** PIP, ORx accurately reported performance indicator data for the PIP.

- ORx should revisit its causal/barrier analysis processes frequently to ensure that the PIPs remain on track and that the identified barriers and opportunities for improvement are still relevant and applicable.
- ORx should consider testing more than one intervention over the duration of a PIP.
- ORx should test interventions long enough to generate sufficient data to decide to adopt, adapt, abandon, or continue testing the intervention. Small-scale testing will allow the PBM to determine whether the intervention is having the desired results or if mid-course corrections are necessary.

For additional information concerning HSAG's methodology for conducting PIPs, see Appendix A. Methodologies for Conducting EQR Activities, PIPs.

PMV

Summary

As the EQR contractor for TennCare, HSAG conducted PMV of managed care entities operating in Tennessee, including all MCOs, the PBM, and the DBM. HSAG validated the PBM's and DBM's information systems and data processes to ensure accurate reporting of performance measures selected by TennCare to measure progress toward the goals and objectives in the TennCare Quality Assessment and Performance Improvement Strategy (Quality Strategy). As part of the PMV, HSAG reviewed the PBM's and DBM's collection, validation, and transmission of member data, provider data, and service data, and reviewed TennCare's data integration and measure calculation processes to ensure the accurate calculation of measure rates on behalf of the PBM and DBM. For the MCOs, HSAG reviewed and confirmed the results of the NCQA HEDIS Compliance Audit™[11] documented in each MCO's Final Audit Report (FAR) and performance measure rates reported via NCQA's IDSS. HSAG conducted PMV activities as outlined in the CMS publication, **Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity**, February 2023 (CMS EQR Protocol 2).[12]

Each MCC validated by HSAG during CY 2025 was found to be in full compliance with relevant specifications for performance measure reporting and received an **R** validation finding designation for all reported measures. The sections below discuss findings and conclusions from the validation of the MCCs.

MCO/PIHP PMV

Findings

TennCare contracts with three MCOs (BC, UHC, WLP) and a PIHP (TCS) to manage medical, behavioral, and long-term care benefits for TennCare beneficiaries. Annually, the MCOs and PIHP participate in an NCQA HEDIS Compliance Audit with an NCQA-licensed organization (LO) to maintain their accreditation with NCQA and ensure the accuracy of performance measure rates reported via NCQA's IDSS. For CY 2025, TennCare agreed to update its Quality Strategy to implement the non-duplication provision included in the CMS EQR Protocols, which revamped HSAG's approach to conduct the PMV of the MCOs and PIHP. Instead of reviewing the MCOs' and PIHP's information systems and measure calculation processes for select HEDIS performance measures, HSAG obtained TennCare's approval to conduct a review of each MCO's and the PIHP's FAR and IDSS reports for MY 2024 to confirm the results of the annual HEDIS Compliance Audit and ensure alignment with the CMS EQR Protocol 2.

[11] NCQA HEDIS Compliance Audit™ is a trademark of NCQA. The purpose of conducting a HEDIS audit is to ensure that rates submitted by the MCOs are reliable, valid, accurate, and can be compared to one another.

[12] Department of Health and Human Services, Centers for Medicare & Medicaid Services. **Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,** February 2023. Available at: CMS External Quality Review (EQR) Protocols. Accessed on: Feb 9, 2026.

The FARs and IDSS reports documented the MCOs' and PIHP's MY 2024 performance on all elements of the HEDIS Compliance Audit. Table 3-18 lists the Information System (IS) standards outlined in the **HEDIS MY 2024 Volume 5 HEDIS Compliance Audit: Standards, Policies and Procedures**, and indicates whether each MCO/PIHP complied with IS standards, which demonstrates whether the MCO/PIHP has effective IS practices and control procedures for data reporting.

Table 3-18—Compliance With IS Standards

IS Standards	BC	UHC	WLP	TCS
IS R Data Management and Reporting	**Met**	**Met**	**Met**	**Met**
IS C Clinical and Care Delivery Data	**Met**	**Met**	**Met**	**Met**
IS M Medical Record Review Processes	**Met**	**Met**	**Met**	**Met**
IS A Administrative Data	**Met**	**Met**	**Met**	**Met**

Table 3-19 summarizes the MY 2024 results of each MCO's and the PIHP's HEDIS Compliance Audit as documented in their individual FAR and IDSS reports.

Table 3-19—MY 2024 Summary of HEDIS Compliance Audit Results

Organization	Product Line	Findings
BC (Org ID 780/Sub IDs 16381, 6889, 12387, 8737, 14162)	Medicaid HMO	• BC contracted with Dunwoody Technology Services Group, LLC (DTS Group) as its HEDIS Compliance Audit LO. • BC used Cotiviti, an NCQA-certified measure vendor, to calculate its HEDIS measures. • BC was fully compliant with all NCQA-defined IS standards for HEDIS. • BC received a **Reportable** (**R**) audit designation for most measures and measure indicators included in the scope of the audit. One measure (i.e., **Oral Evaluation, Dental Services**) received an audit designation of **NB** for No Benefit. Some measures and measure indicators received an audit status of **NA** for small denominators.
UHC (Org ID 8751/Sub IDs 16481, 8421, 8422, 9572, 16482)	Medicaid HMO	• UHC contracted with Attest Health Care Advisors (Attest) as its HEDIS Compliance Audit LO. • UHC used an NCQA-certified measure vendor to calculate its HEDIS measures; however, the vendor was not identified in the FAR. • UHC was fully compliant with all NCQA-defined IS standards for HEDIS. • UHC received a **R** audit designation for all measures and measure indicators included in the scope of the audit. Some measures and measure indicators received an audit status of **NA** for small denominators.

Organization	Product Line	Findings
WLP (Org ID 9269/Sub IDs 16174, 12790, 12789, 12791, 16173)	Medicaid HMO	• WLP contracted with Attest as its HEDIS Compliance Audit LO. • WLP used an NCQA-certified measure vendor to calculate its HEDIS measures; however, the vendor was not identified in the FAR. • WLP was fully compliant with all NCQA-defined IS standards for HEDIS. • WLP received a **R** audit designation for most measures and measure indicators included in the scope of the audit. One measure (i.e., **Oral Evaluation, Dental Services**) received an audit designation of **NB** for No Benefit. Some measures and measure indicators received an audit status of **NA** for small denominators.
TCS (Org ID 780/Sub ID 6890)	Medicaid HMO	• TCS contracted with DTS Group as its HEDIS Compliance Audit LO. • TCS used Cotiviti, an NCQA-certified measure vendor, to calculate its HEDIS measures. • TCS was fully compliant with all NCQA-defined IS standards for HEDIS. • TCS received a **R** audit designation for most measures and measure indicators included in the scope of the audit. One measure (i.e., **Oral Evaluation, Dental Services**) received an audit designation of **NB** for No Benefit. Some measures and measure indicators received an audit status of **NA** for small denominators.

Conclusions and Recommendations

The MCOs and PIHP were audited by their contracted LO in compliance with HEDIS requirements. The MCOs and PIHP fully complied with HEDIS IS standards and used an NCQA-certified measure vendor to calculate their HEDIS measures for MY 2024. The MCOs and PIHP received an **R** audit designation for most of their HEDIS measures, and BC, TCS, and WLP did not offer the benefit necessary for reporting on one HEDIS measure (i.e., **Oral Evaluation, Dental Services**).

DBM and TennCare PMV

Findings

In CY 2025, HSAG conducted PMV of the MCC tasked with managing dental benefits for TennCare beneficiaries: DQ. The DBM collected and processed data used for reporting on two performance measures selected by TennCare to measure progress toward the goals and objectives detailed in the TennCare Quality Strategy. Since DQ did not calculate rates on selected performance measures, HSAG

assessed the information systems used by DQ in MY 2024 to collect and process member and service data, and validated the transmission of these data to TennCare for the calculation and reporting of performance measure rates.

HSAG assessed DQ's data systems for processing of each data type used to support reporting on TennCare-selected performance measures. Table 3-20 lists the data types processed in DQ's systems and indicates whether or not DQ had effective system processes and controls in place to ensure data accuracy and completeness.

Table 3-20—Summary of Information Systems Assessment for DQ

Data Type	DQ
Medical Services Data	**No Issues Identified**
Enrollment Data	**No Issues Identified**
Encounter Data	**No Issues Identified**

HSAG reviewed DQ's processes for obtaining, validating, and processing enrollment and eligibility data from TennCare, including the IS where DQ stored member enrollment and eligibility data. HSAG determined that DQ had adequate reconciliation and validation processes in place to ensure the completeness and accuracy of enrollment and eligibility data and confirmed that DQ's IS stored member information and tracked historical spans of eligibility. In addition, HSAG reviewed DQ's process for receiving, validating, and adjudicating claims from providers, and reporting encounters to TennCare, including the IS where DQ stored claims data. HSAG determined that DQ had adequate processes in place to validate and adjudicate claims, and to ensure the completeness and accuracy of claims data captured in encounters submitted to TennCare.

HSAG also conducted PMV of TennCare to assess the IS used to collect and process encounters reported by DQ in MY 2024, and to ensure that TennCare performed rate calculations and reporting in alignment with specifications outlined in the **Federal Fiscal Year (FFY) 2025 CMS Core Set of Children's Health Care Quality Measures for Medicaid and Children's Health Insurance Program (CHIP)** (Child Core Set). HSAG's PMV of TennCare focused on the measures selected by the State to assess the progress of DQ toward the goals and objectives detailed in its Quality Strategy.

HSAG assessed TennCare's data systems for processing of each data type used for reporting on the performance measures calculated on behalf of DQ. Table 3-21 lists the data types processed in TennCare's systems and indicates whether or not TennCare had effective system processes and controls in place to ensure data accuracy and completeness, and to calculate performance measure rates in alignment with measure specifications.

Table 3-21—Summary of Information Systems Assessment for TennCare

Data Type	TennCare
Encounter Data	**No Issues Identified**
Enrollment Data	**No Issues Identified**

Data Type	TennCare
Practitioner Data	**No Issues Identified**
Data Preproduction Processing	**No Issues Identified**
Data Integration and Reporting	**No Issues Identified**

HSAG reviewed TennCare's processes for obtaining and processing applications for Medicaid and CoverKids, determining eligibility for these programs, and submitting daily enrollment files to DQ. HSAG also reviewed the IS and vendors TennCare used to process Medicaid and CoverKids applications, store member enrollment information, and generate enrollment files for DQ. HSAG determined that TennCare had adequate processes for maintaining accurate and complete member demographic and enrollment information, and had effective methods for maintaining oversight of vendors. Additionally, HSAG determined that TennCare's IS captured and maintained the necessary information to support reporting on the performance measures in the scope of the PMV.

HSAG reviewed TennCare's processes for obtaining and validating encounter data from DQ, including the IS where TennCare stored encounter data. HSAG determined that TennCare had adequate validation and reconciliation processes to ensure the completeness and accuracy of encounter data, as well as the appropriateness of paid services, and maintained the service data necessary to report on performance measures. Additionally, HSAG reviewed TennCare's processes for obtaining and validating practitioner data from DQ, including the IS where TennCare stored these data. HSAG determined that TennCare had adequate processes in place to ensure the completeness and accuracy of practitioner data, and maintained the necessary information to support performance measure reporting. Lastly, HSAG reviewed TennCare's data preproduction and integration processes used to support measure calculation and reporting, including a review of TennCare's programing logic (i.e., source code) for measure calculation. HSAG determined that TennCare had adequate processes to ensure the accurate integration of enrollment, service, and practitioner data from its IS and confirmed that TennCare's source code aligned with FFY 2025 CMS Child Core Set specifications.

Table 3-22 lists the performance measures calculated and reported by TennCare on behalf of DQ for MY 2024 and indicates whether the measures address the domains of **quality**, **timeliness**, and/or **access**.

Table 3-22—TennCare-Reported Performance Measures Validated by HSAG in CY 2025 for MY 2024

Performance Measures	Quality	Timeliness	Access
Oral Evaluation, Dental Services (OEV-CH)	✓		✓
Sealant Receipt on Permanent First Molars (SFM-CH)	✓	✓	✓

Table 3-23 presents the validation findings designation HSAG assigned to each measure reported by TennCare on behalf of DQ based on the PMV results.

Table 3-23—PMV Results for TennCare

Performance Measure	Audit Designation
Oral Evaluation, Dental Services (OEV-CH)	R
Sealant Receipt on Permanent First Molars (SFM-CH)	R

Table 3-24 and Table 3-25 present HSAG-validated results for each measure reported by TennCare on behalf of DQ for MY 2024.

Table 3-24—Validated Results for Oral Evaluation, Dental Services (OEV-CH)

Data Element	MY 2024 Rate*
Medicaid Population	
Less than 3 Years	19.18%
3–5 Years	51.83%
6–14 Years	54.97%
15–20 Years	36.77%
Total	**45.03%**
CoverKids Population	
Less than 3 Years	21.21%
3–5 Years	44.08%
6–14 Years	50.81%
15–20 Years	29.80%
Total	**41.84%**

*Trending between MY 2023 and MY 2024 is not possible for **OEV-CH** because CMS updated measure specifications (i.e., age stratifications) for this measure.

Table 3-25—Validated Results for Sealant Receipt on Permanent First Molars (SFM-CH)

Data Element	MY 2023 Rate	MY 2024 Rate
Medicaid Population		
At Least One Sealant	52.35%	56.21%
All Four Molars Sealed	36.13%	40.09%
CoverKids Population		
At Least One Sealant	42.50%	48.98%
All Four Molars Sealed	30.63%	34.38%

Conclusions and Recommendations

HSAG determined that DQ had robust processes in place to ensure the accuracy and completeness of the data needed to support reporting on TennCare-selected performance measures. HSAG validated that DQ maintained accurate and complete enrollment information for Medicaid and CoverKids members, and transmitted accurate and complete encounters to TennCare to calculate rates on performance measures. During PMV, DQ demonstrated engagement, partnership, and commitment to the process by providing timely responses to HSAG's questions and supplying the follow-up information requested by HSAG auditors.

HSAG determined that TennCare had robust processes in place to calculate and report valid rates on the performance measures in the scope of the PMV. HSAG validated that TennCare maintained accurate and complete member demographic and enrollment information, and effectively monitored the performance on contracted vendors. Additionally, HSAG verified that TennCare validated encounter and practitioner data from DQ to ensure accuracy and completeness. Lastly, HSAG validated that TennCare ensured the accurate integration of enrollment, service, and practitioner data for performance measure calculation, and confirmed that TennCare's measure calculation source code aligned with FFY 2025 CMS Child Core Set specifications. During PMV, TennCare staff members demonstrated their knowledge and experience with calculating performance measures.

While trending was not possible for the **OEV-CH** measure due to changes in the measure specifications, HSAG was able to trend DQ's performance on the **SFM-CH** measure between MY 2023 and MY 2024. The TennCare-calculated rates on **SFM-CH** demonstrate that DQ improved its performance on this measure across the MYs for both the Medicaid and CoverKids populations. [**Quality, Timeliness, Access**]

PBM and TennCare PMV

Findings

In CY 2025, HSAG conducted PMV of the MCC tasked with managing pharmacy benefits for TennCare beneficiaries: ORx. The PBM collected and processed data used for reporting on two performance measures selected by TennCare to measure progress toward the goals and objectives detailed in the TennCare Quality Strategy. HSAG validated the IS used by ORx in MY 2024 to collect and process member and service data, and validated the calculation and reporting of performance measure rates to ensure alignment with specifications outlined in the **FFY 2025 CMS Core Set of Adult Health Care Quality Measures** (Adult Core Set).

HSAG assessed ORx's data systems for processing of each data type used for reporting on the TennCare-selected performance measures. Table 3-26 lists the data types processed in ORx's systems and indicates whether or not ORx had effective system processes and controls in place to ensure data accuracy and completeness, and to calculate performance measure rates in alignment with measure specifications.

Table 3-26—Summary of Information Systems Assessment for ORx

Data Type	ORx
Medical Services Data	No Issues Identified
Enrollment Data	No Issues Identified
Encounter Data	No Issues Identified
Data Preproduction Processing	Issues Identified
Data Integration and Reporting	Issues Identified

HSAG reviewed ORx's processes for obtaining, validating, and processing enrollment and eligibility data from TennCare, including the IS where ORx stored member enrollment and eligibility data. HSAG determined that ORx had adequate reconciliation and validation processes in place to ensure the completeness and accuracy of enrollment and eligibility data, and confirmed that ORx's IS stored member information and tracked historical spans of eligibility. In addition, HSAG reviewed ORx's process for receiving, validating, and adjudicating claims from providers, and reporting encounters to TennCare, including the IS where ORx stored claims data. HSAG determined that ORx had adequate processes in place to validate and adjudicate claims, and to ensure the completeness and accuracy of claims data captured in encounters submitted to TennCare.

HSAG reviewed ORx's data preproduction and integration processes used to support measure calculation and reporting, including a review of ORx's programing logic (i.e., source code) and manual workflows for measure calculation. HSAG determined that ORx did not have adequate processes to ensure the accurate integration of enrollment, service, and practitioner data from its IS and was not able to calculate rates according to FFY 2025 CMS Child Core Set specifications. HSAG shared this finding with TennCare and was informed that TennCare calculated performance measure rates on behalf of ORx for reporting to CMS. While HSAG did not assess TennCare's data systems for processing each data type used for reporting on the measures calculated on behalf of ORx, HSAG reviewed TennCare's MY 2023 and MY 2024 programming logic (i.e., source code) for calculating the ORx performance measures to ensure alignment with specifications outlined in the **FFY 2024** and **FFY 2025 CMS Core Set of Adult Health Care Quality Measures** (Adult Core Set).

Table 3-27 lists the performance measures calculated and reported by TennCare on behalf of ORx for MY 2024 and indicates whether the measures address the domains of **quality**, **timeliness**, and/or **access**.

Table 3-27—PBM-Reported Performance Measures Validated by HSAG in CY 2025 for MY 2024

Performance Measures	Quality	Timeliness	Access
Concurrent Use of Opioids and Benzodiazepines (COB-AD)	✓		
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	✓		

Table 3-28 presents the validation findings designation HSAG assigned to each measure reported by TennCare on behalf of ORx based on the PMV results.

Table 3-28—PMV Results for ORx

Performance Measure	Audit Designation
Concurrent Use of Opioids and Benzodiazepines (COB-AD)	R
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	R

Table 3-29 and Table 3-30 present HSAG-validated results for each measure reported by TennCare on behalf of ORx for MY 2024 as well as the previous MY.

Table 3-29—Validated Results for Concurrent Use of Opioids and Benzodiazepines (COB-AD)

Data Element	MY 2023 Rate	MY 2024 Rate
18–64 Years	12.50%	13.30%
65 Years and Older	15.30%	15.20%

Table 3-30—Validated Results for Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)

Data Element	MY 2023 Rate	MY 2024 Rate
Rate 1: Total	59.79%	55.42%
Rate 2: Buprenorphine	49.11%	47.05%
Rate 3: Oral Naltrexone	1.86%	1.37%
Rate 4: Long-Acting Injectable Naltrexone	2.53%	1.81%
Rate 5: Methadone	8.60%	8.45%

Conclusions and Recommendations

HSAG determined that ORx had robust processes in place to ensure the accuracy and completeness of the data needed to support reporting on TennCare-selected performance measures. HSAG validated that ORx maintained accurate and complete enrollment information and transmitted accurate and complete encounters to TennCare to calculate rates on performance measures. During PMV, ORx demonstrated engagement, partnership, and commitment to the process by providing timely responses to HSAG's questions and supplying the follow-up information requested by HSAG auditors.

Although HSAG did not validate TennCare's IS and processes related to the ORx performance measures, HSAG's PMV of TennCare demonstrated that TennCare has robust processes in place to calculate and report valid rates on various performance measures, including the measures used to evaluate ORx's progress toward the goals and objectives of TennCare's Quality Strategy. Additionally,

HSAG's review of TennCare's source code for MYs 2023 and 2024 confirmed that the measure calculation source code aligned with FFY 2024 and FFY 2025 Adult Core Set specifications.

When trending ORx's performance on the **COB-AD** and **OUD-AD** measures between MY 2023 and MY 2024, the TennCare-calculated rates on these measures show little change in ORx's performance across the MYs. **[Quality]**

For additional information concerning HSAG's methodology for conducting PMV, see Appendix A. Methodologies for Conducting EQR Activities, PMV.

NAV

As the EQRO for TennCare, HSAG is required by the BBA and Title 42 of the CFR §438.364(a)(3) to assess the "strengths and weaknesses for the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries" for each MCO, PIHP, and PAHP.[13] One activity included in the EQR contract with TennCare was to complete an annual review of the provider network adequacy of the MCOs, PIHP, DBM, and PBM, collectively referred to as MCCs. The review also examined the completeness of each MCC's communication with its members and providers regarding TennCare-covered services.

The contractor risk agreement (CRA), which is also referred to as the contract between TennCare and its contracted MCOs, establishes minimum benefit and service requirements/limitations to be provided to members by each MCO. The TennCare*Select* agreement (TSA), which is also referred to as the contract between TennCare and TCS, establishes minimum benefit and service requirements/limitations to be provided to members. The CRA and TSA also include the provision that the MCCs are required to ensure the availability and accessibility of primary care and specialty care services. The TennCare Dental Benefits Manager Contract (DBMC) between TennCare and DBM establishes minimum benefit and service requirements/limitations to be provided to members by the DBM. The contract also includes the provision that requires the DBM to ensure the availability and accessibility of primary and specialty dental care services. The Pharmacy Benefits Manager Contract (PBMC) between TennCare and the PBM establishes minimum benefit and service requirements/limitations to be provided to members by the PBM. The contract also includes the provision that the PBM is required to ensure the availability and accessibility of pharmacy services.

The requirements outlined in the CRA, TSA, DBMC, and PBMC are supported in TennCare's quality assessment and performance improvement strategy. HSAG conducted the CY 2025 NAV, assessing the accuracy of the state-defined network adequacy indicators that the MCCs reported. HSAG evaluated the collection, reliability, and validity of provider and network adequacy data, and the methodologies, systems, and processes the MCCs and TennCare used to calculate and report indicators of network adequacy. While the validation is conducted for each MCC, HSAG also reviewed TennCare's approach for calculating the network adequacy indicators since TennCare is ultimately responsible for the network

[13] National Archives. Code of Federal Regulations. (2024). Available at: eCFR :: 42 CFR Part 438 Subpart E -- Quality Measurement and Improvement; External Quality Review. Accessed on: Feb 9, 2026.

adequacy calculations. HSAG used a CMS-suggested methodology to determine an overall validation rating for each indicator which reflects HSAG's overall confidence that each MCC used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators set by TennCare.

MCOs

All three MCOs (BC, WLP, and UHC) and TennCare cooperated fully with the Information Systems Capabilities Assessment (ISCA) process and provided HSAG with the requested access to their information systems. Based on the validation ratings across all types of standards and all individual indicators that HSAG examined, HSAG has high confidence in the MCOs' data systems, methodologies, and the accuracy and reliability of their reported results. HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems for any of the MCOs, although HSAG did identify some opportunities for improvement and discusses them more fully in the appropriate MCO's individual results.

PIHP

TCS and TennCare cooperated fully with the ISCA process and provided HSAG with the requested access to their information systems. Based on the validation ratings across all types of standards and all individual indicators that HSAG examined, HSAG has high confidence in the PIHP's data systems, methodologies, and the accuracy and reliability of reported results. HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems for the PIHP although HSAG did identify some opportunities for improvement and discusses them more fully in the PIHP's individual results.

DBM

DQ and TennCare cooperated fully with the ISCA process and provided HSAG with the requested access to their information systems. HSAG has high confidence in the DBM's data systems, methodologies, and the accuracy and reliability of reported results. HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems for DQ.

PBM

ORx and TennCare cooperated fully with the ISCA process and provided HSAG with the requested access to their information systems. HSAG has high confidence in the PBM's data systems, methodologies, and the accuracy and reliability of reported results. HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems for ORx.

Statewide Findings:

HSAG has high confidence in the MCC- and TennCare-reported data, methods, and results. All MCCs received a **High Confidence** rating for all indicators. This indicates that HSAG is confident in the data

systems, methods, and reporting the MCCs and TennCare used to calculate the network adequacy indicators. While HSAG identified areas of opportunity for TennCare and some MCCs, the overall findings indicate that the MCCs and TennCare are doing very well in monitoring the adequacy of provider networks according to the indicators.

Table 3-31 highlights the compliance match between the MCCs' reported results and HSAG's calculated results for the two-per-county network adequacy indicators. No compliance mismatch indicates that HSAG and the MCC agree on the indicator passing or failing, whereas a compliance mismatch indicates that HSAG and the MCC disagree on the indicator passing or failing. HSAG found no compliance mismatches between any of the 78 network adequacy indicators, resulting in 100 percent agreement between the MCCs' reported results and HSAG's calculated results. The high level of agreement between the two results indicates a high level of confidence in the MCC's reporting of the two-per-county network adequacy indicators.

Table 3-31—Provider Capacity (Two-Per-County) Compliance Mismatch

MCC	Number of Standards	No Compliance Mismatch[1]	Compliance Mismatch[2]
BC	26	100%	0%
UHC	26	100%	0%
WLP	26	100%	0%

[1] HSAG and MCC reported results agree on passing or failing.
[2] HSAG and MCC reported results disagree on passing or failing.

In evaluating the time and distance network adequacy indicators, HSAG reports a 100 percent high confidence in the MCCs' results. HSAG evaluates the level of confidence on not just where HSAG and the MCCs agree, but also the extent of the disagreement if one exists. For over 98 percent of all indicators across all health plans, HSAG and the MCC either agree on their results or are within a 2 percentage point absolute difference of one another. For those remaining indicators with a greater than 2 percentage point absolute difference, HSAG noted analytic methodological differences in the approach to the calculation of those network adequacy indicators. These analytic methodological differences do not negatively impact HSAG's high confidence with the MCCs and their reported results on each network adequacy indicator. An example of this analytic methodological difference was the separation of member and provider populations for some BH services to be distinct populations, whereas HSAG calculates these services using the full member population and thus the whole provider population.

Table 3-32 provides an overall look at the compliance match between the MCCs' reported results and HSAG's calculated results for the time and distance network adequacy indicators. While dual standards for the same provider category (e.g., 75 percent of members must have access to one provider within 60 miles and 90 mins; 100 percent of members must have access to one provider within 90 miles and 120 mins) are assessed as one indicator in Worksheet 4.6, the compliance results shown in Table 3-33 are presented for each individual standard.

No compliance mismatch indicates that HSAG and the MCC agree on the indicator passing or failing, whereas a compliance mismatch indicates that HSAG and the MCC disagree on the indicator passing or

failing. For those indicators for which HSAG and the MCC disagreed, HSAG provides a breakdown to show the extent of the agreement as an absolute percentage difference between the MCC's reported result and HSAG's reported result.

Table 3-32—MCC Standard Assessment Compliance Mismatch for Time and Distance Indicators

		No Compliance Mismatch[1]	Compliance Mismatch[2]			
MCC	Total Number of Standards	Match	Exact Match[3]	Near Match (≤1.0%)	Greater Than 1.0% to ≤2.0% Difference	More Than 2% Difference[4]
BC	104	97.12%	0.96%	0%	0.96%	0.96%
UHC	104	94.23%	0.96%	2.88%	0.96%	0.96%
WLP	104	90.38%	1.92%	2.88%	0.96%	3.85%
TCS	51	100%	0%	0%	0%	0%
DQ	10	70.00%	10.00%	20.00%	0%	0%
ORx	3	66.67%	0%	33.33%	0%	0%

[1] HSAG and MCC reported results agree on passing or failing.
[2] HSAG and MCC reported results disagree on passing or failing.
[3] TennCare reports MCC time and distance indicators as "Met" if greater than 99 percent of members have access, whereas HSAG requires all members (i.e., 100 percent) to have access to consider the indicator as "Met." This means HSAG and TennCare could agree that 99 percent of members have access, but HSAG would report the standard as "Not Met" and TennCare would report the standard as "Met."
[4] Differences greater than 2 percent may be due to differences in analytic calculation methodology.

Table 3-33 highlights the compliance match between the MCCs' reported results and HSAG's calculated results for the provider ratio network adequacy indicators. No compliance mismatch indicates that HSAG and the MCC agree on the indicator passing or failing, whereas a compliance mismatch indicates that HSAG and the MCC disagree on the indicator passing or failing. HSAG found no compliance mismatches between any of the 148 network adequacy indicators, resulting in 100 percent agreement between the MCC's reported results and HSAG's calculated results. The high level of agreement between the two results indicates a high level of confidence in the MCC's reporting of the provider ratio network adequacy indicators.

Table 3-33—MCC Ratio Assessment Compliance Mismatch for Provider Ratio Indicators

Health Plan	Number of Standards	No Compliance Mismatch[1]	Compliance Mismatch[2]
BC	42	100%	0%
UHC	42	100%	0%
WLP	42	100%	0%
TCS	21	100%	0%
DQ	1	100%	0%

[1] HSAG and MCC reported results agree on passing or failing.
[2] HSAG and MCC reported results disagree on passing or failing.

Based on the results of the ISCAs combined with the detailed validation of each indicator, HSAG assessed the validity, accuracy, and reliability of network adequacy indicator results and the accuracy of the MCCs' interpretation of data. Table 3-34 presents HSAG's calculated validation ratings for each MCC. As shown below, all MCCs received a **High Confidence** rating across all indicators.

Table 3-34—Validation Ratings by MCC

MCC	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
BC	100%	0%	0%	0%
UHC	100%	0%	0%	0%
WLP	100%	0%	0%	0%
TCS	100%	0%	0%	0%
DQ	100%	0%	0%	0%
ORx	100%	0%	0%	0%

Conclusions and Recommendations

TennCare used sound and consistent methodologies to assess all network adequacy indicators across MCCs. HSAG noted that TennCare used a manual process to populate the Spec Sheets with the Quest generated time/distance results, the provider ratio results, and the provider capacity results.

HSAG proposes the following statewide recommendations be considered by TennCare during the calculation and reporting of the network analysis indicators.

- HSAG recommends that TennCare and the MCCs continue to build on the collaboration and established framework for ensuring members have access to Medicaid providers. Clear expectations were conveyed effectively and supported strong partnership with the plans, particularly for any updates made to reporting network adequacy data.
- During the virtual review, TennCare stated that it is in the process of automating population of the Spec Sheets, which are used to track network adequacy indicators across quarters, with Quest Analytics Suite (QAS) results, which TennCare used for data extracts and network adequacy calculations on behalf of the MCCs. HSAG recommends that TennCare continue to explore opportunities to streamline and automate this process to mitigate inaccuracies and errors in reporting due to manual edits.
- HSAG recommends that TennCare continue to review all contractual network adequacy standards to ensure the Spec Sheet requirements align with the contract standards.

Plan-specific findings, strengths, and opportunities for improvement are available in Section 4. For additional information concerning HSAG's methodology for conducting NAV, see Appendix A. Methodologies for Conducting EQR Activities, NAV.

ANA

HSAG conducts a review of ANA at the direction of the Tennessee Department of Commerce and Insurance (TDCI) and TennCare. According to the applicable contract, the MCOs, PIHP, DBM, and PBM, collectively referred to as MCCs, must ensure the availability and accessibility of primary care, specialty care, dental care, and pharmacy services for TennCare Medicaid and CoverKids members. In addition to the federal regulations, Tennessee also established State rules that govern the oversight of health maintenance organizations (HMOs) operating in the TennCare program. The Tennessee Code Annotated (TCA), Title 56, Chapter 32 of the HMO Act of 1986 required that the EQRO conduct annual reviews to ensure that the HMOs are "delivering health care services in conformity with the TennCare contract and applicable statutory authority"[14] (TCA, Title 56, 1986, Section 32-131).

In collaboration with TDCI and TennCare, HSAG developed an action plan that described the methodology for completing the 2025 Provider Network Adequacy and Benefit Delivery Review (also referred to as the annual network adequacy review or ANA). The action plan was approved in November 2024.

The ANA activities included two separate tasks: administrative data analyses and compliance with State and federal access and availability requirements. HSAG requested various types of data files from the MCCs, TennCare, and TDCI and conducted analyses to evaluate each MCC's performance in meeting access and availability standards as described in their contracts with TennCare. The specific requirements involved:

- Evaluating distance/time requirements for all MCCs.
- Ensuring compliance with member-to-provider ratio analyses for the MCOs, PIHP, and DBM.
- Reviewing plan documents for all MCCs to ensure inclusion of applicable federal and State requirements for access and availability.
- Confirming that the MCCs' documents sent to providers and members contain current and correct benefit information for members enrolled in the TennCare Medicaid programs (i.e., TennCare Medicaid, CoverKids, Katie Beckett, CHOICES, and ECF CHOICES).

Compliance With State and Federal Requirements

While the HSAG analysts reviewed the data files from TennCare and the MCCs, the HSAG compliance team began reviewing information submitted by the MCCs to describe their processes to ensure compliance with TDCI and TennCare's access and availability standards. The compliance activities evaluated federal requirements found in 42 CFR §438.206 (e.g., requirements for availability of services) and §438.207 (e.g., assurances of adequate capacity and services). The compliance activities

[14] FindLaw.com. Tennessee Code Title 56. Insurance § 56-32-131 - last updated January 02, 2024. Available at: Tennessee Code Title 56. Insurance § 56-32-131 | FindLaw. Accessed on: Feb 9, 2026.

also evaluated State benefit delivery requirements found in the MCO's CRA and TSA, the DBM's Dental Benefits Manager Contract, and the PBM's Pharmacy Benefit Manager Contract.

HSAG followed the guidelines set forth in the CMS EQR Protocol 3 cited earlier in this report when developing the tools and interview questions used to evaluate the MCCs. The ANA reports presented statewide rates for the MCCs with the exception of regional rates for Essential Hospital Services, COEs, and health promotion strategies for the MCOs.

Results

The review period for the 2025 ANA Review was from January 1 to December 1, 2024. The ANA Report included separate MCC scores for network adequacy and benefit delivery. TennCare and the MCCs sent data and documents to HSAG effective November 30, 2024, for the ANA evaluations. The following sections explain the information analyzed to produce the overall scores for the two areas included in the review.

Network Adequacy

HSAG obtained member eligibility/enrollment data from TennCare and provider files from the MCCs. HSAG reviewed the member and provider addresses and used Quest Analytics software to ensure that the addresses could be geocoded to exact geographic locations in terms of latitude and longitude. If geographic coordinates could not be assigned using address-based coding, HSAG attempted geocoding using member and provider ZIP Codes. To obtain the most accurate estimates of network adequacy possible, the design of the Quest Analytics applications assisted in ensuring that HSAG counted:

- A single provider with multiple addresses once for each address.
- Multiple providers at the same address as distinct providers.
- A single provider with more than one specialty for each specialty.

After cleaning and geocoding the data, HSAG eliminated duplicates and used the files for all subsequent quantitative analyses to ensure internal consistency. HSAG calculated statewide results of the distance/time analyses for the MCCs.

HSAG also performed statewide ratio analyses to calculate MCO- and PIHP-specific member-to-provider ratios and evaluated whether the ratios met the ratio requirements, as identified in the MCO and PIHP contracts. To calculate the member-to-provider ratios, HSAG divided the total number of members in the MCO and PIHP by the total number of a specific provider type (e.g., PCPs and specialty care providers [SCPs]). HSAG determined the number of members in the MCOs, PIHP, and DBM by extracting members from the TennCare enrollment and eligibility files and determined the number of in-network providers for the MCOs, PIHP, and DBM from their provider files.

For the MCOs and PIHP, HSAG applied certain member restrictions when calculating the member-to-provider ratios for TennCare Kids and OB/GYNs and based the numerator for TennCare Kids providers on the number of members younger than 21 years of age as of November 30, 2024. The numerator for

OB/GYNs included the number of female members older than 13 years of age as of November 30, 2024. HSAG conducted ratio analyses for four provider types: PCPs, TennCare Kids, OB/GYNs, and SCPs.

The complete delivery of covered benefits by the MCOs and PIHP frequently required the involvement and coordination of many medical professionals. In addition to being cared for by PCPs and specialists, a member can receive care delivered by a hospital. Some hospitals provide very specialized care, referred to hereafter as essential hospital services. TennCare designated a few hospitals as COEs for specific services (i.e., human immunodeficiency virus [HIV]/acquired immunodeficiency syndrome [AIDS] and BH). The CRA/TSA also required MCOs and the PIHP to conduct quarterly non-interactive educational interventions in each Grand Region to address strategies for improving members' health.

Table 3-35 includes the type of providers included in the evaluations to determine the network adequacy results for the MCCs.

Table 3-35—MCC Provider Types Included in the ANA Network Adequacy Review

MCOs/PIHP		DBM		PBM	
Ratios ☐Yes ☐No	Distance/Time ☐Yes ☐No	Ratios ☐Yes ☐No	Distance/Time ☐Yes ☐No	Ratios ☐Yes ☐No	Distance/Time ☐Yes ☐No
PCPs* ☒Yes ☐No	☐Yes ☐No	General Dental Provider (GDP) for non-ECF CHOICES members under age 21** ☒ Yes ☐ No	☒ Yes ☐ No	Pharmacies in urban areas ☐ Yes ☒ No	☒ Yes ☐ No
SCPs ☒ Yes ☐ No	☒ Yes ☐ No	ECF CHOICES*** ☐ Yes ☒ No	☒ Yes ☐ No	Pharmacies in suburban areas ☐ Yes ☒ No	☒ Yes ☐ No
BH ☒ Yes ☐ No	☒ Yes ☐ No	Oral surgeons**** ☐ Yes ☒ No	☒ Yes ☐ No	Pharmacies in rural areas ☐ Yes ☒ No	☒ Yes ☐ No
Opioid Use Disorder ☒ Yes ☐ No	☒ Yes ☐ No	Orthodontists**** ☐ Yes ☒ No	☒ Yes ☐ No		
Ophthalmology/Optometry ☒ Yes ☐ No	☒ Yes ☐ No	Pediatric Dentists**** ☐ Yes ☒ No	☒ Yes ☐ No		
Hospital ☐ Yes ☒ No	☒ Yes ☐ No				
Essential hospital services One tertiary care center in each region (i.e., East, Middle, West) for neonatal, perinatal, pediatric, trauma, and burn services					
COEs Two COEs per region for HIV/AIDS and all BH COEs					
Health Promotion Strategies One educational intervention quarterly					

MCOs/PIHP	DBM	PBM
Adult Day Care ☐ Yes ☐ No ☒ Yes ☐ No		
CHOICES Providers Two per county		
ECF CHOICES Providers Two per county		

* Includes OB/GYNs and TennCare Kids providers
**Excludes dual-eligible members (i.e., eligible for Medicare and Medicaid)
*** HSAG calculated the ECF CHOICES distance/time requirements using all ECF members selecting dental benefits.
****Excluding ECF CHOICES members

After generating the results for each provider type, HSAG aggregated the results to produce an overall score for the MCCs. Table 3-36 displays the final scores from the review of administrative data to determine compliance with statewide network adequacy requirements.

Table 3-36—Overall Scores for Network Adequacy

Measure	Score					
	BC	UHC	WLP	TCS	DQ	ORx
Overall Network Adequacy Score	99.33%	99.25%	99.39%	100%	>99.99%	99.99%

The overall scores for network adequacy ranged from 99.25 percent to 100 percent across the MCCs. TCS achieved the highest overall network adequacy score of 100 percent, and UHC achieved the lowest overall network adequacy score of 99.25 percent.

Benefit Delivery

Members must be informed of the covered benefits available to them and how to obtain these services from network providers. The ANA review included determining if the MCOs, PIHP, and DBM had an effective process in place to inform members and providers of all covered benefits and the requirements/guidelines involved in the delivery of those benefits.

HSAG generated the MCO, PIHP, and DBM benefit delivery scores by comparing the required benefits established by TennCare to the information given to members and providers. The benefits review included evaluating the following documents:

- Information sent to members and providers (handbooks, manuals, newsletters, educational brochures, etc.)
- Contract file review scores by selecting a random sample of 10 PCP/primary dental provider (PDP) and 10 SCP/specialty dental provider (SDP) contracts and ensuring that the contracts included required TennCare information
- Complaint scores by reviewing all access-related complaints generated by members as recorded in data files received from the MCCs and TDCI

Table 3-37 provides detailed information concerning the documents used to determine the rates for each requirement that comprises the MCOs', PIHP's, and DBM's benefit delivery scores.

Table 3-37—Documents Included in the MCOs', PIHP's and DBM's ANA Benefit Delivery Scores

MCOs/PIHP	DBM
Availability and Accessibility (includes policies and procedures, workflow documents, standard operating procedures [SOPs], etc.)	Availability and Accessibility (includes policies and procedures, workflow documents, SOPs, etc.)
Provider Information (includes provider manual, newsletters, new provider orientation materials, TennCare contract, etc.)	Provider Information (includes provider manual, newsletters, new provider orientation materials, TennCare contract, etc.)
Member Information (includes handbooks, newsletters, educational brochures, flyers, etc.)	Member Information (includes handbooks, newsletters, educational brochures, flyers, etc.)
Member Complaints (files from TDCI and the MCO/PIHP)	Member Complaints (files from TDCI and the DBM)
Provider Contract File Review—Quantity (number of files requested compared to number of files produced for review)	Provider Contract File Review—Quantity (number of files requested compared to number of files produced for review)
Provider Contract File Review—Quality (accuracy and completeness of contracts with State and federal requirements)	Provider Contract File Review—Quality (accuracy and completeness of contracts with State and federal requirements)

After generating the results of the document reviews explaining benefits to members and providers, HSAG aggregated the results to produce an overall score for the MCOs, PIHP, and DBM. Table 3-38 displays the final scores from the review to determine compliance with benefit delivery requirements.

Table 3-38—Overall Benefit Delivery Scores for the MCOs, PIHP, and DBM

Measure	Score				
	BC	UHC	WLP	TCS	DQ
Overall Benefit Delivery Score	>99.99%	98.33%	99.94%	98.33%	>99.99%

The difference between the highest score (i.e., >99.99 percent) and the lowest score (i.e., 98.33 percent) for benefit delivery was >1.66 percentage points. The three MCOs, the PIHP, and the DBM scored 100 percent compliance with the requirements in network availability and accessibility and benefit delivery for both members and providers. The DBM received a score of >99.99 percent for member complaints. The three MCOs and the PIHP scored 100 percent in the contract reviews.

The PBM must strive to contract with qualified pharmacy providers who have adequate resources to guarantee that members may easily access pharmacy services. Since the PBM does not send information directly to members, HSAG calculated an appointment availability rate that included a document review (policies and procedures, workflow documents, SOPs, provider manuals, etc.) and an assessment of member complaints as shown in Table 3-39.

Table 3-39—Documents Included in the PBM's ANA Benefit Delivery Scores

ORx
Availability and Accessibility (includes policies and procedures, workflow documents, SOPs, provider manuals, newsletters, new provider orientation materials, TennCare contract, etc.)
Member Complaints (files from TDCI and the PBM)

Table 3-40 displays the overall appointment availability score achieved by the PBM.

Table 3-40—Overall Benefit Delivery Scores for the PBM

Measure	Score ORx
Overall Benefit Delivery Score	96.87%

The overall benefit delivery score achieved by the PBM was 96.87 percent. The PBM did not submit information to confirm that ORx had a documented CAP process for pharmacies that fail to comply with access requirements or that ORx ensured that network pharmacies provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities. ORx had four access-related complaints during the review period.

For additional information concerning HSAG's methodology for conducting ANA, see Appendix A. Methodologies for Conducting EQR Activities, ANA.

CAHPS

In October 2020, the Agency for Healthcare Research and Quality (AHRQ) released the 5.1 versions of the Adult and Child Health Plan Surveys. These surveys acknowledged for the first time that members could receive care in person, by phone, or by video. Based on the CAHPS 5.1 versions developed by AHRQ, the NCQA introduced new HEDIS versions of the Health Plan Surveys—the CAHPS 5.1H Health Plan Surveys.[15]

The CAHPS 5.1H Surveys include a set of standardized items including four global ratings, four composite scores, three medical assistance with smoking and tobacco use cessation measure items (adult population only), and five children with chronic conditions (CCC) composite measures/items (CCC population only). The global ratings reflect patients' overall experience with their personal doctor, specialist, health plan, and all healthcare. The composite scores were derived from sets of questions to address different aspects of care (e.g., **Getting Needed Care and How Well Doctors Communicate**). The medical assistance with smoking and tobacco use cessation measure items assess the various aspects of providing assistance with smoking and tobacco use cessation. The CCC composite measures/items evaluate the experience of families with children with chronic conditions accessing various services (e.g., specialized services, prescription medications).

For each of the four global ratings, HSAG calculated the percentage of respondents who chose a positive experience rating on a scale of 0 to 10. The definition of a positive response for the global ratings included a value of 9 or 10. For each of the four composite scores and CCC composite measures/items, HSAG calculated the percentage of respondents who chose a positive response. CAHPS composite and item question response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always" or (2) "No" or "Yes." A positive response for the composites and items included responses of "Usually/Always" or "Yes." For the medical assistance with smoking and tobacco use cessation measure items, responses of "Always/Usually/Sometimes" were used to determine if the respondent qualified for inclusion in the numerator. The scores presented follow NCQA's methodology of calculating a rolling average using the current and prior year results.[16]

HSAG compared each measure's score to the prior year's score and identified statistically significant differences. HSAG used arrows to denote statistically significant differences. An upward arrow (↑) denotes if the MY 2024 score was statistically significantly higher than the MY 2023 score. A downward arrow (↓) denotes if the MY 2024 score was statistically significantly lower than the MY 2023 score. Scores that are not statistically significantly different are not denoted with arrows.

[15] National Committee for Quality Assurance. **HEDIS® Measurement Year 2020, Volume 3: Specifications for Survey Measures**. Washington, DC: NCQA Publication, 2020.

[16] Please exercise caution when reviewing the trend analysis results for the medical assistance with smoking and tobacco use cessation measure items, as the MY 2024 results contain members who responded to the survey and indicated they were current smokers or tobacco users in 2024 or 2025, and MY 2023 results contain members who responded to the survey and indicated they were current smokers or tobacco users in 2023 or 2024.

Statewide Average

Table 3-41 contains the MY 2023 and MY 2024 adult Medicaid, general child Medicaid, and CCC Medicaid CAHPS scores for the statewide average and comparisons to the MY 2023 scores.

Table 3-41—Summary of CAHPS Scores for Statewide Average: Adult, General Child, and CCC Medicaid

CAHPS Measure	MY 2023 Adult Medicaid Scores	MY 2024 Adult Medicaid Scores	MY 2023 General Child Medicaid Scores	MY 2024 General Child Medicaid Scores	MY 2023 CCC Medicaid Scores	MY 2024 CCC Medicaid Scores
Global Ratings						
Rating of Health Plan	66.56%	62.85%	78.69%	77.70%	76.27%	73.97%
Rating of All Health Care	58.39%	51.82%↓	72.40%	73.05%	72.39%	71.48%
Rating of Personal Doctor	71.77%	69.26%	80.70%	78.93%	80.10%	80.06%
Rating of Specialist Seen Most Often	69.35%	67.98%	77.58%	77.44%	78.07%	75.74%
Composite Measures						
Getting Needed Care	85.48%	85.16%	88.12%	88.32%	89.33%	88.91%
Getting Care Quickly	85.84%	84.26%	90.09%	90.99%	91.67%	92.43%
How Well Doctors Communicate	93.15%	95.22%	94.85%	95.06%	94.91%	95.43%
Customer Service	91.54%	90.82%	89.92%	90.05%	92.26%	90.47%
Medical Assistance With Smoking or Tobacco Use Cessation Items*						
Advising Smokers and Tobacco Users to Quit	74.77%	75.64%	—	—	—	—
Discussing Cessation Medications	52.01%	51.76%	—	—	—	—
Discussing Cessation Strategies	43.59%	46.12%	—	—	—	—
CCC Composite Measures and Items						
Access to Specialized Services	—	—	—		76.96%	76.77%
Family-Centered Care (FCC): Personal Doctor Who Knows Child	—	—	—		92.96%	93.29%
Coordination of Care for Children with Chronic Conditions	—	—	—		80.47%	79.44%
Access to Prescription Medicines	—	—	—		90.90%	92.04%
FCC: Getting Needed Information	—	—	—		92.13%	92.46%

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as NA (Not Applicable).
* These scores follow NCQA's methodology of calculating a rolling two-year average.
— Indicates the measure does not apply to the population.

Table 3-42 contains the MY 2023 and MY 2024 general child and CCC CHIP CAHPS scores for the statewide average.[17,18]

Table 3-42—Summary of CAHPS Scores for Statewide Average: General Child and CCC CHIP

CAHPS Measure	MY 2023 General Child CHIP Scores	MY 2024 General Child CHIP Scores	MY 2023 CCC CHIP Scores	MY 2024 CCC CHIP Scores
Global Ratings				
Rating of Health Plan	72.87%	65.82%↓	70.92%	62.64%↓
Rating of All Health Care	71.99%	72.61%	67.34%	66.08%
Rating of Personal Doctor	77.91%	78.26%	76.39%	78.64%
Rating of Specialist Seen Most Often	72.34%	79.07%	68.83%	77.30%
Composite Measures				
Getting Needed Care	89.36%	89.75%	88.24%	90.56%
Getting Care Quickly	90.68%	90.41%	91.76%	93.36%
How Well Doctors Communicate	96.77%	95.32%	97.57%	96.08%
Customer Service	88.85%	88.80%	NA	88.16%
CCC Composite Measures and Items				
Access to Specialized Services	—	—	NA	NA
FCC: Personal Doctor Who Knows Child	—	—	93.57%	94.35%
Coordination of Care for Children with Chronic Conditions	—	—	NA	77.40%
Access to Prescription Medicines	—	—	91.35%	92.86%
FCC: Getting Needed Information	—	—	93.95%	93.97%

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as NA (Not Applicable).
— Indicates the measure does not apply to the population.

[17] MY 2022 scores were not available for comparison. Therefore, only the MY 2023 scores are presented.
[18] TCS only participates in the Medicaid program; therefore, the statewide average results contain the combined results from BC, UHC, and WLP.

BC

Table 3-43 presents the MY 2023 and MY 2024 CAHPS scores for BC's adult Medicaid, general child Medicaid, and CCC Medicaid populations. Arrows (↓ or ↑) indicate MY 2024 scores that were statistically significantly lower or higher than the MY 2023 scores.

Table 3-43—Summary of CAHPS Scores for BC: Adult, General Child, and CCC Medicaid

CAHPS Measure	MY 2023 Adult Medicaid Scores	MY 2024 Adult Medicaid Scores	MY 2023 General Child Medicaid Scores	MY 2024 General Child Medicaid Scores	MY 2023 CCC Medicaid Scores	MY 2024 CCC Medicaid Scores
Global Ratings						
Rating of Health Plan	72.05%	71.43%	83.33%	82.27%	78.52%	75.82%
Rating of All Health Care	65.77%	52.23%↓	78.69%	73.75%	75.37%	72.40%
Rating of Personal Doctor	76.15%	70.17%	84.69%	78.31%↓	78.86%	81.38%
Rating of Specialist Seen Most Often	NA	NA	83.18%	NA	83.59%	74.60%
Composite Measures						
Getting Needed Care	NA	85.65%	90.59%	87.28%	90.71%	89.13%
Getting Care Quickly	NA	84.83%↓	91.91%	90.46%	94.39%	91.05%
How Well Doctors Communicate	93.84%	95.11%	96.94%	95.56%	94.60%	94.94%
Customer Service	NA	NA	NA	90.21%	NA	NA
Medical Assistance With Smoking or Tobacco Use Cessation Items*						
Advising Smokers and Tobacco Users to Quit	80.33%	81.15%	—	—	—	—
Discussing Cessation Medications	65.00%	52.89%	—	—	—	—
Discussing Cessation Strategies	56.67%	49.17%	—	—	—	—
CCC Composite Measures and Items						
Access to Specialized Services	—	—	—	—	NA	NA
FCC: Personal Doctor Who Knows Child	—	—	—	—	90.95%	94.40%
Coordination of Care for Children with Chronic Conditions	—	—	—	—	NA	NA
Access to Prescription Medicines	—	—	—	—	88.32%	93.62%
FCC: Getting Needed Information	—	—	—	—	94.58%	90.54%

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as NA (Not Applicable).
* These scores follow NCQA's methodology of calculating a rolling two-year average.
— Indicates the measure does not apply to the population.

Table 3-44 presents the MY 2023 and MY 2024 CAHPS scores for BC's general child and CCC CHIP populations.[19]

Table 3-44—Summary of CAHPS Scores for BC: General Child and CCC CHIP

CAHPS Measure	MY 2023 General Child CHIP Scores	MY 2024General Child CHIP Scores	MY 2023 CCC CHIP Scores	MY 2024 CCC CHIP Scores
Global Ratings				
Rating of Health Plan	71.62%	65.39%	72.30%	65.24%
Rating of All Health Care	72.06%	72.66%	65.25%	68.42%
Rating of Personal Doctor	78.33%	81.28%	79.86%	84.31%
Rating of Specialist Seen Most Often	NA	NA	NA	NA
Composite Measures				
Getting Needed Care	89.42%	89.49%	NA	87.58%
Getting Care Quickly	91.19%	91.32%	NA	NA
How Well Doctors Communicate	97.54%	95.43%	97.54%	96.06%
Customer Service	NA	92.57%	NA	NA
CCC Composite Measures and Items				
Access to Specialized Services	—	—	NA	NA
FCC: Personal Doctor Who Knows Child	—	—	94.41%	94.21%
Coordination of Care for Children with Chronic Conditions	—	—	NA	NA
Access to Prescription Medicines	—	—	92.62%	92.70%
FCC: Getting Needed Information	—	—	95.76%	93.94%

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as NA (Not Applicable).
— Indicates the measure does not apply to the population.

Conclusions and Recommendations for Improvement

HSAG compared the adult Medicaid and child Medicaid populations' MY 2024 CAHPS survey results to the MY 2023 CAHPS survey results, to determine potential areas for improvement.

One of the MY 2024 measure scores for the adult Medicaid population was statistically significantly lower than the MY 2023 measure scores; therefore, HSAG recommends that BC focus **quality of care** improvement efforts on the **Rating of All Health Care** measure. Additionally, one of the MY 2024

[19] MY 2022 scores were not available for comparison. Therefore, only the MY 2023 scores are presented.

measure scores for the general child Medicaid population was statistically significantly lower than the MY 2023 measure score; therefore, HSAG recommends that BC focus **quality of care** improvement efforts on the **Rating of Personal Doctor** measure.

To improve CAHPS rates related to **quality of care**, BC could consider including information about the CAHPS survey ratings in provider communications, including reminders about the importance of improving communication with patients from different cultures, handling challenging patient encounters, and emphasizing patient-centered communication for members. Patient-centered communication could have a positive impact on patient experience, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of members' perspectives. Physicians could ask questions about members' concerns, priorities, and values, and listen to their answers.

UHC

Table 3-45 presents the MY 2023 and MY 2024 CAHPS scores for UHC's adult Medicaid, general child Medicaid, and CCC Medicaid populations.

Table 3-45—Summary of CAHPS Scores for UHC: Adult, General Child, and CCC Medicaid

CAHPS Measure	MY 2023 Adult Medicaid Scores	MY 2024 Adult Medicaid Scores	MY 2023 General Child Medicaid Scores	MY 2024 General Child Medicaid Scores	MY 2023 CCC Medicaid Scores	MY 2024 CCC Medicaid Scores
Global Ratings						
Rating of Health Plan	63.21%	59.00%	74.74%	77.42%	74.52%	74.27%
Rating of All Health Care	52.17%	51.52%	67.05%	73.60%	70.33%	71.81%
Rating of Personal Doctor	67.52%	69.54%	76.29%	81.71%	78.51%	81.00%
Rating of Specialist Seen Most Often	NA	64.22%	NA	NA	78.26%	71.29%
Composite Measures						
Getting Needed Care	84.90%	83.29%	91.75%	88.52%	89.77%	87.52%
Getting Care Quickly	NA	81.99%	87.17%	88.68%	89.93%	88.99%
How Well Doctors Communicate	91.66%	94.68%	94.45%	93.13%	95.75%	94.52%
Customer Service	NA	NA	NA	NA	NA	NA
Medical Assistance With Smoking or Tobacco Use Cessation Items*						
Advising Smokers and Tobacco Users to Quit	74.69%	71.69%	—	—	—	—
Discussing Cessation Medications	48.16%	50.60%	—	—	—	—

CAHPS Measure	MY 2023 Adult Medicaid Scores	MY 2024 Adult Medicaid Scores	MY 2023 General Child Medicaid Scores	MY 2024 General Child Medicaid Scores	MY 2023 CCC Medicaid Scores	MY 2024 CCC Medicaid Scores
Discussing Cessation Strategies	41.22%	44.31%	—	—	—	—
CCC Composite Measures and Items						
Access to Specialized Services	—	—	—	—	NA	NA
FCC: Personal Doctor Who Knows Child	—	—	—	—	95.07%↑	93.29%
Coordination of Care for Children with Chronic Conditions	—	—	—	—	NA	NA
Access to Prescription Medicines	—	—	—	—	92.89%	93.91%
FCC: Getting Needed Information	—	—	—	—	91.39%	92.02%

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as NA (Not Applicable).
* These scores follow NCQA's methodology of calculating a rolling two-year average.
— Indicates the measure does not apply to the population.

Table 3-46 presents the MY 2023 and MY 2024 CAHPS scores for UHC's general child and CCC CHIP populations.[20]

Table 3-46—Summary of CAHPS Scores for UHC: General Child and CCC CHIP

CAHPS Measure	MY 2023 General Child CHIP Scores	MY 2024 General Child CHIP Scores	MY 2023 CCC CHIP Scores	MY 2024 CCC CHIP Scores
Global Ratings				
Rating of Health Plan	73.82%	65.78%↓	68.70%	NA
Rating of All Health Care	71.58%	71.67%	NA	NA
Rating of Personal Doctor	76.79%	72.73%	72.64%	NA
Rating of Specialist Seen Most Often	NA	NA	NA	NA
Composite Measures				
Getting Needed Care	92.66%	89.74%	NA	NA
Getting Care Quickly	90.30%	89.62%	NA	NA
How Well Doctors Communicate	96.60%	93.83%	NA	NA
Customer Service	NA	NA	NA	NA

[20] MY 2022 scores were not available for comparison. Therefore, only the MY 2023 scores are presented.

CAHPS Measure	MY 2023 General Child CHIP Scores	MY 2024 General Child CHIP Scores	MY 2023 CCC CHIP Scores	MY 2024 CCC CHIP Scores
CCC Composite Measures and Items				
Access to Specialized Services	—	—	NA	NA
FCC: Personal Doctor Who Knows Child	—	—	NA	NA
Coordination of Care for Children with Chronic Conditions	—	—	NA	NA
Access to Prescription Medicines	—	—	90.29%	NA
FCC: Getting Needed Information	—	—	NA	NA

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as NA (Not Applicable).
— Indicates the measure does not apply to the population.

Conclusions and Recommendations for Improvement

HSAG compared the adult Medicaid and child Medicaid populations' MY 2024 CAHPS survey results to the MY 2023 CAHPS survey results to determine potential areas for improvement. One of the MY 2024 measure scores for the general child CHIP population was statistically significantly lower than the MY 2023 measure score; therefore, HSAG recommends that UHC focus **quality of care** improvement efforts on the **Rating of Health Plan** measure.

To improve CAHPS rates related to **quality of care**, UHC could consider including information about the CAHPS survey results in provider communications, including reminders about the importance of improving communication with patients from different cultures, handling challenging patient encounters, and emphasizing patient-centered communication for members. Patient-centered communication could have a positive impact on patient experience, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of members' perspectives. Physicians could ask questions about members' concerns, priorities, and values, and listen to their answers.

WLP

Table 3-47 presents the MY 2023 and MY 2024 CAHPS scores for WLP's adult Medicaid, general child Medicaid, and CCC Medicaid populations. Arrows (↓ or ↑) indicate MY 2024 scores that were statistically significantly lower or higher than the MY 2023 scores.

Table 3-47—Summary of CAHPS Scores for WLP: Adult, General Child, and CCC Medicaid

CAHPS Measure	MY 2023 Adult Medicaid Scores	MY 2024 Adult Medicaid Scores	MY 2023 General Child Medicaid Scores	MY 2024 General Child Medicaid Scores	MY 2023 CCC Medicaid Scores	MY 2024 CCC Medicaid Scores
Global Ratings						
Rating of Health Plan	63.40%	56.25%	78.00%	75.23%	73.68%	67.03%
Rating of All Health Care	58.04%	49.63%	70.28%	73.13%	69.04%	68.25%
Rating of Personal Doctor	67.81%	63.13%	80.29%	74.93%	78.54%	77.48%
Rating of Specialist Seen Most Often	NA	NA	NA	NA	74.55%	78.74%
Composite Measures						
Getting Needed Care	80.51%	86.01%	86.31%	87.34%	88.61%	86.58%
Getting Care Quickly	NA	NA	89.85%	90.04%	90.38%	94.93%↑
How Well Doctors Communicate	92.65%	94.83%	94.05%	94.66%	93.90%	95.91%
Customer Service	NA	NA	91.88%	91.15%	NA	NA
Medical Assistance With Smoking or Tobacco Use Cessation Items*						
Advising Smokers and Tobacco Users to Quit	74.03%	78.63%	—	—	—	—
Discussing Cessation Medications	51.16%	53.45%	—	—	—	—
Discussing Cessation Strategies	40.47%	46.55%	—	—	—	—
CCC Composite Measures and Items						
Access to Specialized Services	—	—	—	—	NA	NA
FCC: Personal Doctor Who Knows Child	—	—	—	—	93.43%	91.76%
Coordination of Care for Children with Chronic Conditions	—	—	—	—	NA	NA
Access to Prescription Medicines	—	—	—	—	90.40%	91.03%
FCC: Getting Needed Information	—	—	—	—	90.86%	92.89%

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as NA (Not Applicable).
* These scores follow NCQA's methodology of calculating a rolling two-year average.
— Indicates the measure does not apply to the population.

Table 3-48 presents the MY 2024 CAHPS scores for WLP's general child and CCC CHIP populations.[21]

Table 3-48—Summary of CAHPS Scores for WLP: General Child and CCC CHIP

CAHPS Measure	MY 2023 General Child CHIP Scores	MY 2024 General Child CHIP Scores	MY 2023 CCC CHIP Scores	MY 2023 CCC CHIP Scores
Global Ratings				
Rating of Health Plan	74.03%	66.44%	NA	61.40%
Rating of All Health Care	72.44%	73.53%	NA	NA
Rating of Personal Doctor	78.70%	79.03%	NA	79.81%
Rating of Specialist Seen Most Often	NA	NA	NA	NA
Composite Measures				
Getting Needed Care	NA	90.19%	NA	NA
Getting Care Quickly	NA	89.73%	NA	NA
How Well Doctors Communicate	95.60%	96.52%	NA	NA
Customer Service	NA	NA	NA	NA
CCC Composite Measures and Items				
Access to Specialized Services	—	—	NA	NA
FCC: Personal Doctor Who Knows Child	—	—	NA	NA
Coordination of Care for Children with Chronic Conditions	—	—	NA	NA
Access to Prescription Medicines	—	—	NA	NA
FCC: Getting Needed Information	—	—	NA	NA

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as NA (Not Applicable).
— Indicates the measure does not apply to the population.

Conclusions and Recommendations for Improvement

HSAG compared the adult Medicaid and child Medicaid populations' 2024 CAHPS survey results to the 2023 CAHPS survey results to determine potential areas for improvement. None of the MY 2024 measure scores for the adult and child Medicaid and CHIP populations were statistically significantly lower than the MY 2023 measure scores; therefore, HSAG did not identify any recommendations for improvement.

For additional information concerning HSAG's methodology for conducting CAHPS, see Appendix A. Methodologies for Conducting EQR Activities, CAHPS.

[21] MY 2022 scores were not available for comparison. Therefore, only the MY 2023 scores are presented.

TCS

Table 3-49 presents the MY 2023 and MY 2024 CAHPS scores for TCS's adult Medicaid, general child Medicaid, and CCC Medicaid populations.[22] MY 2024 scores were not statistically significantly lower or higher than the MY 2023 scores.

Table 3-49—Summary of CAHPS Scores for TCS: Adult, General Child, and CCC Medicaid

CAHPS Measure	MY 2023 Adult Medicaid Scores	MY 2024 Adult Medicaid Scores	MY 2023 General Child Medicaid Scores	MY 2024 General Child Medicaid Scores	MY 2023 CCC Medicaid Scores	MY 2024 CCC Medicaid Scores
Global Ratings						
Rating of Health Plan	NA	NA	78.05%	76.08%	77.31%	76.18%
Rating of All Health Care	NA	NA	72.12%	72.05%	73.74%	72.38%
Rating of Personal Doctor	NA	NA	80.33%	81.52%	82.39%↑	80.32%
Rating of Specialist Seen Most Often	NA	NA	75.47%	75.42%	76.74%	76.38%
Composite Measures						
Getting Needed Care	NA	NA	85.56%	89.46%	88.88%	90.15%
Getting Care Quickly	NA	NA	90.45%	93.79%	91.52%	93.49%
How Well Doctors Communicate	NA	NA	93.81%	96.26%	95.13%	95.82%
Customer Service	NA	NA	91.67%	87.07%	90.66%	90.57%
Medical Assistance With Smoking or Tobacco Use Cessation Items*						
Advising Smokers and Tobacco Users to Quit	NA	NA	—	—	—	—
Discussing Cessation Medications	NA	NA	—	—	—	—
Discussing Cessation Strategies	NA	NA	—	—	—	—
CCC Composite Measures and Items						
Access to Specialized Services	—	—	—	—	76.55%	78.91%
FCC: Personal Doctor Who Knows Child	—	—	—	—	92.73%	93.49%

[22] TCS only participates in the Medicaid program; therefore, results for the CHIP population are not available.

CAHPS Measure	MY 2023 Adult Medicaid Scores	MY 2024 Adult Medicaid Scores	MY 2023 General Child Medicaid Scores	MY 2024 General Child Medicaid Scores	MY 2023 CCC Medicaid Scores	MY 2024 CCC Medicaid Scores
Coordination of Care for Children with Chronic Conditions	—	—	—	—	82.92%	85.78%
Access to Prescription Medicines	—	—	—	—	91.39%	91.05%
FCC: Getting Needed Information	—	—	—	—	91.88%	93.36%

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as NA (Not Applicable).

* These scores follow NCQA's methodology of calculating a rolling two-year average.

— Indicates the measure does not apply to the population.

Conclusions and Recommendations for Improvement

HSAG compared the adult Medicaid and child Medicaid populations' MY 2024 CAHPS survey results to the MY 2023 CAHPS survey results to determine potential areas for improvement. None of the MY 2024 measure scores for the adult and child Medicaid populations were statistically significantly lower than the MY 2023 measure scores; therefore, HSAG did not identify any recommendations for improvement.

HEDIS

Overview

HEDIS is a standardized set of nationally recognized measures, developed by the NCQA, to measure the performance of managed care plans. MCOs and the PIHP contracted by TennCare are required to be accredited by the NCQA and must report on HEDIS performance measures and participate in an annual HEDIS Compliance Audit to maintain their accreditation. For CY 2025, HSAG validated the results of each MCO's and the PIHP's HEDIS Compliance Audit to ensure the validation activities were conducted as outlined in the CMS EQR Protocol 2 cited earlier in this report.

Each MCO and the PIHP worked with an NCQA- LO of its choice to undergo the HEDIS Compliance Audit. Since the audits were conducted in compliance with the **HEDIS Measurement Year (MY) 2024 Volume 5 HEDIS Compliance Audit: Standards, Policies and Procedures**, and the HEDIS Compliance Audit is consistent with the CMS EQR Protocol 2, HSAG was able to review, validate, and eventually accept the results from the HEDIS Compliance Audits as findings for the validation of performance measures to meet the managed care requirements.

IS Review Results

HSAG reviewed two sources of HEDIS data to determine if the LOs' audit processes met CMS requirements and to summarize the overall HEDIS reporting capabilities and functions for the MCOs and PIHP. The first data sources reviewed were the FARs prepared by the LOs to present key findings from the HEDIS Compliance Audits. HSAG reviewed the FARs for documentation of MCOs' and the PIHP's IS capabilities based on the assessment conducted by the LOs. The LOs evaluated aspects of the MCOs' and PIHP's information systems that impacted reporting of HEDIS performance measures, and determined whether the MCOs and PIHP had the automated processes, information management practices, processing environment, and control procedures to capture, access, translate, analyze, and report each HEDIS measure.

The **HEDIS MY 2024 Volume 5 HEDIS Compliance Audit: Standards, Policies and Procedures** publication establishes the minimum requirements that MCOs' and the PIHP's information systems should meet to report HEDIS performance measures (i.e., IS standards). For circumstances in which a particular IS standard was not met, the LO rated the impact on HEDIS reporting capabilities and, specifically, any measure that could be impacted. The MCOs and PIHP may not be fully compliant with several of the IS standards but may still be able to report the selected measures.

Table 3-50 provides a summary of MCOs' and PIHP key findings for each IS standard as noted in the FARs reviewed by HSAG.

Table 3-50—Summary of MCOs' and the PIHP's Compliance With IS Standards

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2024 FARs Review
IS R—Data Management and Reporting • IS R1—The organization's data management enables measurement. • IS R2—Data extraction and loads are complete and accurate. • IS R3—Data transformation and integration is accurate and valid. • IS R4—Data quality and governance are components of the organization's data management. • IS R5—Oversight and controls ensure correct implementation of measure reporting software. • IS R6—Cybersecurity practices are in place to promote protection and resiliency of the systems and data used for measurement.	• All MCOs were compliant with IS Standard R for Data Management and Reporting. • The MCOs had procedures in place so that all data extraction and transformation was accurate and valid. • The MCOs had processes for oversight and controls to ensure correct implementation of measure reporting software. • The MCOs had practices in place to promote protection and resiliency of systems and data. • Sufficient validation processes were in place, ensuring data accuracy.
IS C—Clinical and Care Delivery Data • IS C1—Data capture is complete. • IS C2—Data conform with industry standards.	• All MCOs were compliant with IS Standard C for Clinical and Care Delivery Data.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2024 FARs Review
• IS C3—Transaction file data are accurate. • IS C4—Organization confirms ingested data meet expectations for data quality.	• The MCOs had procedures in place so that all data elements required for HEDIS reporting were completely captured. • Adequate validation processes were in place, ensuring data accuracy and quality.
IS M—Medical Record Review Processes • IS M1—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 M2—Retrieval and abstraction of data from medical records is reliably and accurately performed. • IS M3—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 M4—The organization continually assesses data completeness and takes steps to improve performance. • IS M5—The organization regularly monitors vendor performance against expected performance standards.	• All MCOs were compliant with IS Standard M for Medical Record Review (MRR) Processes. • Data collection tools used by the MCOs were able to capture all data fields necessary for measure reporting. • Sufficient validation processes were in place to ensure data accuracy.
IS A—Administrative Data • IS A1—Data conform with industry standards and measure requirements. • IS A2—Data are complete and accurate. • IS A3—Membership information system enables measurement.	• All MCOs were compliant with IS Standard A for Administrative Data. • The MCOs validated that data conform with industry standards and measure requirements. • The MCOs verified that their membership information systems appropriately enabled measurement. • Adequate validation processes were in place, ensuring data accuracy.

HEDIS Results—Medicaid Population

HSAG reviewed IDSS files that contained the final MCO- and PIHP-reported HEDIS rates that were verified, reviewed, and locked by the LOs. HSAG received MY 2024 IDSS reports from the following TennCare MCOs: BC, UHC, WLP, and the PIHP (TCS). Effective MY 2023, these MCOs and PIHP reported audited HEDIS results separately for their Medicaid and CHIP populations. This section presents MCOs' and the PIHP's HEDIS results for their Medicaid population.

Table 3-51 presents the MY 2023 and MY 2024 weighted average statewide rate for each HEDIS performance measure specified in TennCare's Quality Strategy. HSAG calculated the weighted statewide rates by applying the size of the eligible population within each plan to the overall results. This approach allowed for plan-specific findings to contribute to the TennCare statewide average in a manner proportionate to each plan's eligible population size. The "Change From MY 2023 to MY 2024" column compares weighted statewide rates on HEDIS measures between MY 2023 and MY 2024 and indicates whether there was an improvement (↑) or a decline (↓) in statewide performance across the MYs, when measure data are available for both years. Note that MCOs' and the PIHP's MY 2023 statewide rates may be based on HEDIS results for the combined Medicaid and CHIP populations, while their MY 2024 statewide rates reflect only the Medicaid population. HSAG therefore recommends caution when comparing MCOs' and the PIHP's statewide rates between MY 2023 and MY 2024.

Table 3-51—HEDIS Medicaid Statewide Results on Measures Included in TennCare's Quality Strategy

Measure	Weighted Statewide Average Rate		Change From MY 2023 to MY 2024
	MY 2023	MY 2024	
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
Body Mass Index (BMI) Percentile Documentation			
3–11 Years	84.36%	84.07%	↓
12–17 Years	79.08%	79.89%	↑
Total	**82.32%**	**82.43%**	↑
Counseling for Nutrition			
3–11 Years	70.98%	71.56%	↑
12–17 Years	64.28%	64.92%	↑
Total	**68.57%**	**69.00%**	↑
Counseling for Physical Activity			
3–11 Years	64.22%	64.24%	↑
12–17 Years	62.67%	62.61%	↓
Total	**63.81%**	**63.60%**	↓
Childhood Immunization Status (CIS)			
DTaP	70.33%	76.05%	↑
IPV	85.31%	88.33%	↑
MMR	83.38%	85.98%	↑
HiB	81.44%	86.55%	↑
HepB	88.77%	89.56%	↑
VZV	82.28%	86.04%	↑
PCV	72.49%	75.94%	↑
HepA	82.73%	85.37%	↑
RV	68.17%	73.46%	↑

Measure	Weighted Statewide Average Rate		Change From MY 2023 to MY 2024
	MY 2023	MY 2024	
Influenza	30.48%	32.17%	↑
Combination 3	66.48%	72.01%	↑
Combination 7	57.13%	63.77%	↑
Combination 10	24.33%	27.48%	↑
Immunizations for Adolescents (IMA)			
Meningococcal	74.47%	74.14%	↓
Tdap	83.82%	84.62%	↑
HPV	33.65%	35.49%	↑
Combination 1	74.29%	74.00%	↓
Combination 2	33.29%	34.79%	↑
Cervical Cancer Screening (CCS)			
Cervical Cancer Screening	55.53%	56.20%	↑
Effectiveness of Care: Respiratory Conditions			
Asthma Medication Ratio (AMR)			
5–11 Years	81.85%	72.74%	↓
12–18 Years	77.61%	71.74%	↓
19–50 Years	65.27%	63.75%	↓
51–64 Years	64.30%	59.78%	↓
Total	**74.41%**	**69.24%**	↓
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)			
Controlling High Blood Pressure	64.41%	70.59%	↑
Effectiveness of Care: Diabetes			
Eye Exam for Patients With Diabetes (EED)[1]			
Eye Exam for Patients With Diabetes	53.51%	55.27%	↑
Blood Pressure Control (<140/90 mmHg) for Patients With Diabetes (BPD)[1]			
Blood Pressure Control (<140/90 mmHg) for Patients With Diabetes	69.37%	72.50%	↑
Kidney Health Evaluation for Patients With Diabetes (KED)[1]			
18–64 Years	32.73%	38.27%	↑
65–75 Years	41.37%	50.45%	↑
76–85 Years	42.92%	52.99%	↑
Total	**33.78%**	**40.02%**	↑

Measure	Weighted Statewide Average Rate		Change From MY 2023 to MY 2024
	MY 2023	MY 2024	
Effectiveness of Care: Behavioral Health			
Follow-Up After Hospitalization for Mental Illness (FUH)			
7-Day Follow-Up			
6–17 Years	49.82%	51.39%	↑
18–64 Years	36.79%	36.27%	↓
65 Years and Older	27.80%	26.03%	↓
Total	**40.41%**	**41.09%**	↑
30-Day Follow-Up			
6–17 Years	73.80%	73.58%	↓
18–64 Years	56.64%	56.42%	↓
65 Years and Older	47.98%	44.63%	↓
Total	**61.45%**	**61.89%**	↑
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
20–44 Years	74.93%	79.99%	↑
45–64 Years	84.87%	86.76%	↑
65 Years and Older	94.51%	94.74%	↑
Total	**78.45%**	**82.95%**	↑
Prenatal and Postpartum Care (PPC)[1]			
Postpartum Care	77.46%	80.40%	↑
Utilization and Risk-Adjusted Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	66.59%	70.09%	↑
Child and Adolescent Well-Care Visits (WCV)			
3–11 Years	63.52%	66.97%	↑
12–17 Years	53.98%	56.17%	↑
18–21 Years	27.97%	31.89%	↑
Total	**55.38%**	**59.33%**	↑
Electronic Clinical Data Systems (ECDS)			
Breast Cancer Screening (BCS-E)			
Breast Cancer Screening	49.86%	51.46%	↑
Long-Term Services and Supports (LTSS)			
Comprehensive Assessment and Update (LTSS-CAU)			
Assessment of Core Elements	94.52%	96.19%	↑
Assessment of Supplemental Elements	94.52%	95.86%	↑

Measure	Weighted Statewide Average Rate		Change From MY 2023 to MY 2024
	MY 2023	MY 2024	
Comprehensive Care Plan and Update (LTSS-CPU)			
Care Plan With Core elements Documented	94.99%	95.78%	↑
Care Plan With Supplemental Elements Documented	94.99%	95.70%	↑
Reassessment/Care Plan Update After Inpatient Discharge (LTSS-RAC)			
Reassessment After Inpatient Discharge	51.98%	63.50%	↑
Reassessment and Care Plan Update After Inpatient Discharge	48.53%	57.99%	↑
Shared Care Plan With Primary Care Practitioner (LTSS-SCP)			
Shared Care Plan With Primary Care Practitioner	86.11%	90.92%	↑

[1] Measure should be trended with caution due to specification changes for MY 2024.

Conclusions and Recommendations

For the Medicaid population, TennCare MCOs improved their performance by 5 percentage points or more from MY 2023 to MY 2024 on the following measure indicators: **Childhood Immunization Status (CIS)—DTaP**, **HiB**, **RV**, **Combination 3**, **and Combination 7**; **Controlling High Blood Pressure (CBP)**; **Kidney Health Evaluation for Patients With Diabetes (KED)—18–64 Years**, **65–75 Years**, **76–85 Years**, **and Total**; **Adults' Access to Preventive/Ambulatory Health Services (AAP)—20–44 Years**; **and Reassessment/Care Plan Update After Inpatient Discharge (LTSS-RAC)—Reassessment After Inpatient Discharge** and **Reassessment and Care Plan Update After Inpatient Discharge**. The results on the **CIS** measure suggest that MCOs are improving child members' access to immunizations to protect against preventable diseases. The results on the **CBP** and **KED** measures suggest that MCOs are improving their monitoring, management, and treatment of adult members' chronic conditions, while the result on the **AAP** measure suggests that MCOs are improving adult members' access to preventive healthcare services. Lastly, the results on the **LTSS-RAC** measure suggest that MCOs are ensuring that members are reassessed after a hospital inpatient stay to enable an update to their care plan. [**Quality, Timeliness, Access**]

For the Medicaid population, TennCare MCOs experienced a decline in performance of 5 percentage points or more from MY 2023 to MY 2024 on the following measure indicators: **Asthma Medication Ratio (AMR)—5–11 Years**, **12–18 Years**, **51–64 Years**, and **Total**. The results on the **AMR** measure suggest that the MCOs were not as effective in managing persistent asthma for child and adult members in 2024 compared to the previous year. HSAG recommends that TennCare work with the MCOs to identify and address circumstances or conditions preventing members from accessing the medication they need to effectively manage their persistent asthma. [**Quality**]

Table 3-52 presents MCO- and PIHP-reported rates on HEDIS performance measures specified in TennCare's Quality Strategy and indicates whether the reported rate is below the MY 2024 NCQA Quality Compass National 25th percentile benchmark, between the 25th percentile and 75th percentile benchmarks, or above the 75th percentile benchmark.

Note that TCS's statewide HEDIS results are included in the statewide HEDIS results presented in BC's statewide IDSS report.

Table 3-52—HEDIS MY 2024 Medicaid Plan-Specific Statewide Results on Measures Included in TennCare's Quality Strategy

Color Designation	National Percentile Achieved	Additional Comments
Green Shading+	Greater than 75th percentile	No additional comments
No Shading	25th to 75th percentile	No additional comments
Red Shading^	Less than 25th percentile	No additional comments
Gray Shading○	No rating available	Benchmarking data not available

Measure	BC	UHC	WLP
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile Documentation			
3–11 Years	85.65%	81.18%	84.62%
12–17 Years	83.19%	76.28%^	79.10%
Total	**84.76%**	**79.32%**	**82.24%**
Counseling for Nutrition			
3–11 Years	78.95%	59.61%^	72.65%
12–17 Years	76.47%	47.44%^	66.67%
Total	**78.05%**	**54.99%^**	**70.07%**
Counseling for Physical Activity			
3–11 Years	69.86%	52.94%^	67.09%
12–17 Years	74.79%	43.59%^	64.97%
Total	**71.65%**	**49.39%^**	**66.18%**
Childhood Immunization Status (CIS)			
DTaP	76.16%	74.21%	77.62%+
IPV	88.32%	87.83%	88.81%
MMR	87.83%	84.43%	84.91%

Measure	BC	UHC	WLP
HiB	87.59%	84.43%	87.10%
HepB	90.27%	88.81%	89.29%
VZV	87.83%	85.16%	84.43%
PCV	77.13%	73.97%	76.16%
HepA	86.37%	84.67%	84.67%
RV	75.67%+	71.53%	72.26%
Influenza	32.60%	32.12%	31.63%
Combination 3	72.99%+	70.56%	72.02%
Combination 7	65.69%+	62.04%	62.77%
Combination 10	29.20%	26.28%	26.28%
Immunizations for Adolescents (IMA)			
Meningococcal	77.86%	74.21%^	69.83%^
Tdap	86.86%	84.43%	82.24%^
HPV	36.01%	34.79%	35.52%
Combination 1	77.86%	73.72%^	69.83%^
Combination 2	34.55%	34.55%	35.28%
Cervical Cancer Screening (CCS)			
Cervical Cancer Screening	61.48%	54.01%	52.31%
Effectiveness of Care: Respiratory Conditions			
Asthma Medication Ratio (AMR)			
5–11 Years	73.86%	73.44%	69.62%
12–18 Years	74.66%+	69.50%	71.43%
19–50 Years	68.87%+	59.58%	64.36%
51–64 Years	71.52%	52.58%^	62.76%
Total	**72.68%+**	**67.00%**	**68.23%**
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)			
Controlling High Blood Pressure	76.28%+	68.61%	66.67%
Effectiveness of Care: Diabetes			
Eye Exam for Patients With Diabetes (EED)			
Eye Exam for Patients With Diabetes	55.21%	60.83%	48.42%^

Measure	BC	UHC	WLP
Blood Pressure Control (<140/90 mmHg) for Patients With Diabetes (BPD)			
Blood Pressure Control (<140/90 mmHg) for Patients With Diabetes	76.82%+	72.99%	66.91%^
Kidney Health Evaluation for Patients With Diabetes (KED)			
18–64 Years	37.16%	39.84%	37.70%
65–75 Years	52.01%	51.54%	46.49%
76–85 Years	53.88%	53.46%	50.80%
Total	**38.81%**	**42.10%**	**38.77%**
Effectiveness of Care: Behavioral Health			
Follow-Up After Hospitalization for Mental Illness (FUH)			
7-Day Follow-Up			
6–17 Years	48.04%	53.78%	54.67%
18–64 Years	38.53%	38.07%	32.53%
65 Years and Older	29.41%	28.21%	20.27%^
Total	**42.39%**	**42.04%**	**38.79%**
30-Day Follow-Up			
6–17 Years	69.70%	77.71%	76.23%
18–64 Years	60.79%	59.81%	49.25%
65 Years and Older	56.86%	44.44%	36.49%^
Total	**64.46%**	**64.21%**	**56.92%**
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
20–44 Years	81.99%+	80.48%	77.35%
45–64 Years	88.81%+	88.46%+	82.99%
65 Years and Older	96.34%+	96.00%+	90.76%+
Total	**84.38%+**	**84.76%+**	**79.67%**
Prenatal and Postpartum Care (PPC)			
Postpartum Care	81.36%	80.78%	78.59%
Utilization and Risk-Adjusted Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	72.53%+	70.51%+	66.55%
Child and Adolescent Well-Care Visits (WCV)			
3–11 Years	69.31%+	66.75%	64.20%

Measure	BC	UHC	WLP
12–17 Years	58.15%	57.02%	53.10%
18–21 Years	34.66%	31.68%	28.79%
Total	**61.70%+**	**59.63%**	**56.18%**
Electronic Clinical Data Systems (ECDS)			
Breast Cancer Screening (BCS-E)			
Breast Cancer Screening	55.35%	53.86%	44.18%^
Long-Term Services and Supports (LTSS)			
Comprehensive Assessment and Update (LTSS-CAU)			
Assessment of Core Elements	98.54%+	91.97%	98.05%+
Assessment of Supplemental Elements	98.54%+	91.00%	98.05%+
Comprehensive Care Plan and Update (LTSS-CPU)			
Care Plan With Core Elements Documented	98.05%+	90.75%	98.54%+
Care Plan With Supplemental Elements Documented	98.05%+	90.51%	98.54%+
Reassessment/Care Plan Update After Inpatient Discharge (LTSS-RAC)			
Reassessment After Inpatient Discharge	60.34%	51.58%	78.59%+
Reassessment and Care Plan Update After Inpatient Discharge	55.47%	49.15%	69.34%+
Shared Care Plan With Primary Care Practitioner (LTSS-SCP)			
Shared Care Plan With Primary Care Practitioner	90.75%+	85.64%	96.35%+

Conclusions and Recommendations

All TennCare MCOs had MY 2024 rates that were above the MY 2024 Quality Compass national 75th percentile benchmark for the following measure indicator: **Adults' Access to Preventive/Ambulatory Health Services (AAP)—65 Years and Older**. BC's MY 2024 rates on the **AAP** measure were above the national 75th percentile benchmark for all age stratifications, while UHC and WLP had some MY 2024 rates that were between the national 25th and 75th percentile benchmarks for members ages **20–44 Years** and **45–64 Years**. These results suggest that the MCOs ensured that adult members had timely access to preventive healthcare services to reduce the potential for adverse healthcare events. [**Timeliness, Access**]

Excluding WLP, TennCare MCOs' MY 2024 rates were above the MY 2024 Quality Compass national 75th percentile benchmark for the following measure indicator: **Well-Child Visits in the First 30 Months of Life (W30)—First 15 Months**. WLP's MY 2024 rate on the **W30—First 15 Months** indicator fell between the national 25th and 75th percentile benchmarks. These results suggest that MCOs effectively monitored the health of members during the first 15 months of life by ensuring regular well-child visits with PCPs. [**Quality, Access**]

Excluding UHC, TennCare's MCOs' MY 2024 rates were above the MY 2024 Quality Compass national 75th percentile benchmark for the following LTSS measures: **Comprehensive Assessment and Update (LTSS-CAU)**, **Comprehensive Care Plan and Update (LTSS-CPU)**, and **Shared Care Plan With Primary Care Practitioner (LTSS-SCP)**. UHC's MY 2024 rates on these LTSS measures fell between the national 25th and 75th percentile benchmarks. These results suggest that MCOs had effective processes in place to ensure that members' care plans reflected their current long-term support needs and to inform PCPs of any updates to members' care plans. [**Quality**]

Excluding BC, TennCare MCOs' MY 2024 rates on the **Immunizations for Adolescents (IMA)—Meningococcal and Combination 1** measure indicators fell below the MY 2024 Quality Compass national 25th percentile benchmark. These results suggest that few adolescent members received essential immunizations to protect against preventable diseases. HSAG recommends that MCOs educate members to help them understand the importance of receiving preventive care and screenings. MCOs should remind providers to review preventive care measures for every patient, including children and adolescents, at every visit to ensure that members receive timely preventive health screenings. MCOs also could inform members through newsletters about the importance of timely immunizations for adolescents. Best practices that MCOs may consider piloting to improve immunization rates include offering member incentives, such as gift cards, for accessing timely preventive and immunization services. [**Quality**]

HEDIS Results—CHIP Population

Effective MY 2023, TennCare MCOs and the PIHP reported audited HEDIS results separately for their Medicaid and CHIP populations. This section presents MCOs' and the PIHP's HEDIS results for their CHIP population.

Table 3-53 presents the MY 2023 and MY 2024 weighted average statewide rate for each HEDIS measure specified in TennCare's Quality Strategy. HSAG calculated the weighted average statewide rates by applying the size of the eligible population within each plan to the overall results. This approach allowed for plan-specific findings to contribute to the TennCare statewide average in a manner proportionate to each plan's eligible population size.

Table 3-53—HEDIS MY 2023 and MY 2024 CHIP Statewide Results on Measures Included in TennCare's Quality Strategy

Measure	Weighted Statewide Average Rate		Change From MY 2023 to MY 2024
	MY 2023	MY 2024	
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile Documentation			
3–11 Years	79.07%	81.61%	↑
12–17 Years	74.88%	79.11%	↑
Total	**77.31%**	**80.66%**	↑

Measure	Weighted Statewide Average Rate		Change From MY 2023 to MY 2024
	MY 2023	MY 2024	
Counseling for Nutrition			
3–11 Years	66.27%	68.24%	↑
12–17 Years	56.07%	62.83%	↑
Total	**61.92%**	**66.17%**	↑
Counseling for Physical Activity			
3–11 Years	59.23%	63.85%	↑
12–17 Years	57.79%	62.32%	↑
Total	**58.52%**	**63.27%**	↑
Childhood Immunization Status (CIS)			
DTaP	76.61%	81.82%	↑
IPV	86.83%	90.91%	↑
MMR	83.33%	88.16%	↑
HiB	84.41%	89.37%	↑
HepB	86.83%	91.08%	↑
VZV	82.53%	87.99%	↑
PCV	75.54%	81.82%	↑
HepA	83.06%	88.51%	↑
RV	73.92%	79.07%	↑
Influenza	37.90%	39.28%	↑
Combination 3	70.97%	77.53%	↑
Combination 7	65.05%	70.84%	↑
Combination 10	31.99%	35.33%	↑
Immunizations for Adolescents (IMA)			
Meningococcal	70.23%	73.01%	↑
Tdap	82.91%	83.96%	↑
HPV	26.88%	25.15%	↓
Combination 1	69.99%	72.76%	↑
Combination 2	26.21%	24.81%	↓
Cervical Cancer Screening (CCS)			
Cervical Cancer Screening	63.82%	71.28%	↑
Effectiveness of Care: Respiratory Conditions			
Asthma Medication Ratio (AMR)			
5–11 Years	83.47%	86.44%	↑
12–18 Years	81.08%	80.61%	↓
19–50 Years	NA	NA	NA

Measure	Weighted Statewide Average Rate		Change From MY 2023 to MY 2024
	MY 2023	MY 2024	
51–64 Years	—	—	—
Total	**82.28%**	**83.49%**	↑
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)			
Controlling High Blood Pressure	NA	NA	NA
Effectiveness of Care: Diabetes			
Eye Exam for Patients With Diabetes (EED)[1]			
Eye Exam for Patients With Diabetes	23.69%	35.90%	↑
Blood Pressure Control (<140/90 mmHg) for Patients With Diabetes (BPD)[1]			
Blood Pressure Control (<140/90 mmHg) for Patients With Diabetes	NA	NA	NA
Kidney Health Evaluation for Patients With Diabetes (KED)[1]			
18–64 Years	20.39%	15.00%	↓
65–74 Years	—	—	—
75–85 Years	—	—	—
Total	**20.39%**	**15.00%**	↓
Effectiveness of Care: Behavioral Health			
Follow-Up After Hospitalization for Mental Illness (FUH)			
7-Day Follow-Up			
6–17 Years	61.76%	59.14%	↓
18–64 Years	NA	NA	NA
65 Years and Older	—	—	—
Total	**56.45%**	**56.07%**	↓
30-Day Follow-Up			
6–17 Years	80.39%	87.10%	↑
18–64 Years	NA	NA	NA
65 Years and Older	—	—	—
Total	**74.19%**	**82.24%**	↑
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
20–44 Years	71.43%	85.09%	↑
45–64 Years	NA	NA	NA
65 Years and Older	—	—	—
Total	**71.23%**	**84.88%**	↑

Measure	Weighted Statewide Average Rate		Change From MY 2023 to MY 2024
	MY 2023	MY 2024	
Prenatal and Postpartum Care (PPC)[1]			
Postpartum Care	80.54%	82.08%	↑
Utilization and Risk-Adjusted Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	76.95%	74.16%	↓
Child and Adolescent Well-Care Visits (WCV)			
3–11 Years	58.63%	65.25%	↑
12–17 Years	49.78%	53.88%	↑
18–21 Years	31.75%	36.15%	↑
Total	**52.28%**	**58.83%**	↑
Electronic Clinical Data Systems (ECDS)			
Breast Cancer Screening (BCS-E)			
Breast Cancer Screening	—	—	—

NA indicates that the MCO/PIHP followed the specifications for the measure indicator, but the denominator was too small (<30) to report a valid rate.
— Indicates that the MCO/PIHP reported a rate of zero or did not report a rate for the measure indicator.
[1] Measure should be trended with caution due to specification changes for MY 2024.

Conclusions and Recommendations

For the CoverKids population, TennCare MCOs improved their performance by 5 percentage points or more from MY 2023 to MY 2024 on the following measure indicators: **Childhood Immunization Status (CIS)—DTaP**, **VZV**, **PCV**, **HepA**, **RV**, **Combination 3**, **and Combination 7**; **Cervical Cancer Screening (CCS)**; **Eye Exam for Patients With Diabetes (EED)**; **Follow-Up After Hospitalization for Mental Illness (FUH)—30-Day Follow-Up—6–17 Years** and **Total**; **Adults' Access for Preventive/Ambulatory Health Services (AAP)—20–44 Years** and **Total**; and **Child and Adolescent Well-Care Visits (WCV)—3–11 Years** and **Total**. The results on the **CIS** measure suggest that MCOs are improving child members' access to immunizations to protect against preventable diseases. The results on the **AAP** and **WCV** measures suggest that MCOs are improving child and young adult members' access to preventive healthcare services delivered during visits with a healthcare provider. The results on the **CCS** and **EED** measures suggest that MCOs are improving child and young adult members' access to screenings and exams to facilitate the monitoring, management, and treatment of cancer and chronic conditions. Lastly, the results on the **FUH** measure suggest that the MCOs are improving child and adult members' access to timely follow-up visits following a mental health-related hospital stay. [**Quality, Timeliness, Access**]

For the CoverKids population, TennCare MCOs experienced a decline in performance of 5 percentage points or more from MY 2023 to MY 2024 on the following measure indicator: **Kidney Health Evaluation for Patients With Diabetes (KED)—18–64 Years**. The result on the **KED** measure

suggests that MCOs were not as effective in monitoring and managing the health impacts of diabetes in young adult members in 2024 compared to the previous year. HSAG recommends that TennCare work with the MCOs to identify and address circumstances or conditions that prevent members from receiving key exams to evaluate the impact of diabetes on the kidneys. [**Quality**]

Table 3-54 presents MCO- and PIHP-reported rates on HEDIS performance measures specified in TennCare's Quality Strategy and indicates whether the reported rate is below the MY 2024 NCQA Quality Compass National 25th percentile benchmark, between the 25th percentile and 75th percentile benchmarks, or above the 75th percentile benchmark.

Table 3-54—HEDIS MY 2024 CHIP Plan-Specific Results on Measures Included in TennCare's Quality Strategy

Color Designation	National Percentile Achieved	Additional Comments
Green Shading+	Greater than 75th percentile	No additional comments
No Shading	25th to 75th percentile	No additional comments
Red Shading^	Less than 25th percentile	No additional comments
Gray Shading○	No rating available	Benchmarking data not available

Measure	BC	UHC	WLP
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile Documentation			
3–11 Years	82.94%	80.24%	81.15%
12–17 Years	81.06%	76.07%^	79.64%
Total	**82.29%**	**78.59%**	**80.54%**
Counseling for Nutrition			
3–11 Years	72.62%	58.47%^	71.31%
12–17 Years	71.21%	44.17%^	70.06%
Total	**72.14%**	**52.80%^**	**70.80%**
Counseling for Physical Activity			
3–11 Years	71.03%	48.79%^	68.03%
12–17 Years	71.21%	41.10%^	71.26%
Total	**71.09%**	**45.74%^**	**69.34%**
Childhood Immunization Status (CIS)			
DTaP	81.82%+	77.48%+	85.07%+
IPV	91.77%+	89.40%	91.04%+
MMR	89.18%+	87.42%	87.56%

Measure	BC	UHC	WLP
HiB	89.18%+	88.08%	90.55%+
HepB	91.34%+	89.40%	92.04%+
VZV	89.18%+	86.75%	87.56%
PCV	84.85%+	76.82%	82.09%+
HepA	88.74%+	88.08%+	88.56%+
RV	78.35%+	76.16%+	82.09%+
Influenza	38.96%	36.42%	41.79%+
Combination 3	80.09%+	72.19%+	78.61%+
Combination 7	71.00%+	66.89%+	73.63%+
Combination 10	36.80%+	30.46%	37.31%+
Immunizations for Adolescents (IMA)			
Meningococcal	75.56%^	69.41%^	73.95%^
Tdap	86.67%	81.23%^	83.87%
HPV	22.47%^	25.96%^	27.05%^
Combination 1	75.31%^	69.41%^	73.45%^
Combination 2	22.47%^	25.45%^	26.55%^
Cervical Cancer Screening (CCS)			
Cervical Cancer Screening	76.16%+	70.98%+	67.20%+
Effectiveness of Care: Respiratory Conditions			
Asthma Medication Ratio (AMR)			
5–11 Years	91.67%+	86.00%+	81.25%+
12–18 Years	83.87%+	78.00%+	NA
19–50 Years	NA	NA	—
51–64 Years	—	—	—
Total	**88.24%+**	**81.19%+**	**81.63%+**
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)			
Controlling High Blood Pressure	NA	NA	NA
Effectiveness of Care: Diabetes			
Eye Exam for Patients With Diabetes (EED)			
Eye Exam for Patients With Diabetes	NA	NA	NA

Measure	BC	UHC	WLP
Blood Pressure Control (<140/90 mmHg) for Patients With Diabetes (BPD)			
Blood Pressure Control (<140/90 mmHg) for Patients With Diabetes	NA	NA	NA
Kidney Health Evaluation for Patients With Diabetes (KED)			
18–64 Years	NA	NA	NA
65–75 Years	—	—	—
76–85 Years	—	—	—
Total	**NA**	**NA**	**NA**
Effectiveness of Care: Behavioral Health			
Follow-Up After Hospitalization for Mental Illness (FUH)			
7-Day Follow-Up			
6–17 Years	68.75%+	60.00%+	48.39%
18–64 Years	NA	NA	NA
65 Years and Older	—	—	—
Total	**58.97%+**	**59.38%+**	**50.00%+**
30-Day Follow-Up			
6–17 Years	90.63%+	80.00%+	90.32%+
18–64 Years	NA	NA	NA
65 Years and Older	—	—	—
Total	**76.92%+**	**81.25%+**	**88.89%+**
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
20–44 Years	87.02%+	82.80%+	85.84%+
45–64 Years	NA	—	NA
65 Years and Older	—	—	—
Total	**86.67%+**	**82.80%**	**85.53%+**
Prenatal and Postpartum Care (PPC)			
Postpartum Care	83.85%	82.00%	80.05%
Utilization and Risk-Adjusted Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	73.88%+	76.15%+	72.57%+

Measure	BC	UHC	WLP
Child and Adolescent Well-Care Visits (WCV)			
3–11 Years	67.27%	65.28%	62.85%
12–17 Years	55.35%	53.41%	52.82%
18–21 Years	37.39%	34.51%	36.30%
Total	**60.92%**	**58.36%**	**56.94%**
Electronic Clinical Data Systems (ECDS)			
Breast Cancer Screening (BCS-E)			
Breast Cancer Screening	—	—	—

NA indicates that the MCO/PIHP followed the specifications for the measure indicator, but the denominator was too small (<30) to report a valid rate.
— Indicates that the MCO/PIHP reported a rate of zero or did not report a rate for the measure indicator.

Conclusions and Recommendations

- All TennCare MCOs' MY 2024 rates were above the MY 2024 Quality Compass national 75th percentile benchmark for the **Childhood Immunization Status (CIS)—DTaP**, **HepA**, **RV**, **Combination 3**, and **Combination 7** measure indicators. BC had MY 2024 rates above the national 75th percentile benchmark for all but one indicator (**Influenza**). WLP had MY 2024 rates above the national 75th percentile benchmark for all but two indicators (**MMR**, **VZV**). Lastly, UHC had eight **CIS** indicators with MY 2024 rates that were between the national 25th and 75th percentile benchmarks. These results suggest that the MCOs ensured that CHIP members had access to essential immunizations to protect against preventable diseases. [**Quality, Access**]
- All TennCare MCOs' MY 2024 rates were above the MY 2024 Quality Compass national 75th percentile benchmark for the **Cervical Cancer Screening (CCS)** measure. These results suggest that MCOs ensured that CHIP members had access to screenings to enable the detection and treatment of cervical cancer. [**Quality**]
- Excluding WLP, TennCare MCO's MY 2024 rates were above the MY 2024 Quality Compass national 75th percentile benchmark for the following **Asthma Medication Ratio (AMR)** age stratifications: **5–11 Years**, **12–18 Years**, and **Total**. These results suggest that MCOs effectively managed persistent asthma in enrolled CHIP members with the appropriate medications. [**Quality**]
- All TennCare MCOs' MY 2024 rates were above the MY 2024 Quality Compass national 75th percentile benchmark for the following **Follow-Up After Hospitalization for Mental Illness (FUH)** measure indicators: **7-Day Follow-Up—Total** and **30-Day Follow-Up—6–17 Years** and **Total.** WLP had a MY 2024 rate that was between the national 25th and 75th percentile benchmarks for the **7-Day Follow-Up—6–17 Years** indicator. These results suggest that the MCOs ensured that enrolled CHIP members received timely follow-up care after a mental health-related hospital inpatient stay. [**Quality, Timeliness, Access**]
- All TennCare MCOs' MY 2024 rates were above the MY 2024 Quality Compass national 75th percentile benchmark for the **Adults' Access to Preventive/Ambulatory Health Services (AAP)—**

20–44 Years measure indicator. BC and WLP had MY 2024 rates that were above the national 75th percentile benchmark for the **AAP—Total** indicator, while UHC had a MY 2024 rate that was between the national 25th and 75th percentile benchmarks for the **AAP—Total** indicator. These results suggest that the MCOs ensured that CHIP members had access to preventive services to reduce the potential for adverse healthcare events. [**Timeliness, Access**]

- All TennCare MCOs' MY 2024 rates were above the MY 2024 Quality Compass national 75th percentile benchmark for the **Well-Child Visits in the First 30 Months of Life (W30)—First 15 Months** measure indicator. These results suggest that MCOs effectively monitored the health of CHIP members during their first 15 months of life by ensuring regular well-child visits with PCPs. [**Quality, Access**]
- All TennCare MCOs' MY 2024 rates fell below the MY 2024 Quality Compass national 25th percentile benchmark for the following **Immunizations for Adolescents (IMA)** measure indicators: **Meningococcal**, **HPV**, **Combination 1**, and **Combination 2**. UHC had MY 2024 rates that were below the national 25th percentile benchmark for all **IMA** indicators. These results suggest that few adolescent CHIP members enrolled with the MCOs were receiving important immunizations to prevent adverse healthcare events. HSAG recommends that MCOs educate CHIP members to help them understand the importance of receiving preventive care and screenings. MCOs should remind providers to review preventive care measures for every patient, including children and adolescents, at every visit to ensure that CHIP members receive timely preventive health screenings. MCOs also could inform CHIP members through newsletters about the importance of timely immunizations for adolescents. Best practices that MCOs may consider piloting to improve immunization rates include offering member incentives, such as gift cards, for accessing timely preventive and immunization services. [**Quality**]

For additional information concerning HSAG's methodology for conducting HEDIS audits, see Appendix A. Methodologies for Conducting EQR Activities, HEDIS.

PDV

As the EQRO, HSAG conducted quarterly PDV surveys from Q4 2024 to Q3 2025. HSAG used the results of the activities to determine the accuracy of the provider data files submitted by the Medicaid MCCs and the extent to which providers are available to and accessible by Medicaid and CHIP members. For this activity, Tennessee MCCs included statewide MCOs—BC, UHC, WLP, the PIHP TCS, and the DBM DQ.

Table 3-55 through Table 3-64 present the accuracy and overall rates for 2024 and 2025 that HSAG reported for each data element reviewed for validation.[23] Of note, cells shaded in green with a + indicate that 2025 overall rates scored higher than 2024 overall rates, while cells shaded in red with a ^ indicate that 2025 overall rates scored lower than 2024 overall rates. Compared to the 2024 overall rate, eight data elements showed declines in 2025, including Active Contract Status, Provider Specialty/BH Service Code, Routine Care Services, Urgent Care Services, Services for Children, Services for Adults, Primary Care Services, and Prenatal Care Services. However, Provider Address and Provider Panel Status data elements experienced an increase in overall rates compared to 2024.

Table 3-55—Active Contract Status

MCC	Q4 2024	Q1 2025	Q2 2025	Q3 2025	2024 Overall	2025 Overall
BC	89.71%	90.14%	84.85%	88.00%	**90.19%^**	**88.17%^**
UHC	90.91%	94.29%	91.04%	90.43%	**90.65%+**	**91.67%+**
WLP	88.89%	84.21%	80.22%	88.31%	**86.38%^**	**85.41%^**
TCS	90.00%	87.10%	85.00%	90.00%	**88.44%^**	**88.02%^**
DQ	80.70%	80.47%	94.67%	91.72%	**90.54%^**	**86.89%^**
Overall	**88.08%**	**87.30%**	**87.99%**	**89.86%**	**89.51%^**	**88.31%^**

Table 3-56—Provider Address

MCC	Q4 2024	Q1 2025	Q2 2025	Q3 2025	2024 Overall	2025 Overall
BC	92.62%	92.97%	91.96%	94.55%	**89.12%+**	**93.03%+**
UHC	95.00%	91.92%	88.52%	87.50%	**82.78%+**	**90.74%+**
WLP	84.38%	90.63%	97.26%	92.65%	**76.87%+**	**91.23%+**
TCS	94.02%	88.89%	95.80%	94.02%	**79.41%+**	**93.18%+**

[23] 2024 overall rates include quarterly PDV results from Q4 2023 to Q3 2024, and 2024 overall rates include quarterly PDV results from Q4 2024 to Q3 2025.

MCC	Q4 2024	Q1 2025	Q2 2025	Q3 2025	2024 Overall	2025 Overall
DQ	95.65%	96.12%	96.25%	92.48%	94.75%+	95.12%+
Overall	**92.93%**	**92.23%**	**93.86%**	**92.29%**	85.60%+	92.83%+

Table 3-57—Provider Specialty/BH Service Code

MCC	Q4 2024	Q1 2025	Q2 2025	Q3 2025	2024 Overall	2025 Overall
BC	80.33%	82.81%	82.14%	80.00%	91.54%^	81.32%^
UHC	74.00%	74.75%	72.13%	76.92%	89.79%^	74.45%^
WLP	81.25%	70.31%	91.78%	86.76%	82.80%^	82.53%^
TCS	88.03%	84.26%	85.71%	88.89%	90.13%^	86.72%^
DQ	85.87%	90.29%	87.50%	89.47%	97.80%^	88.28%^
Overall	**82.02%**	**81.47%**	**83.45%**	**84.59%**	91.44%^	82.88%^

Table 3-58—Provider Panel Status

MCC	Q4 2024	Q1 2025	Q2 2025	Q3 2025	2024 Overall	2025 Overall
BC	86.07%	86.72%	92.86%	82.73%	87.90%^	87.09%^
UHC	85.00%	84.85%	95.08%	81.73%	80.01%+	86.67%+
WLP	78.13%	70.31%	89.04%	88.24%	85.26%^	81.43%^
TCS	88.89%	89.81%	86.55%	92.31%	87.90%+	89.39%+
DQ	96.74%	90.29%	92.50%	90.23%	88.04%+	92.44%+
Overall	**87.47%**	**85.66%**	**91.47%**	**87.22%**	86.02%+	87.95%+

Table 3-59—Routine Care Services

MCC	Q4 2024	Q1 2025	Q2 2025	Q3 2025	2024 Overall	2025 Overall
BC	64.75%	62.50%	56.25%	57.27%	80.77%^	60.19%^
UHC	69.00%	69.70%	73.77%	71.15%	78.86%^	70.91%^
WLP	73.44%	65.63%	63.01%	69.12%	77.81%^	67.80%^
TCS	61.54%	50.00%	52.10%	68.38%	79.35%^	58.00%^

MCC	Q4 2024	Q1 2025	Q2 2025	Q3 2025	2024 Overall	2025 Overall
DQ	59.78%	68.93%	70.00%	71.43%	83.26%^	67.54%^
Overall	**65.05%**	**62.95%**	**63.65%**	**67.48%**	**80.40%^**	**64.78%^**

Table 3-60—Urgent Care Services

MCC	Q4 2024	Q1 2025	Q2 2025	Q3 2025	2024 Overall	2025 Overall
BC	72.13%	69.53%	60.71%	49.09%	82.64%^	62.87%^
UHC	54.00%	53.54%	67.21%	48.08%	71.11%^	55.71%^
WLP	51.56%	42.19%	61.64%	50.00%	73.35%^	51.35%^
TCS	62.39%	56.48%	45.38%	55.56%	73.01%^	54.95%^
DQ	82.61%	80.58%	79.38%	74.44%	91.46%^	79.25%^
Overall	**65.45%**	**62.35%**	**64.16%**	**56.77%**	**79.11%^**	**62.18%^**

Table 3-61—Services for Children

MCC	Q4 2024	Q1 2025	Q2 2025	Q3 2025	2024 Overall	2025 Overall
BC	68.03%	75.78%	50.00%	51.82%	81.73%^	61.41%^
UHC	75.00%	56.57%	51.64%	67.31%	86.59%^	62.63%^
WLP	71.88%	73.44%	54.79%	57.35%	84.42%^	64.36%^
TCS	82.91%	87.04%	63.87%	66.67%	83.71%^	75.12%^
DQ	91.30%	97.09%	90.00%	89.47%	97.69%^	91.97%^
Overall	**77.78%**	**78.49%**	**64.68%**	**68.23%**	**87.40%^**	**72.29%^**

Table 3-62—Services for Adults

MCC	Q4 2024	Q1 2025	Q2 2025	Q3 2025	2024 Overall	2025 Overall
BC	85.00%	92.06%	96.55%	92.19%	94.53%^	91.45%^
UHC	94.44%	93.48%	93.22%	88.33%	92.39%^	92.37%^
WLP	83.87%	90.00%	92.11%	85.29%	88.17%^	87.82%^
TCS	92.31%	96.30%	90.76%	94.02%	91.05%+	93.34%+

MCC	Q4 2024	Q1 2025	Q2 2025	Q3 2025	2024 Overall	2025 Overall
DQ	72.46%	60.26%	65.22%	76.00%	72.37%^	68.48%^
Overall	**86.40%**	**85.97%**	**84.58%**	**87.20%**	89.22%^	86.04%^

Table 3-63—Primary Care Services

MCC	Q4 2024	Q1 2025	Q2 2025	Q3 2025	2024 Overall	2025 Overall
BC	90.98%	83.59%	92.79%	83.33%	92.21%^	87.68%^
UHC	90.91%	85.57%	91.67%	93.07%	88.95%+	90.30%+
WLP	75.00%	82.81%	90.41%	83.58%	86.46%^	82.95%^
TCS	90.60%	86.92%	87.18%	93.10%	92.96%^	89.45%^
Overall	**88.31%**	**84.85%**	**90.50%**	**88.78%**	90.80%^	88.11%^

Table 3-64—Prenatal Care Services

MCC	Q4 2024	Q1 2025	Q2 2025	Q3 2025	2024 Overall	2025 Overall
BC	92.62%	98.44%	98.20%	77.78%	94.31%^	91.76%^
UHC	98.99%	91.75%	95.00%	95.05%	93.25%+	95.20%+
WLP	90.63%	90.63%	98.63%	85.07%	92.71%^	91.24%^
TCS	96.58%	95.33%	98.29%	94.83%	96.84%^	96.26%^
Overall	**95.02%**	**94.70%**	**97.39%**	**88.52%**	94.76%^	93.91%^

Health Plan-Specific Conclusions and Recommendations

Drawing from the survey results, HSAG included the following MCC-specific conclusions and recommendations to evaluate and address potential provider data **quality** concerns.

BC

For 2025, BC had overall rates below 90 percent for all data elements except Provider Address, Services for Adults, and Prenatal Care Services.

UHC

For 2025, UHC had overall rates below 90 percent for Provider Specialty/BH Service Code, Routine Care Services, Provider Panel Status, Urgent Care Services, and Services for Children.

WLP

For 2025, WLP had overall rates below 90 percent for all data elements except Provider Address and Prenatal Care Services.

TCS

For 2025, TCS had overall rates below 90 percent for all data elements except Provider Address, Services for Adults, and Prenatal Care Services.

DQ

For 2025, DQ had overall rates below 90 percent for all data elements except Provider Address, Provider Panel Status, and Services for Children.

For additional information concerning HSAG's methodology for conducting PDV, see Appendix A. Methodologies for Conducting EQR Activities, PDV.

Secret Shopper Survey

As the contracted EQRO for TennCare, HSAG conducted quarterly secret shopper surveys among active and inactive providers. The Secret Shopper Survey evaluated access and availability of providers contracted with the Medicaid MCOs that serve TennCare Medicaid members. For details on the specialties included in the quarterly surveys, please refer to Appendix A. Methodologies for Conducting EQR Activities, Secret Shopper.

Using the MCO's provider enrollment files (PEFs), HSAG determined the accuracy of the managed care network information supplied to TennCare Medicaid members and ensured that the provider networks comply with appointment wait time standards (i.e., 30 calendar days).

HSAG assessed the following MCOs in the secret shopper activity: BC, UHC, and WLP.

Provider Data Accuracy

The following tables reflect the accuracy of key data elements throughout the survey process and display the percentage of cases with validated provider data. Table 3-65 and Table 3-66 summarize the Q4 2024 through Q3 2025 telephone survey call outcomes for active and inactive providers by MCO, in addition to the 2025 overall rates.[24]

[24] 2025 overall rates include quarterly Secret Shopper Survey results from Q4 2024 to Q3 2025.

The following are 2025 overall key findings related to provider data accuracy, and access and availability:

- Overall, callers were able to reach 72.73 percent of active providers and 71.01 percent of inactive providers.
- Among the cases that the callers reached, 81.71 percent of active providers and 77.52 percent of inactive providers confirmed the correct location.
- Among the cases that the callers reached, 69.44 percent of active providers and 59.61 percent of inactive providers offered the requested services.
- For inactive providers, 46.98 percent accepted TennCare Medicaid for the requested MCO.
- Of the cases that verified the provider data, 65.20 percent of active providers and 46.12 percent of inactive providers accepted new patients.
- Additionally, 36.66 percent of active providers and 23.40 percent of inactive providers offered a new patient appointment.
- Overall, the average wait time for an appointment with an active and inactive provider was 21 and 30 calendar days, respectively. Among the cases that offered an appointment, 84.09 percent of active provider cases and 67.04 percent of inactive provider cases were compliant with the wait time standards.

Table 3-65—Survey Call Outcomes for Active Providers

MCO/Provider Type	Able to Contact*	Correct Address Location**	Offering Requested Services**	Accepting New Patients**	Offering Appointment**
2024 Q4 Overall	**71.32%**	**70.10%**	**45.88%**	**45.36%**	**26.29%**
Cardiology	71.63%	70.30%	50.50%	50.50%	29.70%
Neurology	70.99%	69.89%	40.86%	39.78%	22.58%
BC	**77.08%**	**75.68%**	**54.05%**	**52.70%**	**22.97%**
Cardiology	78.05%	78.13%	59.38%	59.38%	28.13%
Neurology	76.36%	73.81%	50.00%	47.62%	19.05%
UHC	**64.65%**	**67.19%**	**40.63%**	**40.63%**	**18.75%**
Cardiology	71.19%	71.43%	42.86%	42.86%	19.05%
Neurology	55.00%	59.09%	36.36%	36.36%	18.18%
WLP	**72.73%**	**66.07%**	**41.07%**	**41.07%**	**39.29%**
Cardiology	65.85%	59.26%	51.85%	51.85%	48.15%
Neurology	80.56%	72.41%	31.03%	31.03%	31.03%
2025 Q1 Overall	**73.74%**	**75.76%**	**68.94%**	**68.18%**	**26.52%**
Oncology/Hematology	72.12%	78.67%	72.00%	72.00%	13.33%
Ophthalmology	76.00%	71.93%	64.91%	63.16%	43.86%
BC	**73.68%**	**75.00%**	**71.43%**	**71.43%**	**25.00%**
Oncology/Hematology	66.67%	83.33%	77.78%	77.78%	22.22%
Ophthalmology	90.91%	60.00%	60.00%	60.00%	30.00%

MCO/Provider Type	Able to Contact*	Correct Address Location**	Offering Requested Services**	Accepting New Patients**	Offering Appointment**
UHC	**72.41%**	**74.60%**	**73.02%**	**73.02%**	**22.22%**
Oncology/Hematology	74.07%	82.50%	80.00%	80.00%	10.00%
Ophthalmology	69.70%	60.87%	60.87%	60.87%	43.48%
WLP	**75.93%**	**78.05%**	**60.98%**	**58.54%**	**34.15%**
Oncology/Hematology	73.91%	64.71%	47.06%	47.06%	11.76%
Ophthalmology	77.42%	87.50%	70.83%	66.67%	50.00%
2025 Q2 Overall	**82.52%**	**94.12%**	**90.59%**	**78.82%**	**74.12%**
Chiropractic	84.95%	94.94%	93.67%	82.28%	78.48%
Neurosurgery	60.00%	83.33%	50.00%	33.33%	16.67%
BC	**85.19%**	**93.48%**	**89.13%**	**73.91%**	**69.57%**
Chiropractic	89.13%	95.12%	95.12%	80.49%	75.61%
Neurosurgery	62.50%	80.00%	40.00%	20.00%	20.00%
UHC	**80.77%**	**100.0%**	**95.24%**	**95.24%**	**90.48%**
Chiropractic	83.33%	100.0%	95.00%	95.00%	95.00%
Neurosurgery	50.00%	100.0%	100.0%	100.0%	0.00%
WLP	**78.26%**	**88.89%**	**88.89%**	**72.22%**	**66.67%**
Chiropractic	78.26%	88.89%	88.89%	72.22%	66.67%
Neurosurgery	NA	NA	NA	NA	NA
2025 Q3 Overall	**63.33%**	**86.84%**	**72.37%**	**68.42%**	**19.74%**
General Surgery	68.63%	85.71%	68.57%	65.71%	17.14%
Gastroenterology	58.18%	90.63%	78.13%	75.00%	25.00%
Nephrology	64.29%	77.78%	66.67%	55.56%	11.11%
BC	**64.44%**	**89.66%**	**65.52%**	**65.52%**	**20.69%**
General Surgery	72.73%	87.50%	56.25%	56.25%	12.50%
Gastroenterology	54.55%	91.67%	75.00%	75.00%	25.00%
Nephrology	100.0%	100.0%	100.0%	100.0%	100.0%
UHC	**58.14%**	**88.00%**	**80.00%**	**68.00%**	**32.00%**
General Surgery	50.00%	85.71%	85.71%	71.43%	42.86%
Gastroenterology	56.52%	92.31%	84.62%	76.92%	38.46%
Nephrology	83.33%	80.00%	60.00%	40.00%	0.00%
WLP	**68.75%**	**81.82%**	**72.73%**	**72.73%**	**4.55%**
General Surgery	80.00%	83.33%	75.00%	75.00%	8.33%
Gastroenterology	70.00%	85.71%	71.43%	71.43%	0.00%
Nephrology	42.86%	66.67%	66.67%	66.67%	0.00%
2025 Overall* **	**72.73%**	**81.71%**	**69.44%**	**65.20%**	**36.66%**

*The denominator includes all sampled providers.
**The denominator includes cases reached.
***2025 overall rates include quarterly Secret Shopper Survey results from Q4 2024 to Q3 2025.
N/A indicates "not applicable" as no active neurosurgeons were sampled for WLP due to the overlapping phone numbers among MCOs.

Table 3-66—Survey Call Outcomes for Inactive Providers

MCO/Provider Type	Able to Contact*	Correct Address Location**	Offering Requested Services**	Accepting Insurance**	Accepting New Patients**	Offering Appointment **
2024 Q4 Overall	**70.49%**	**72.34%**	**44.49%**	**40.19%**	**38.13%**	**15.89%**
Cardiology	76.44%	72.79%	56.07%	50.16%	48.52%	20.98%
Neurology	63.89%	71.74%	29.13%	26.96%	24.35%	9.13%
BC	**78.45%**	**81.87%**	**55.49%**	**50.55%**	**47.80%**	**14.84%**
Cardiology	81.75%	79.46%	61.61%	55.36%	53.57%	16.96%
Neurology	73.68%	85.71%	45.71%	42.86%	38.57%	11.43%
UHC	**68.85%**	**66.67%**	**42.26%**	**40.48%**	**38.10%**	**14.29%**
Cardiology	75.37%	68.32%	52.48%	50.50%	47.52%	17.82%
Neurology	60.91%	64.18%	26.87%	25.37%	23.88%	8.96%
WLP	**65.37%**	**68.11%**	**35.68%**	**29.73%**	**28.65%**	**18.38%**
Cardiology	71.88%	69.57%	53.26%	43.48%	43.48%	29.35%
Neurology	60.00%	66.67%	18.28%	16.13%	13.98%	7.53%
2025 Q1 Overall	**74.88%**	**81.40%**	**62.79%**	**54.15%**	**53.16%**	**37.21%**
Oncology/Hematology	64.44%	80.17%	56.90%	50.86%	50.00%	18.10%
Ophthalmology	83.33%	82.16%	66.49%	56.22%	55.14%	49.19%
BC	**74.65%**	**84.91%**	**59.43%**	**57.55%**	**55.66%**	**40.57%**
Oncology/Hematolo	62.30%	81.58%	42.11%	39.47%	36.84%	10.53%
Ophthalmology	83.95%	86.76%	69.12%	67.65%	66.18%	57.35%
UHC	**75.00%**	**76.32%**	**70.18%**	**57.89%**	**57.89%**	**37.72%**
Oncology/Hematolo	66.67%	78.85%	73.08%	67.31%	67.31%	28.85%
Ophthalmology	83.78%	74.19%	67.74%	50.00%	50.00%	45.16%
WLP	**75.00%**	**83.95%**	**56.79%**	**44.44%**	**43.21%**	**32.10%**
Oncology/Hematolo	63.41%	80.77%	46.15%	34.62%	34.62%	7.69%
Ophthalmology	82.09%	85.45%	61.82%	49.09%	47.27%	43.64%
2025 Q2 Overall	**73.86%**	**80.53%**	**68.14%**	**36.28%**	**36.28%**	**28.32%**
Chiropractic	88.24%	88.33%	85.00%	36.67%	36.67%	36.67%
Neurosurgery	62.35%	71.70%	49.06%	35.85%	35.85%	18.87%
BC	**78.38%**	**86.21%**	**82.76%**	**34.48%**	**34.48%**	**24.14%**
Chiropractic	93.33%	100.0%	100.0%	28.57%	28.57%	28.57%
Neurosurgery	68.18%	73.33%	66.67%	40.00%	40.00%	20.00%
UHC	**71.64%**	**79.17%**	**68.75%**	**31.25%**	**31.25%**	**29.17%**
Chiropractic	85.71%	83.33%	80.00%	26.67%	26.67%	26.67%
Neurosurgery	56.25%	72.22%	50.00%	38.89%	38.89%	33.33%
WLP	**73.47%**	**77.78%**	**55.56%**	**44.44%**	**44.44%**	**30.56%**
Chiropractic	88.89%	87.50%	81.25%	62.50%	62.50%	62.50%
Neurosurgery	64.52%	70.00%	35.00%	30.00%	30.00%	5.00%

MCO/Provider Type	Able to Contact*	Correct Address Location**	Offering Requested Services**	Accepting Insurance**	Accepting New Patients**	Offering Appointment **
2025 Q3 Overall	**64.82%**	**75.81%**	**63.01%**	**57.32%**	**56.91%**	**12.20%**
General Surgery	66.42%	73.21%	63.40%	59.62%	59.25%	11.32%
Gastroenterology	59.65%	81.37%	68.63%	55.88%	55.88%	19.61%
Nephrology	66.14%	76.80%	57.60%	53.60%	52.80%	8.00%
BC	**84.09%**	**83.78%**	**72.97%**	**69.73%**	**69.19%**	**11.35%**
General Surgery	87.50%	80.36%	75.89%	74.11%	74.11%	12.50%
Gastroenterology	72.22%	92.31%	57.69%	53.85%	53.85%	7.69%
Nephrology	83.93%	87.23%	74.47%	68.09%	65.96%	10.64%
UHC	**45.42%**	**70.54%**	**55.04%**	**48.84%**	**48.84%**	**16.28%**
General Surgery	47.06%	62.50%	48.44%	48.44%	48.44%	12.50%
Gastroenterology	40.54%	86.67%	76.67%	50.00%	50.00%	26.67%
Nephrology	47.30%	71.43%	48.57%	48.57%	48.57%	14.29%
WLP	**69.80%**	**71.35%**	**58.43%**	**50.56%**	**50.00%**	**10.11%**
General Surgery	65.93%	71.91%	58.43%	49.44%	48.31%	8.99%
Gastroenterology	75.41%	71.74%	69.57%	60.87%	60.87%	21.74%
Nephrology	72.88%	69.77%	46.51%	41.86%	41.86%	0.00%
2025 Overall* **	**71.01%**	**77.52%**	**59.61%**	**46.98%**	**46.12%**	**23.40%**

*The denominator includes all sampled providers.
**The denominator includes cases reached.
***2025 overall rates include quarterly Secret Shopper Survey results from Q4 2024 to Q3 2025.

Table 3-67 displays the average wait times, in calendar days, and percentage of appointments within the compliance standard for routine specialist visits. HSAG assessed appointment wait times using the 30-calendar-day standard for routine specialist visits.

Table 3-67—Average Wait Times and Appointment Compliance for Active and Inactive Providers

MCO/Provider Type	Average Wait Time (Calendar Days)		Appointment Compliance*	
	Active Providers	Inactive Providers	Active Providers	Inactive Providers
2024 Q4 Overall	**29**	**54**	**72.55%**	**45.88%**
Cardiology	21	40	73.33%	53.13%
Neurology	40	95	71.43%	23.81%
BC	**34**	**49**	**64.71%**	**55.56%**
Cardiology	25	32	66.67%	57.89%
Neurology	43	89	62.50%	50.00%
UHC	**29**	**60**	**83.33%**	**37.50%**
Cardiology	13	46	87.50%	50.00%
Neurology	61	104	75.00%	0.00%

MCO/Provider Type	Average Wait Time (Calendar Days)		Appointment Compliance*	
	Active Providers	Inactive Providers	Active Providers	Inactive Providers
WLP	**26**	**53**	**72.73%**	**44.12%**
Cardiology	24	43	69.23%	51.85%
Neurology	29	95	77.78%	14.29%
2025 Q1 Overall	**24**	**25**	**77.14%**	**71.43%**
Oncology/Hematology	13	25	80.00%	76.19%
Ophthalmology	29	25	76.00%	70.33%
BC	**10**	**31**	**85.71%**	**67.44%**
Oncology/Hematology	15	13	75.00%	100.00%
Ophthalmology	4	33	100.00%	64.10%
UHC	**38**	**20**	**64.29%**	**76.74%**
Oncology/Hematology	13	28	75.00%	66.67%
Ophthalmology	48	16	60.00%	82.14%
WLP	**18**	**24**	**85.71%**	**69.23%**
Oncology/Hematology	8	27	100.00%	100.00%
Ophthalmology	19	24	83.33%	66.67%
2025 Q2 Overall	**4**	**11**	**100.00%**	**87.50%**
Chiropractic	4	3	100.00%	100.00%
Neurosurgery	21	27	100.00%	60.00%
BC	**4**	**15**	**100.00%**	**71.43%**
Chiropractic	3	1	100.00%	100.00%
Neurosurgery	21	33	100.00%	33.33%
UHC	**4**	**15**	**100.00%**	**85.71%**
Chiropractic	4	5	100.00%	100.00%
Neurosurgery	NA	28	NA	66.67%
WLP	**3**	**3**	**100.00%**	**100.00%**
Chiropractic	3	3	100.00%	100.00%
Neurosurgery	NA	5	NA	100.00%
2025 Q3 Overall	**26**	**30**	**86.67%**	**63.33%**
General Surgery	9	21	100.00%	80.00%
Gastroenterology	40	31	75.00%	55.00%
Nephrology	17	57	100.00%	30.00%
BC	**55**	**32**	**66.67%**	**66.67%**
General Surgery	6	18	100.00%	85.71%
Gastroenterology	101	53	33.33%	50.00%
Nephrology	17	64	100.00%	20.00%
UHC	**5**	**33**	**100.00%**	**57.14%**
General Surgery	8	21	100.00%	75.00%
Gastroenterology	4	35	100.00%	50.00%

MCO/Provider Type	Average Wait Time (Calendar Days)		Appointment Compliance*	
	Active Providers	Inactive Providers	Active Providers	Inactive Providers
Nephrology	NA	50	NA	40.00%
WLP	**21**	**25**	**100.00%**	**66.67%**
General Surgery	21	26	100.00%	75.00%
Gastroenterology	NA	24	NA	60.00%
Nephrology	NA	NA	NA	NA
2025 Overall**	**21**	**30**	**84.09%**	**67.04%**

* The denominator includes cases that offered an appointment. Appointment compliance represents the rate of appointments within the compliance standard (i.e., within 30 calendar days for routine specialist appointments).
**2025 overall rates include quarterly Secret Shopper Survey results from Q4 2024 to Q3 2025.
NA indicates that no cases were evaluated on the specified measure.

Health Plan-Specific Conclusions

Drawing from the survey results, HSAG included the following MCO-specific recommendations to evaluate and address potential provider data **quality**, **timeliness**, and **access to care** concerns.

BC

Quarterly overall response rates for active and inactive providers ranged from 64.44 percent to 85.19 percent. Among the active provider cases reached, quarterly overall provider data accuracy rates (i.e., provider locations with correct location and offering the requested services) ranged from 54.05 percent to 89.13 percent. Similarly, among the inactive provider cases reached, quarterly overall provider data accuracy rates (i.e., provider locations with correct location, offering the requested services, and accepting the requested insurance) ranged from 34.48 percent to 69.73 percent, indicating data **quality** and **access to care** concerns. Additionally, quarterly overall new patient acceptance rates and appointment availability rates were below 74.00 percent. Among the appointments that were offered, overall appointment wait time compliance rates for active providers ranged from 64.71 percent to 100 percent, while the overall appointment wait time compliance rate for inactive providers ranged from 55.56 percent to 71.43 percent.

- BC should utilize the case-level data files containing the mismatched information between the PEFs and the provider office responses, and address the data deficiencies (e.g., addresses, provider specialty, new patient acceptance information, or incorrect or disconnected telephone numbers that do not correspond to the sampled provider location).
- Additionally, BC should consider conducting outreach to providers to ensure the providers and/or their offices routinely submit up-to-date information on all pertinent provider indicators (e.g., active providers, updated contact information, new patient and MCO TennCare Medicaid acceptance).
- BC should also review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff members on TennCare standards, and incorporate appointment availability standards into educational materials.

- BC should consider conducting a root cause analysis to determine what issues or office procedures may be causing appointment delays and whether additional guidance or standards may be necessary to reduce appointment wait times.

UHC

Quarterly overall response rates for active and inactive providers ranged from 45.42 percent to 80.77 percent. Among the active provider cases reached, quarterly overall provider data accuracy rates (i.e., provider locations with correct location and offering the requested services) ranged from 40.63 percent to 95.24 percent. Similarly, among the inactive provider cases reached, quarterly overall provider data accuracy rates (i.e., provider locations with correct location, offering the requested services, and accepting the requested insurance) ranged from 31.25 percent to 57.89 percent, indicating data **quality** and **access to care** concerns. With the exception of the 2025 Q2 overall rates for active providers, new patient acceptance rates ranged from 31.25 percent to 73.02 percent. Similarly, with the exception of the 2025 Q2 overall rate for active providers, appointment availability rates were below 38.00 percent. Among the appointments that were offered, appointment wait time compliance rates for active providers ranged from 64.29 percent to 100 percent, while the appointment wait time compliance rate for inactive providers ranged from 37.50 percent to 85.71 percent.

- UHC should utilize the case-level data files containing the mismatched information between the PEFs and the provider office responses, and address the data deficiencies (e.g., addresses, provider specialty, new patient acceptance information, or incorrect or disconnected telephone numbers that do not correspond to the sampled provider location).
- UHC should consider conducting outreach to providers to ensure the providers and/or their offices routinely submit up-to-date information on all pertinent provider indicators (e.g., active providers, updated contact information, new patient and MCO TennCare Medicaid acceptance).
- UHC should also review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff members on TennCare standards, and incorporate appointment availability standards into educational materials.
- UHC should consider conducting a root cause analysis to determine what issues or office procedures may be causing appointment delays and whether additional guidance or standards may be necessary to reduce appointment wait times.

WLP

Quarterly overall response rates for active and inactive providers ranged from 65.37 percent to 78.26 percent. Among the active provider cases reached, quarterly overall provider data accuracy rates (i.e., provider locations with correct location and offering the requested services) ranged from 41.07 percent to 88.89 percent. Similarly, among the inactive provider cases reached, quarterly overall provider data accuracy rates (i.e., provider locations with correct location, offering the requested services, and accepting the requested insurance) ranged from 29.73 percent to 50.56 percent, indicating data **quality** and **access to care** concerns. Additionally, quarterly overall new patient acceptance rates and appointment availability rates were below 73.00 percent. Among the appointments that were offered, overall appointment wait time compliance rates for active providers ranged from 72.73 percent to 100

percent, while the overall appointment wait time compliance rate for inactive providers ranged from 44.12 percent to 100 percent.

- WLP should utilize the case-level data files containing the mismatched information between the PEFs and the provider office responses, and address the data deficiencies (e.g., addresses, provider specialty, new patient acceptance information, or incorrect or disconnected telephone numbers that do not correspond to the sampled provider location).
- WLP should consider conducting outreach to providers to ensure the providers and/or their offices routinely submit up-to-date information on all pertinent provider indicators (e.g., active providers, updated contact information, new patient and MCO TennCare Medicaid acceptance).
- WLP should also review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff members on TennCare standards, and incorporate appointment availability standards into educational materials.
- WLP should consider conducting a root cause analysis to determine what issues or office procedures may be causing appointment delays and whether additional guidance or standards may be necessary to reduce appointment wait times.

For additional information concerning HSAG's methodology for conducting the Secret Shopper Survey, see Appendix A. Methodologies for Conducting EQR Activities, Secret Shopper.

BESMART Provider Survey

TennCare requests that the State's EQRO, HSAG, conduct a PDV survey of its network of medications for opioid use disorder (MOUD) providers. HSAG's subcontractor, Qsource, conducted the provider survey of the network, which TennCare renamed the BESMART program in 2021. The PDV's purpose was to determine accuracy of specified data for BESMART providers serving TennCare members with opioid addiction using approved Schedule III, IV, and V opioid medications or combinations of these medications. President Biden signed the Consolidated Appropriations Act on December 29, 2022, which went into effect on January 12, 2023, removing the previously implemented and surveyed Drug Addiction Treatment Act of 2000 Waiver program. The results of this survey can help further determine the extent to which providers are available to and accessible by TennCare members.

For this activity, the Medicaid MCOs that contracted BESMART providers included the statewide MCOs, BC, UHC, and WLP; and the statewide PIHP, TCS.

Results

Deduplication of the initial MCO files left 570 unique TennCare BESMART provider records. Of these, 285 providers completed all or part of the survey. Some of the responding providers offered invalid answers to some questions, which Qsource did not include in the analyses. Qsource also noted unavailable provider responses, which Table 3-68 summarizes below.

Table 3-68—Summary of Unavailable Provider Responses

Reason	Number
Provider changed practices, no longer employed by the practice, or deceased	40
Customer service representative (CSR) could not contact the provider by either email or telephone	171
Invalid provider telephone number	73
Not a BESMART Provider	1
Total Unavailable Provider Responses	**285**

The remainder of this section illustrates provider responses to survey questions about MCO or PIHP contract status, current BESMART provider network capacity, and current capacity to treat additional BESMART patients.

Table 3-69 and Table 3-70 display the information concerning the contract status of providers with the MCOs and the PIHP. Providers' answers to the number of contracting MCOs varied from zero to three. Providers' answers to the number of contracting PIHPs varied from zero to one.

Table 3-69—BESMART Network Provider Survey Results—Contract Status With MCOs/PIHP

BESMART Providers' Contract Status With MCOs/PIHP	Number of BESMART Providers
One MCO or the PIHP	7
Two MCOs or One MCO and the PIHP	21
Three MCOs or Two MCOs and the PIHP	77
All MCOs and the PIHP	180
Non-Contracted Status With Any MCO/PIHP	0

Table 3-70—BESMART Network Provider Survey Results—MCO and PIHP Contracts

BESMART Providers' Contract Status With Specific MCOs/PIHP	Number of BESMART Providers
BC	273
TCS	183
UHC	268
WLP	276

Of the BESMART providers with current/active contracts with TennCare MCOs and/or the PIHP, 273 indicated they had an active contract with BC; 268 indicated they had an active contract with UHC; 276 indicated they had an active contract with WLP; and 183 indicated they had an active contract with TCS.

Table 3-71 lists the number of BESMART patients currently being treated by the providers and the percentage of the providers' current maximum BESMART patient capacity.

Table 3-71—BESMART Network Provider Survey Results—Patient Capacity Utilization

Number of Patients	Percentage of the Providers' Patient Capacity
29	25.00% or less
30	25.01% to 50.00%
19	50.01% to 75.00%
30	75.01% to 100%

Note: 177 providers did not respond or gave invalid responses to this question.

The survey elicited provider responses regarding the number of currently treated BESMART patients.

Table 3-72 displays the number of Medicaid members treated by the providers as a percentage of the total patients for each provider.

Table 3-72—BESMART Network Provider Survey Results—Medicaid Patients

Number of Patients	Percentage of the Providers' Patient Capacity
50	25.00% or less
151	25.01% to 50.00%
22	50.01% to 75.00%
16	75.01% to 100%

Note: 46 providers did not respond or gave invalid responses to this question.

The survey elicited provider responses regarding the capability to expand their practice to reach their BESMART network maximum capacity.

Table 3-73 indicates the capacity for the providers to expand their practice to reach their BESMART network maximum capacity.

Table 3-73—BESMART Network Provider Survey Results—Ability of Providers to Expand the Number of BESMART Patients

Ability of Providers to Expand Their Number of BESMART Patients	Number of Provider Responses
Yes	202
No	78

Note: Five providers did not respond or gave invalid responses to this question.

The survey elicited provider responses regarding the capability to expand their practice to reach their BESMART network maximum capacity.

Table 3-74 defines the number of additional BESMART patients' providers indicated that they could add to their practice.

Table 3-74—BESMART Network Provider Survey Results—Additional Patient Capacity

Number of Providers	Percentage of Additional BESMART Patients That Could Be Added to Practice
26	25.00% or less
13	25.01% to 50.00%
5	50.01% to 75.00%
57	75.01% to 100%

Note: 184 providers did not respond or gave invalid responses to this question.

The survey elicited provider responses regarding the number of additional BESMART patient slots available for exclusive reservation for TennCare members.

Table 3-75 indicates the number of patient slots the providers reserved for TennCare members.

Table 3-75—BESMART Network Provider Survey Results—Slots Reserved for TennCare Members

Number of Providers	Patient Slots Reserved for TennCare Members
50	25.00% or less
21	25.01% to 50.00%
16	50.01% to 75.00%
136	75.01% to 100%

Note: 62 providers did not respond or gave invalid responses to this question.

For each of the TennCare MCOs with which providers contracted, the survey elicited responses regarding the number of slots available for BESMART services and to specify the percentage allocated to each MCO. Table 3-76 displays the provider survey results showing the number of additional BESMART patients the providers could add to their practice.

Table 3-76—BESMART Network Provider Survey Results—BESMART Patient Slots Available by MCO/PIHP

Slot for BESMART Services Available	Number of Slots
BC	
25.00% or less	135
25.01% to 50.00%	112
50.01% to 75.00%	5
75.01% to 100%	13
UHC	
25.00% or less	155
25.01% to 50.00%	95
50.01% to 75.00%	3
75.01% to 100%	8
WLP	
25.00% or less	146
25.01% to 50.00%	105
50.01% to 75.00%	3
75.01% to 100%	11
TCS	
25.00% or less	187
25.01% to 50.00%	5
50.01% to 75.00%	2
75.01% to 100%	8

Note: For BC, 20 records had a missing or invalid response For UHC, 24 records had a missing or invalid response. For WLP, 20 records had a missing or invalid response. For TCS, 83 records had a missing or invalid response.

For additional information concerning HSAG's methodology for conducting BESMART, see Appendix A. Methodologies for Conducting EQR Activities, BESMART Provider Survey.

4. Summary of Strengths and Opportunities for Improvement Concerning Quality, Timeliness of Care, and Access to Care Furnished for Each MCC

From the results of this year's plan-specific activities, HSAG summarizes each MCC's strengths and opportunities for improvement and provides an assessment and evaluation of the quality, timeliness of care, and access to care and services that each MCC provides. The evaluations are based on the following definitions of quality, timeliness, and access:

- **Quality**—CMS defines "quality" in the final rule at 42 CFR §438.320 as follows:

  Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in § 438.310[c][2]) increases the likelihood of desired outcomes of its enrollees through (1) its structural and operational characteristics, (2) the provision of services that are consistent with current professional, evidence-based-knowledge, and (3) interventions for performance improvement.[25]
- **Timeliness**—NCQA defines "timeliness" relative to utilization decisions as follows:

  "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[26] NCQA further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to members and that require a timely response from the MCC (e.g., processing expedited member appeals and providing timely follow-up care).
- **Access**—CMS defines "access" in the final rule at 42 CFR §438.320 as follows:

  Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).[27]

The CFR also requires that the EQR results include a description of how the data from all activities conducted in accordance with §438.358 were aggregated and analyzed and conclusions were drawn as to the **quality**, **timeliness**, and **access** to care furnished by the MCO, PIHP, or PAHP in §438.364(a)(1).[28] HSAG follows a three-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the **quality**, **timeliness**, and **access** to care furnished by each MCC.

First, HSAG analyzes the quantitative results obtained from each EQR activity for each MCC to identify strengths and weaknesses in each domain— **quality**, **timeliness**, and **access** —related to the care and

[25] U. S. Government Publishing Office. (2024). **Electronic Code of Federal Regulations.** Available at: eCFR :: 42 CFR 438.320 -- Definitions. Accessed on: Feb 9, 2026.
[26] NCQA. **2023 Standards and Guidelines for the Accreditation of Health Plans**. Washington, DC: The NCQA; 2023: UM5.
[27] U. S. Government Publishing Office. (2024). **Electronic Code of Federal Regulations**. Definitions. Available at: eCFR :: 42 CFR 438.320 -- Definitions. Accessed on: Feb 9, 2026.
[28] U. S. Government Publishing Office. (2024). **Electronic Code of Federal Regulations**. External quality review results. Available at: eCFR :: 42 CFR 438.364 -- External quality review results. Accessed on: Feb 9, 2026.

services furnished by the MCC for the EQR activity. Second, from the information collected, HSAG identifies common themes and the salient patterns that emerge across EQR activities for each domain and draws conclusions about the overall **quality**, **timeliness**, and **access** to care and services furnished by the MCC. Lastly, HSAG identifies any patterns and commonalities that exist across the program to draw aggregated conclusions about the **quality**, **timeliness**, and **access** to care for the program.

The following sections of this report include the strengths and opportunities for improvement and provide an assessment and evaluation of the **quality**, **timeliness**, and **access** to care for each MCC by activity. That information is followed by a section that identifies common themes and patterns that emerged across the EQR activities for the MCC and includes the aggregated strengths and weaknesses that affect **quality**, **timeliness**, and **access** to care for the TennCare members.

BC

AQS Compliance Review

The AQS review included a review of documents and interviews with BC staff members to determine compliance with State and federal requirements. The extensive document review occurred pre-audit, during the audit, and post-audit to ensure that HSAG reviewed all available information to satisfy the audit requirements. Interviews with BC staff members assisted in clarifying HSAG's outstanding questions and obtained information needed to assign scores for the review.

Table 4-1 displays the detailed scores for each of the standards included in BC's 2025 AQS compliance review. The listing of total elements, total applicable elements (i.e., number of elements with the not applicable [NA] elements removed), **Met** elements, and **Not Met** elements provide details concerning the final score for each standard. Based on the overall score achieved by BC, HSAG established a level of confidence rating for this year's compliance review as defined below:

- 90%–100%: High confidence in the MCO's compliance with State and federal requirements
- 80%–89%: Moderate confidence in the MCO's compliance with State and federal requirements
- 70%–79%: Low confidence in the MCO's compliance with State and federal requirements
- Under 70%: No confidence in the MCO's compliance with State and federal requirements

Table 4-1—2025 AQS Compliance Review Scores for BC

Standard Name	Total Elements	Total Applicable Elements	Met	Partially Met	Not Met	Score*
Coordination and Continuity of Care	12	12	12	0	0	100%
Emergency and Poststabilization Services	9	9	9	0	0	100%
Practice Guidelines	6	6	6	0	0	100%

Standard Name	Total Elements	Total Applicable Elements	Met	Partially Met	Not Met	Score*
Health Information Systems	8	8	8	0	0	100%
Quality Assessment and Performance Improvement (QAPI) Program	6	6	6	0	0	100%
Enrollment and Disenrollment: Requirements and Limitations	12	12	12	0	0	100%
EPSDT	24	23	23	0	0	100%
Overall Score	**77**	**76**	**76**	**0**	**0**	**100%**
Confidence Level	**High**					

* A **Met** score equals 1.0 point, and a **Not Met** score equals 0.0 points.
Total Elements: The total number of elements in each standard.
Total Applicable Elements: The total number of elements within the standard, after removing nonapplicable elements.

BC obtained 100 percent compliance on every standard included in the 2025 AQS compliance review and achieved a **High Confidence** level for the review. HSAG commends BC for achieving 100 percent compliance on the seven standards and 76 applicable elements included in the 2025 AQS compliance review. The MCO submitted written documentation to support the State and federal requirements, and interviews with staff members confirmed their understanding and correct implementation of those requirements. Achieving 100 percent compliance in these areas improved the **quality**, **timeliness**, and **accessibility of care** for members.

HSAG identified one suggestion concerning the EPSDT standard:

- EPSDT—Element #18 required that if a member under 16 years of age is seeking BH TennCare Kids services and the member's parent(s) or legally appointed representative is unable to accompany the member to the examination, the MCO shall require that its providers either contact the member's parent(s) or legally appointed representative to discuss the findings and inform the family of any other necessary healthcare, diagnostic services, treatment, or other measures recommended for the member or notify the MCO to contact the parent(s) or legally appointed representative with the results. HSAG suggests that BC review internal documents to ensure that the process for monitoring provider compliance with the requirements is clearly outlined.

BC achieved 100 percent compliance with the Transition of CHOICES Members Between MCOs and CHOICES Annual LOC Assessments file reviews. Achieving 100 percent compliance in these areas improved the **quality**, **timeliness**, and **accessibility of care** for CHOICES members. Table 4-2displays the detailed scores for the 2025 AQS File Reviews.

Table 4-2—Scores Achieved in the File Reviews Included in the CY 2025 AQS Compliance Review

File Review	Total Files Requested/ Reviewed	Total Applicable Elements	Number of Files Containing Required Element		Score[2]
			Met[1]	Not Met[1]	
Transition of CHOICES Members Between MCOs	10/10	29	29	0	100%
CHOICES Annual LOC Assessment	10/10	20	20	0	100%
Overall File Review Score	**20/20**	**49**	**49**	**0**	**100%**

[1] A **Met** score equals 1.0 point, and a **Not Met** score equals 0.0 points.
[2] The overall score is the number of **Met** elements divided by the number of total applicable elements.

TennCare required the MCCs to submit a CAP for any element in the AQS that received a score of less than 100 percent. Because BC achieved 100 percent compliance with the standards and file reviews, the MCO was not required to submit a CAP.

PIPs

For CY 2025, BC submitted the following PIPs: **LTSS Reassessment/Care Plan Update After Inpatient Discharge (RAC)** and **Improving Glycemic Status Assessment for Patients with Diabetes (GSD) <8.0%**. BC received **Met** validation scores for 100 percent of all applicable evaluation elements validated for the **Improving Glycemic Status Assessment for Patients with Diabetes (GSD) <8.0%** PIP and received a **High Confidence** level rating for both the overall confidence of adherence to acceptable methodology for all phases of the PIP and confidence that the PIP achieved significant improvement. For the **LTSS Reassessment/Care Plan Update After Inpatient Discharge (RAC)** PIP, BC received a **High Confidence** level rating for the overall confidence of adherence to acceptable methodology for all phases of the PIP, and a **Low Confidence l**evel rating for the overall confidence that the PIP achieved significant improvement. HSAG did not identify any opportunities for improvement.

PMV

The review of BC's FAR and IDSS reports confirmed that BC was audited in compliance with HEDIS requirements. BC fully complied with HEDIS IS standards and used an NCQA-certified measure vendor to calculate its HEDIS measures for MY 2024. BC received an **R** audit designation for most of its HEDIS measures and did not offer the benefit necessary for reporting on the HEDIS measure **Oral Evaluation, Dental Services**.

NAV

For each evaluation item for each provider type, a performance score was determined by calculating the percentage of the actual point value that the MCO achieved based on the applicable CRA standard. Table 4-3 presents a high-level summary of the scores for the Network Adequacy portion of the ANA audit.

Table 4-3—Summary of Statewide Network Adequacy Scores for BC

Evaluation Area	Total Items	Lowest Performance Score	Percentage Achieving 100% Score	Score[1]
PCPs	8	100%	100%	100%
SCPs[2]	36	100%	100%	100%
BH Providers	5	100%	100%	100%
Opioid Use Disorder Treatment Providers	1	100%	100%	100%
General Optometry and Hospitals	2	99.99%	50.00%	>99.99%
Essential Hospital Services and COEs	7	100%	100%	100%
Health Promotion Strategies	1	100%	100%	100%
CHOICES Providers	11	43.16%	81.82%	94.68%
ECF CHOICES Providers	17	100%	100%	100%
Overall Network Adequacy Score	**88**	**43.16%**	**96.59%**	**99.33%**

[1]Average of the performance scores for items in each evaluation area.

[2] HSAG based the overall score on the combination of scores for Standard 1 (75 percent of members within 60 miles travel distance and ≤90 minutes travel time) and Standard 2 (100 percent of members within 90 miles travel distance and ≤120 minutes travel time). However, because Standard 1 is based on 75 percent of the non-dual members, HSAG adjusted, or weighted, the Standard 1 score to the total population. This adjusted score was combined with the Standard 2 score to obtain the overall score.

Table 4-3 shows that BC achieved total compliance with the availability and geographic accessibility standards, except for General Optometry and Hospitals and CHOICES Providers.

BC received a score of 100 percent for general optometry, but did not meet the standard for hospitals for some members (less than 0.1 percent).

BC received a score of 100 percent in all CHOICES provider categories except adult day care providers and pest control. All members (i.e., 100 percent) in urban areas had access within the adult day care distance/time standard, compared to 97.27 percent of members in suburban areas and 98.50 percent of members in rural areas. Of the 95 counties in Tennessee, BC reported that only 41 counties had at least two pest control providers.

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 130 indicators for BC. Of these indicators, 100 percent received ratings of **High Confidence**. Table 4-4 summarizes HSAG's validation results.

Table 4-4—Summary of BC's Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Provider Capacity Indicators	100%	0%	0%	0%
Ratio Indicators	100%	0%	0%	0%
Time/Distance Indicators	100%	0%	0%	0%

HSAG evaluated and assessed the data methods used by BC to calculate results generated for each network adequacy indicator in scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that BC used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator. HSAG determined that data collection procedures and network adequacy methods in place at BC and TennCare, and network adequacy results calculated by TennCare were **Acceptable**.

Recommendations

After reviewing materials submitted by BC, the administrative data analyses (including distance analyses, ratio analyses, county analyses, and complaint analyses), HSAG concluded the following recommendations:

- BC must ensure that all counties have access to at least two CHOICES pest control service providers. Based on the current submitted data, only members in 41 of 95 counties (43.16 percent) have access to at least two pest control providers in their counties.
- BC must ensure that all members have access to hospitals within the TennCare required travel distance and travel time standards.
- BC must ensure that all members have access to adult day care providers within the TennCare required travel distance and travel time standards.

BC established a robust process to maintain the accuracy and completeness of provider information through its attestation process, which included reminders sent to providers to update their information within the Council for Affordable Quality Healthcare (CAQH) system. Additionally, all providers go through a review of credentialing every three years. BC demonstrated strong oversight of their delegated entities by conducting quarterly reviews that included an evaluation of each of the delegated entities credentialing and recredentialing data and an audit of their systems. TennCare maintained robust processes for collecting and reviewing the provider data from BC. HSAG did not identify specific opportunities for improvement related to the data collection and management processes BC had in place to inform network adequacy reporting.

ANA

This section presents the results of all ANA-related activities for BC and includes requirements for members who receive services from the TennCare Medicaid program, CoverKids, CHOICES HCBS program, and the ECF CHOICES program.

The ANA activities included a summary of BC's statewide network adequacy scores as previously presented in Table 4-3 in the NAV section of this report. In addition to the network adequacy review, the ANA activities also include a statewide benefit delivery score for BC.

Table 4-5 presents the percentage scores for the six areas used to determine the effectiveness of the MCO's delivery of covered benefits. The overall Benefit Delivery score was the average score for the total of these six measures.

Table 4-5—Summary of BC's Statewide Benefit Delivery Scores[1]

Measure	Score
Benefit Delivery—Accessibility: Member	100%
Benefit Delivery—Accessibility: Provider	100%
Network Availability and Accessibility	100%
Appointment Availability—MCO Complaints	99.97%
MCO Provider Contracts File Review Results—Quantity	100%
MCO Provider Contracts File Review Results—Quality	100%
Overall Benefit Delivery Score	**>99.99%**

[1] HSAG obtained the information in this table from the analysis of policies and procedures, contracts, complaint files, member handbooks, provider manual, and virtual review interviews.

BC achieved a rate of >99.99 percent on its overall benefit delivery score. The lowest score, 99.97 percent, represents the rate for statewide complaints by comparing the total number of access and availability complaints to the total BC population.

Recommendations

After reviewing materials submitted by BC (including policies and procedures; newsletters; member handbooks; provider manuals; and a sample of provider contracts), administrative data analyses (including a travel distance and travel time analysis; ratio analysis; county analysis; and complaint analysis), and interviews with BC's staff members, HSAG made the following recommendations:

- BC must ensure that all counties have access to at least two CHOICES pest control service providers. Based on the current submitted data, only members in 41of 95 counties (43.16 percent) have access to at least two pest control providers in their counties.
- BC must ensure that all members have access to hospitals within the TennCare required travel distance and travel time standards.
- BC must ensure that all members have access to adult day care providers within the TennCare required travel distance and travel time standards.

CAHPS

One of the MY 2024 measure scores representing the **quality of care** domain (i.e., **Rating of All Health Care**) for BC's adult Medicaid population were statistically significantly lower than the MY 2023 measure scores, while one measure rate representing the **quality of care** domain (i.e., **Rating of Personal Doctor**) for BC's general child Medicaid population was statistically significantly lower than the MY 2023 measure score.

To improve CAHPS rates related to **quality of care** domain, BC could consider including information about the CAHPS survey ratings in provider communications, including reminders about the importance of improving communication with patients from different cultures, handling challenging patient encounters, and emphasizing patient-centered communication for members.

HEDIS

IS Review Results

Table 4-6 identifies the key elements used by BC while conducting its MY 2024 HEDIS Compliance Audit. These key elements were reviewed by HSAG during validation activities. A checkmark in Table 4-6 indicates that the LO reviewed the HEDIS activities, which confirmed that HEDIS methodology was being followed. Some activities are identified as being compliant by inserting the name of the company with which BC contracted to perform the required tasks.

Table 4-6—Validation Activities for BC

Licensed Organization	Dunwoody Technology Services Group, LLC
Pre-on-site Visit Call/Meeting	✓
Roadmap Review	✓
Software Vendor	Cotiviti, Inc.
Source Code/HEDIS Certified Measures[29] Review	✓
Survey Vendor	Press Ganey
CAHPS Sample Frame Validation	✓
Supplemental Data Validation	✓
Medical Record Review	✓
IDSS Review	✓

[29] HEDIS Certified Measures[SM] is a service mark of the NCQA.

In addition to ensuring that data were captured, reported, and presented in a uniform manner, HSAG evaluated BC's IS capabilities for accurate HEDIS reporting. HSAG reviewed BC's FAR for its LO's assessment of IS capabilities, specifically focused on those aspects of BC's system that could have impacted reporting on HEDIS performance measures.

The LO evaluated BC's compliance with the IS standards outlined in the **HEDIS MY 2024 Volume 5 HEDIS Compliance Audit: Standards, Policies and Procedures**. These standards detail the minimum requirements that BC's information systems should meet to report HEDIS performance measures. For circumstances in which a particular IS standard was not met, the LO rated the impact on HEDIS reporting capabilities and, specifically, any measure that could be impacted. BC may not be fully compliant with several of the IS standards but may still be able to report the selected measures.

Table 4-7 provides a summary of BC's key findings for each IS standard as noted in its FAR.

Table 4-7—Summary of Compliance With IS Standards for BC

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2024 FARs Review
IS R—Data Management and Reporting • IS R1—The organization's data management enables measurement. • IS R2—Data extraction and loads are complete and accurate. • IS R3—Data transformation and integration is accurate and valid. • IS R4—Data quality and governance are components of the organization's data management. • IS R5—Oversight and controls ensure correct implementation of measure reporting software. • IS R6—Cybersecurity practices are in place to promote protection and resiliency of the systems and data used for measurement.	• BC was compliant with IS Standard R for Data Management and Reporting. • The LO determined that BC had procedures in place so that all data elements required for HEDIS reporting were adequately captured. • The LO determined that the MCO had policies and procedures in place for validation of data extraction, transformation, and integration. • The LO determined that BC was compliant for the standard for oversight and controls that ensure correct implementation of measure reporting software. • The LO determined that BC had practices in place to promote protection and resiliency of systems and data. • Adequate validation processes were in place, ensuring data accuracy.
IS C—Clinical and Care Delivery Data • IS C1—Data capture is complete. • IS C2—Data conform with industry standards. • IS C3—Transaction file data are accurate. • IS C4—Organization confirms ingested data meet expectations for data quality.	• BC was compliant with IS Standard C for Clinical and Care Delivery Data. • The LO determined that BC had policies and procedures in place for submitted data that conform with industry standards. • Adequate validation processes were in place, ensuring data accuracy and quality.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2024 FARs Review
IS M—Medical Record Review Processes • IS M1—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 M2—Retrieval and abstraction of data from medical records is reliably and accurately performed. • IS M3—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 M4—The organization continually assesses data completeness and takes steps to improve performance. • IS M5—The organization regularly monitors vendor performance against expected performance standards.	• BC was compliant with IS Standard M for MRR Processes. • The LO determined that the data collection tool used by the MCO was able to capture all data fields necessary for HEDIS reporting. • Sufficient validation processes were in place to ensure data accuracy.
IS A—Administrative Data • IS A1—Data conform with industry standards and measure requirements. • IS A2—Data are complete and accurate. • IS A3—Membership information system enables measurement.	• BC was compliant with IS Standard A for Administrative Data. • The LO determined that the MCO appropriately validated that data conform with industry standards and measure requirements. • The LO reviewed the membership information system to ensure that it appropriately enables measurement. • Sufficient validation processes were in place to ensure that data are accurate and complete.

HEDIS Results—Medicaid Population

Table 4-8 presents BC's HEDIS performance on measures specified in TennCare's Quality Strategy and indicates whether the reported rate is below the MY 2024 NCQA Quality Compass National 25th percentile benchmark, between the 25th percentile and 75th percentile benchmarks, or above the 75th percentile benchmark.

Table 4-8—HEDIS MY 2024 Medicaid Plan-Specific Results on Measures Included in TennCare's Quality Strategy

Color Designation	National Percentile Achieved	Additional Comments
Green Shading+	Greater than 75th percentile	No additional comments
No Shading	25th to 75th percentile	No additional comments
Red Shading^	Less than 25th percentile	No additional comments
Gray Shading○	No rating available	Benchmarking data not available

Measure	BC
Effectiveness of Care: Prevention and Screening	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	
BMI Percentile Documentation	
3–11 Years	85.65%
12–17 Years	83.19%
Total	**84.76%**
Counseling for Nutrition	
3–11 Years	78.95%
12–17 Years	76.47%
Total	**78.05%**
Counseling for Physical Activity	
3–11 Years	69.86%
12–17 Years	74.79%
Total	**71.65%**
Childhood Immunization Status (CIS)	
DTaP	76.16%
IPV	88.32%
MMR	87.83%
HiB	87.59%
HepB	90.27%

Measure	BC
VZV	87.83%
PCV	77.13%
HepA	86.37%
RV	75.67%+
Influenza	32.60%
Combination 3	72.99%+
Combination 7	65.69%+
Combination 10	29.20%
Immunizations for Adolescents (IMA)	
Meningococcal	77.86%
Tdap	86.86%
HPV	36.01%
Combination 1	77.86%
Combination 2	34.55%
Cervical Cancer Screening (CCS)	
Cervical Cancer Screening	61.48%
Effectiveness of Care: Respiratory Conditions	
Asthma Medication Ratio (AMR)	
5–11 Years	73.86%
12–18 Years	74.66%+
19–50 Years	68.87%+
51–64 Years	71.52%
Total	**72.68%+**
Effectiveness of Care: Cardiovascular Conditions	
Controlling High Blood Pressure (CBP)	
Controlling High Blood Pressure	76.28%+
Effectiveness of Care: Diabetes	
Eye Exam for Patients With Diabetes (EED)	
Eye Exam for Patients With Diabetes	55.21%
Blood Pressure Control (<140/90 mmHg) for Patients With Diabetes (BPD)	
Blood Pressure Control (<140/90 mmHg) for Patients With Diabetes	76.82%+

Measure	BC
Kidney Health Evaluation for Patients With Diabetes (KED)	
18–64 Years	37.16%
65–75 Years	52.01%
76–85 Years	53.88%
Total	**38.81%**
Effectiveness of Care: Behavioral Health	
Follow-Up After Hospitalization for Mental Illness (FUH)	
7-Day Follow-Up	
6–17 Years	48.04%
18–64 Years	38.53%
65 Years and Older	29.41%
Total	**42.39%**
30-Day Follow-Up	
6–17 Years	69.70%
18–64 Years	60.79%
65 Years and Older	56.86%
Total	**64.46%**
Access/Availability of Care	
Adults' Access to Preventive/Ambulatory Health Services (AAP)	
20–44 Years	81.99%+
45–64 Years	88.81%+
65 Years and Older	96.34%+
Total	**84.38%+**
Prenatal and Postpartum Care (PPC)	
Postpartum Care	81.36%
Utilization and Risk-Adjusted Utilization	
Well-Child Visits in the First 30 Months of Life (W30)	
First 15 Months	72.53%+
Child and Adolescent Well-Care Visits (WCV)	
3–11 Years	69.31%+
12–17 Years	58.15%

Measure	BC
18–21 Years	34.66%
Total	**61.70%+**
Electronic Clinical Data Systems (ECDS)	
Breast Cancer Screening (BCS-E)	
Breast Cancer Screening	55.35%
Long-Term Services and Supports (LTSS)	
Comprehensive Assessment and Update (LTSS-CAU)	
Assessment of Core Elements	98.54%+
Assessment of Supplemental Elements	98.54%+
Comprehensive Care Plan and Update (LTSS-CPU)	
Care Plan With Core Elements Documented	98.05%+
Care Plan With Supplemental Elements Documented	98.05%+
Reassessment/Care Plan Update After Inpatient Discharge (LTSS-RAC)	
Reassessment After Inpatient Discharge	60.34%
Reassessment and Care Plan Update After Inpatient Discharge	55.47%
Shared Care Plan With Primary Care Practitioner (LTSS-SCP)	
Shared Care Plan With Primary Care Practitioner	90.75%+

The following HEDIS performance measures were a strength for BC in MY 2024:

- BC's rates on the following **Childhood Immunization Status (CIS)** measure indicators were above the MY 2024 Quality Compass national 75th percentile benchmark: **RV**, **Combination 3**, and **Combination 7**. These results suggest that BC ensured that child members had access to essential immunizations to protect against preventable diseases. [**Quality, Access**]
- BC's rates on the **Asthma Medication Ratio (AMR)** measure were above the MY 2024 Quality Compass national 75th percentile benchmark for three of the four age stratifications: **12–18 Years**, **19–50 Years**, and **Total**. These results suggest that BC effectively managed asthma in child and adult members with appropriate medications. [**Quality**]
- BC's rate on the **Controlling High Blood Pressure (CBP)** measure was above the MY 2024 Quality Compass national 75th percentile benchmark. This result suggests that BC was effective in helping enrolled members manage their high blood pressure to prevent adverse events. [**Quality, Timeliness**]
- BC's rate on the **Blood Pressure Control (<140/90 mmHg) for Patients With Diabetes (BPD)** measure was above the MY 2024 Quality Compass national 75th percentile benchmark. This result suggests that BC was effective at monitoring and managing adult members' diabetes, as well as monitoring the health impacts of diabetes. [**Quality**]

- BC's MY 2024 rates on the **Adults' Access to Preventive/Ambulatory Health Services (AAP)** measure were above the MY 2024 Quality Compass national 75th percentile benchmark for all age stratifications and **Total**. These results suggest that BC ensured that its adult members had timely access to preventive healthcare services to reduce the potential for adverse healthcare events. [**Timeliness, Access**]
- BC's MY 2024 rate on the **Well-Child Visits in the First 30 Months of Life (W30)—First 15 Months** measure indicator was above the MY 2024 Quality Compass national 75th percentile benchmark. This result suggests that BC effectively monitored the health of members during the first 15 months of life by ensuring regular well-child visits with PCPs. [**Quality, Access**]
- BC's MY 2024 rates on the **Child and Adolescent Well-Care Visits (WCV)—3–11 Years** and **Total** measure indicators were above the MY 2024 Quality Compass national 75th percentile benchmark. This result suggests that BC effectively monitored and influenced the health and development of enrolled child and adolescent members by ensuring regular well-care visits with PCPs. [**Quality, Access**]
- BC's MY 2024 rates on the following LTSS measures were above the MY 2024 Quality Compass national 75th percentile benchmark: **Comprehensive Assessment and Update (LTSS-CAU)**, **Comprehensive Care Plan and Update (LTSS-CPU)**, and **Shared Care Plan With Primary Care Practitioner (LTSS-SCP)**. These results suggest that BC had effective processes in place to ensure that members' care plans reflected their current long-term support needs and to inform PCPs of any updates to members' care plans. [**Quality**]

Based on MY 2024 results, BC did not report rates that fell below the MY 2024 Quality Compass national 25th percentile benchmark on any HEDIS measure included in TennCare's Quality Strategy.

HEDIS Results—CHIP Population

Table 4-9 presents BC's rates on HEDIS performance measures specified in TennCare's Quality Strategy and indicates whether the reported rate is below the MY 2024 NCQA Quality Compass National 25th percentile benchmark, between the 25th percentile and 75th percentile benchmarks, or above the 75th percentile benchmark.

Table 4-9—HEDIS MY 2024 CHIP Plan-Specific Results on Measures Included in TennCare's Quality Strategy

Color Designation	National Percentile Achieved	Additional Comments
Green Shading+	Greater than 75th percentile	No additional comments
No Shading	25th to 75th percentile	No additional comments
Red Shading^	Less than 25th percentile	No additional comments
Gray Shading○	No rating available	Benchmarking data not available

Measure	BC
Effectiveness of Care: Prevention and Screening	
Weight Assessment and Counseling for Nutrition and Physical Activity or Children/Adolescents (WCC)	
BMI Percentile Documentation	
3–11 Years	82.94%
12–17 Years	81.06%
Total	**82.29%**
Counseling for Nutrition	
3–11 Years	72.62%
12–17 Years	71.21%
Total	**72.14%**
Counseling for Physical Activity	
3–11 Years	71.03%
12–17 Years	71.21%
Total	**71.09%**
Childhood Immunization Status (CIS)	
DTaP	81.82%+
IPV	91.77%+
MMR	89.18%+
HiB	89.18%+
HepB	91.34%+
VZV	89.18%+
PCV	84.85%+
HepA	88.74%+
RV	78.35%+
Influenza	38.96%
Combination 3	80.09%+
Combination 7	71.00%+
Combination 10	36.80%+
Immunizations for Adolescents (IMA)	
Meningococcal	75.56%^
Tdap	86.67%
HPV	22.47%^

Measure	BC
Combination 1	75.31%^
Combination 2	22.47%^
Cervical Cancer Screening (CCS)	
Cervical Cancer Screening	76.16%+
Effectiveness of Care: Respiratory Conditions	
Asthma Medication Ratio (AMR)	
5–11 Years	91.67%+
12–18 Years	83.87%+
19–50 Years	NA
51–64 Years	—
Total	**88.24%+**
Effectiveness of Care: Cardiovascular Conditions	
Controlling High Blood Pressure (CBP)	
Controlling High Blood Pressure	NA
Effectiveness of Care: Diabetes	
Eye Exam for Patients With Diabetes (EED)	
Eye Exam for Patients With Diabetes	NA
Blood Pressure Control (<140/90 mmHg) for Patients With Diabetes (BPD)	
Blood Pressure Control (<140/90 mmHg) for Patients With Diabetes	NA
Kidney Health Evaluation for Patients With Diabetes (KED)	
18–64 Years	NA
65–75 Years	—
76–85 Years	—
Total	**NA**
Effectiveness of Care: Behavioral Health	
Follow-Up After Hospitalization for Mental Illness (FUH)	
7-Day Follow-Up	
6–17 Years	68.75%+
18–64 Years	NA
65 Years and Older	—
Total	**58.97%+**

Measure	BC
30-Day Follow-Up	
6–17 Years	90.63%+
18–64 Years	NA
65 Years and Older	—
Total	**76.92%+**
Access/Availability of Care	
Adults' Access to Preventive/Ambulatory Health Services (AAP)	
20–44 Years	87.02%+
45–64 Years	NA
65 Years and Older	—
Total	**86.67%+**
Prenatal and Postpartum Care (PPC)	
Postpartum Care	83.85%
Utilization and Risk-Adjusted Utilization	
Well-Child Visits in the First 30 Months of Life (W30)	
First 15 Months	73.88%+
Child and Adolescent Well-Care Visits (WCV)	
3–11 Years	67.27%
12–17 Years	55.35%
18–21 Years	37.39%
Total	**60.92%**
Electronic Clinical Data Systems (ECDS)	
Breast Cancer Screening (BCS-E)	
Breast Cancer Screening	—

NA indicates that the MCO followed the specifications for the measure indicator, but the denominator was too small (<30) to report a valid rate.
— Indicates that the MCO reported a rate of zero or did not report a rate for the measure indicator.

The following HEDIS performance measures were a strength for BC in MY 2024:

- BC's MY 2024 rates were above the MY 2024 Quality Compass national 75th percentile benchmark for the following **Childhood Immunization Status (CIS)** measure indicators: **DTaP**, **IPV**, **MMR**, **HiB**, **HepB**, **VZV**, **PCV**, **HepA**, **RV**, **Combination 3**, **Combination 7**, and **Combination 10**. These results suggest that BC ensured that its CHIP members had access to essential immunizations to protect against preventable diseases. [**Quality, Access**]

- BC's MY 2024 rates were above the MY 2024 Quality Compass national 75th percentile benchmark for the **Cervical Cancer Screening (CCS)** measure. These results suggest that BC ensured that its CHIP members had access to screenings to enable the detection and treatment of cervical cancer. [**Quality**]
- BC's MY 2024 rates were above the MY 2024 Quality Compass national 75th percentile benchmark for the following **Asthma Medication Ratio (AMR)** age stratifications: **5–11 Years**, **12–18 Years**, and **Total.** These results suggest that BC effectively managed persistent asthma in enrolled CHIP members with the appropriate medications. [**Quality**]
- BC's MY 2024 rates were above the MY 2024 Quality Compass national 75th percentile benchmark for the following **Follow-Up After Hospitalization for Mental Illness (FUH)** measure indicators: **7-Day Follow-Up—6–17 Years** and **Total**; and **30-Day Follow-Up—6–17 Years** and **Total.** These results suggest that BC ensured that enrolled CHIP members received timely follow-up care after a mental health-related hospital inpatient stay. [**Quality, Timeliness, Access**]
- BC's MY 2024 rates were above the MY 2024 Quality Compass national 75th percentile benchmark for the **Adults' Access to Preventive/Ambulatory Health Services (AAP)—20–44 Years** and **Total** measure indicators. These results suggest that BC ensured that CHIP members had access to preventive services to reduce the potential for adverse healthcare events. [**Timeliness, Access**]
- BC's MY 2024 rate was above the MY 2024 Quality Compass national 75th percentile benchmark for the **Well-Child Visits in the First 30 Months of Life (W30)—First 15 Months** measure indicator. This result suggests that BC effectively monitored the health of CHIP members during their first 15 months of life by ensuring regular well-child visits with PCPs. [**Quality, Access**]

Based on MY 2024 results, opportunities existed for BC to improve its performance on the following HEDIS measures:

- BC's MY 2024 rates fell below the MY 2024 Quality Compass national 25th percentile benchmark for the following **Immunizations for Adolescents (IMA)** measure indicators: **Meningococcal**, **HPV**, **Combination 1**, and **Combination 2**. These results suggest that few adolescent CHIP members enrolled with BC were receiving important immunizations to prevent adverse healthcare events. HSAG recommends that BC educate CHIP members to help them understand the importance of receiving preventive care and screenings. BC should remind providers to review preventive care measures for every patient, including children and adolescents, at every visit to ensure that CHIP members receive timely preventive health screenings. BC also could inform CHIP members through newsletters about the importance of timely immunizations for adolescents. Best practices that BC may consider piloting to improve immunization rates include offering member incentives, such as gift cards, for accessing timely preventive and immunization services. [**Quality**]

PDV

Table 4-10 presents the overall rates HSAG reported for each data element reviewed for validation. Of note, cells highlighted in green with a + indicate that 2025 overall rates scored higher than 2024 overall rates, while cells highlighted in red with a ^ indicate that 2025 overall rates scored lower than 2024 overall rates.

Table 4-10—Overall Accuracy Results for BC

Data Element	2025 Overall	2024 Overall
Active Contract Status	88.17%^	90.19%^
Provider Address	93.03%+	89.12%+
Provider Specialty/BH Service Code	81.32%^	91.54%^
Provider Panel Status	87.09%^	87.90%^
Routine Care Services	60.19%^	80.77%^
Urgent Care Services	62.87%^	82.64%^
Services for Children	61.41%^	81.73%^
Services for Adults	91.45%^	94.53%^
Primary Care Services	87.68%^	92.21%^
Prenatal Care Services	91.76%^	94.31%^

Strengths

For 2025, Provider Address, Services for Adults, and Prenatal Care Services resulted in overall rates greater than 90 percent.

Opportunities for Improvement

For 2025, Active Contract Status, Provider Specialty/BH Service Code, Provider Panel Status, Routine Care Services, Urgent Care Services, Services for Children, and Primary Care Services resulted in overall rates below 90 percent, indicating data **quality** concerns.

Recommendation

To address the provider data **quality** concerns, HSAG recommends that BC utilize the case-level data files containing mismatched information between the PEFs and the provider office responses, and address the data deficiencies (e.g., provider specialty/BH service code, provider panel, or incorrect or disconnected telephone numbers that do not correspond to the sampled provider). Additionally, BC

should consider conducting outreach to providers to ensure the providers and/or their offices routinely submit up-to-date information on all pertinent provider indicators (e.g., active contract status, updated contact information, and panel status).

Secret Shopper Survey

The following sections provide information concerning BC's strengths identified during the Secret Shopper study and opportunities in addressing provider data **quality**, **timeliness**, and **access to care** concerns.

Strengths

Among the active provider cases reached for Q2 2025, 93.48 percent confirmed the address was correct. Similarly, of the active provider cases that offered appointments in Q2 2025, 100 percent of cases were compliant with the appointment wait time standard (i.e., 30 calendar days).

Opportunities for Improvement

Quarterly overall response rates for active and inactive providers ranged from 64.44 percent to 85.19 percent. Among the active provider cases reached, quarterly overall provider data accuracy rates (i.e., provider locations with correct location and offering the requested services) ranged from 54.05 percent to 89.13 percent. Similarly, among the inactive provider cases reached, quarterly overall provider data accuracy rates (i.e., provider locations with correct location, offering the requested services, and accepting the requested insurance) ranged from 34.48 percent to 69.73 percent, indicating data **quality** and **access to care** concerns. Additionally, quarterly overall new patient acceptance rates and appointment availability rates were below 74.00 percent. With the exception of 2025 Q2, overall appointment wait time compliance rates for active providers ranged from 64.71 percent to 85.71 percent. Also, the overall appointment wait time compliance rate for inactive providers ranged from 55.56 percent to 71.43 percent.

UHC

AQS Compliance Review

The AQS review included a review of documents and interviews with UHC staff members to determine compliance with State and federal requirements. The extensive document review occurred pre-audit, during the audit, and post-audit to ensure that HSAG reviewed all available information to satisfy the audit requirements. Interviews with UHC staff members assisted in clarifying HSAG's outstanding questions and obtained information needed to assign scores for the review.

Table 4-11 displays the detailed scores for each of the standards included in UHC's 2025 AQS compliance review. The listing of total elements, total applicable elements (i.e., number of elements with the not applicable [NA] elements removed), **Met** elements, and **Not Met** elements provide details concerning the final score for each standard. Based on the overall score achieved by UHC, HSAG established a level of confidence rating for this year's compliance review as defined below:

- 90%–100%: High confidence in the MCO's compliance with State and federal requirements
- 80%–89%: Moderate confidence in the MCO's compliance with State and federal requirements
- 70%–79%: Low confidence in the MCO's compliance with State and federal requirements
- Under 70%: No confidence in the MCO's compliance with State and federal requirements

Table 4-11—2025 AQS Compliance Review Scores for UHC

Standard Name	Total Elements	Total Applicable Elements	Met	Partially Met	Not Met	Score*
Coordination and Continuity of Care	12	12	12	0	0	100%
Emergency and Poststabilization Services	9	9	9	0	0	100%
Practice Guidelines	6	6	6	0	0	100%
Health Information Systems	8	8	8	0	0	100%
Quality Assessment and Performance Improvement (QAPI) Program	6	6	6	0	0	100%
Enrollment and Disenrollment: Requirements and Limitations	12	12	12	0	0	100%
EPSDT	24	24	24	0	0	100%
Overall Score	**77**	**77**	**77**	**0**	**0**	**100%**
Confidence Level	**High**					

* A **Met** score equals 1.0 point, and a **Not Met** score equals 0.0 points.
Total Elements: The total number of elements in each standard.
Total Applicable Elements: The total number of elements within the standard, after removing nonapplicable elements.

UHC obtained 100 percent compliance on every standard included in the 2025 AQS compliance review and achieved a level of **High Confidence** for the review. HSAG commends UHC for achieving 100 percent compliance on the seven standards and 77 elements included in the 2025 AQS compliance review. The MCO submitted written documentation to support the State and federal requirements, and interviews with staff members confirmed their understanding and correct implementation of those requirements. Achieving 100 percent compliance in these areas improved the **quality**, **timeliness**, and **accessibility of care** for members.

HSAG identified one suggestion concerning the EPSDT standard:

- EPSDT—Element #18 required that if a member under 16 years of age is seeking BH TennCare Kids services and the member's parent(s) or legally appointed representative is unable to accompany the member to the examination, the MCO shall require that its providers either contact the member's parent(s) or legally appointed representative to discuss the findings and inform the family of any other necessary healthcare, diagnostic services, treatment, or other measures recommended for the member or notify the MCO to contact the parent(s) or legally appointed representative with the results. HSAG suggests that UHC include evaluation elements related to this requirement on the BH clinical record audit tool.

UHC achieved 100 percent compliance with the Transition of CHOICES Members Between MCOs and CHOICES Annual LOC Assessments file reviews. Achieving 100 percent compliance in these areas improved the **quality**, **timeliness**, and **access to care** for CHOICES members. Table 4-12 shows the detailed scores for the 2025 AQS File Reviews.

Table 4-12—Scores Achieved in the File Reviews Included in the CY 2025 AQS Compliance Review

File Review	Total Files Requested/ Reviewed	Total Applicable Elements	Number of Files Containing Required Element		Score[2]
			Met[1]	Not Met[1]	
Transition of CHOICES Members Between MCOs	10/10	33	33	0	100%
CHOICES Annual LOC Assessment	10/10	20	20	0	100%
Overall File Review Score	**20/20**	**53**	**53**	**0**	**100%**

[1] A **Met** score equals 1.0 point, and a **Not Met** score equals 0.0 points.
[2] The overall score is the number of **Met** elements divided by the number of total applicable elements.

TennCare required the MCCs to submit a CAP for any element in the AQS that received a score of less than 100 percent. Because UHC achieved 100 percent compliance with the standards and file reviews, the MCO was not required to submit a CAP.

PIPs

For CY 2025, UHC submitted the following PIPs: **Follow-Up After Emergency Department (ED) Visit for Mental Illness 7-Day (FUM) and Long-Term Services and Supports Reassessment/Care Plan Update After Inpatient Discharge (LTSS–RAC)**. UHC received **Met** validation scores for 100 percent of all applicable evaluation elements validated for the **LTSS Reassessment/Care Plan Update After Inpatient Discharge (LTSS–RAC)** PIP and received a **High Confidence** level rating for both the overall confidence of adherence to acceptable methodology for all phases of the PIP and confidence that the PIP achieved significant improvement. For the **Follow-Up After ED Visit for Mental Illness 7-Day (FUM)** PIP, UHC received a **High Confidence** level rating for the overall confidence of adherence to acceptable methodology for all phases of the PIP, and a **Moderate Confidence** level rating for the overall confidence that the PIP achieved significant improvement.

PMV

The review of UHC's FAR and IDSS reports confirms that UHC was audited in compliance with HEDIS requirements. UHC fully complied with HEDIS IS standards and used an NCQA-certified measure vendor to calculate its HEDIS measures for MY 2024. UHC received an **R** audit designation for all its HEDIS measures.

NAV

For each evaluation item for each provider type, a performance score was determined by calculating the percentage of the actual point value that the MCO achieved based on the applicable CRA standard. Table 4-13 presents a high-level summary of the scores for the Network Adequacy portion of the ANA audit.

Table 4-13—Summary of Statewide Network Adequacy Scores for UHC

Evaluation Area	Total Items	Lowest Performance Score	Percentage Achieving 100% Score	Score[1]
PCPs	8	99.94%	87.50%	99.99%
SCPs[2]	36	100%	100%	100%
BH Providers	5	100%	100%	100%
Opioid Use Disorder Treatment Providers	1	100%	100%	100%
General Optometry and Hospitals	2	99.89%	50.00%	99.95%
Essential Hospital Services and COEs	7	100%	100%	100%
Health Promotion Strategies	1	100%	100%	100%
CHOICES Providers	11	35.79%	81.82%	94.00%

Evaluation Area	Total Items	Lowest Performance Score	Percentage Achieving 100% Score	Score[1]
ECF CHOICES Providers	17	100%	100%	100%
Overall Network Adequacy Score	**88**	**35.79%**	**95.45%**	**99.25%**

[1]Average of the performance scores for items in each evaluation area.
[2] HSAG based the overall score on the combination of scores for Standard 1 (75 percent of members within 60 miles travel distance and ≤90 minutes travel time) and Standard 2 (100 percent of members within 90 miles travel distance and ≤120 minutes travel time). However, because Standard 1 is based on 75 percent of the non-dual members, HSAG adjusted, or weighted, the Standard 1 score to the total population. This adjusted score was combined with the Standard 2 score to obtain the overall score

Table 4-13 shows that UHC achieved total compliance with the availability and geographic accessibility standards, except for the PCP, General Optometry and Hospitals, and CHOICES Providers categories.

UHC received a score of 100 percent for all PCP provider types except for the Suburban/Rural OB/GYN provider type, for which UHC did not meet the standard for some members (less than 0.1 percent). UHC achieved compliance with the provider ratio standards for OB/GYNs. UHC also achieved 100 percent compliance with the OB/GYN travel distance and travel time standards for members with urban addresses.

UHC received a score of 100 percent for general optometry, but did not meet the standard for hospitals for 0.11 percent of members.

UHC received a score of 100 percent in all CHOICES provider categories, except for Adult Day Care Providers, which received a statewide score of 98.23 percent, and Pest Control, which received a statewide score of 35.79 percent. All members (i.e., 100 percent) in urban areas had access within the travel distance and travel time standard for Adult Day Care Providers, compared to 97.15 percent of members in suburban areas and 98.46 percent of members in rural areas.

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 130 indicators for UHC. Of these indicators, 100 percent received ratings of **High Confidence**. Table 4-14 summarizes HSAG's validation results.

Table 4-14—Summary of UHC's Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Provider Capacity	100%	0%	0%	0%
Ratio Indicators	100%	0%	0%	0%
Time/Distance Indicators	100%	0%	0%	0%

HSAG evaluated and assessed the data methods used by UHC to calculate results generated for each network adequacy indicator in scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that UHC used an acceptable methodology for

all phases of design, data collection, analysis, and interpretation of the network adequacy indicator. HSAG determined that data collection procedures and network adequacy methods in place at UHC and TennCare, and network adequacy results calculated by TennCare were **Acceptable.**

Recommendations

After reviewing materials submitted by UHC, the administrative data analyses (including distance analyses, ratio analyses, county analyses, and complaint analyses), HSAG concluded the following recommendations:

- UHC must ensure that all female members older than 13 years of age have access to an OB/GYN within the TennCare required travel distance and travel time standards.
- UHC must ensure that all members have access to hospitals within the TennCare required travel distance and travel time standards.
- UHC must ensure that all members have access to adult day care providers within the TennCare required travel distance and travel time standards.
- UHC must ensure that all counties have access to at least two CHOICES pest control service providers. Based on the submitted data, only members in 34 of 95 counties (35.79 percent) have access to at least two pest control providers in their counties.

UHC established robust processes to keep provider data up to date and accurate through their quarterly attestation reminder emails and the user interface elements alerting them of a 90-day attestation cycle. TennCare maintained robust processes for collecting and reviewing the provider data from UHC. TennCare also used sound and consistent methodologies to assess all network adequacy indicators. HSAG did not identify specific opportunities related to the data collection and management processes UHC had in place to inform network adequacy reporting. TennCare maintained robust processes for collecting and reviewing the provider data from UHC. HSAG did not identify specific opportunities for improvement related to the data collection and management processes UHC had in place to inform network adequacy reporting.

ANA

This section presents the results of all ANA-related activities for UHC and includes requirements for members who receive services from the TennCare Medicaid program, CoverKids, CHOICES HCBS program, and the ECF CHOICES program.

The ANA activities included a summary of UHC's statewide network adequacy scores as previously presented in Table 4-13 in the NAV section of this report. In addition to the network adequacy review, the ANA activities also include a statewide benefit delivery score for UHC.

Table 4-15 presents the percentage scores for the six areas used to determine the effectiveness of the MCO's delivery of covered benefits. The overall Benefit Delivery score was the average score for the total of these six measures.

Table 4-15—Summary of UHC's Statewide Benefit Delivery Scores[1]

Measure	Score
Benefit Delivery—Accessibility: Member	100%
Benefit Delivery—Accessibility: Provider	100%
Network Availability and Accessibility	100%
Appointment Availability—MCO Complaints	99.98%
MCO Provider Contracts File Review Results—Quantity	95.00%
MCO Provider Contracts File Review Results—Quality	95.00%
Overall Benefit Delivery Score	**98.33%**

[1] HSAG obtained the information in this table from the analysis of policies and procedures, contracts, complaint files, member handbooks, provider manual, and virtual review interviews.

UHC achieved a rate of 98.33 percent on its overall benefit delivery score. The lowest score, 95.00 percent, represents quantity and quality elements of the provider contracts file review.

Recommendations

After reviewing materials submitted by UHC (including policies and procedures, newsletters, member handbooks, provider manuals, and a sample of provider contracts), administrative data analyses (including a travel distance and travel time analysis, ratio analysis, county analysis, and complaint analysis), and interviews with UHC's staff members, HSAG made the following recommendations that could improve the **quality**, **timeliness**, and **access to care** for members:

- UHC must ensure that there is a valid contract for every provider on the network.
- UHC must ensure that all female members older than 13 years of age have access to an OB/GYN within the TennCare required travel distance and travel time standards.
- UHC must ensure that all members have access to hospitals within the TennCare required travel distance and travel time standards.
- UHC must ensure that all members have access to adult day care providers within the TennCare required travel distance and travel time standards.
- UHC must ensure that all counties have access to at least two CHOICES pest control service providers. Based on the submitted data, only members in 34 of 95 counties (35.79 percent) have access to at least two pest control providers in their counties.

CAHPS

One of the MY 2024 measure scores for the general child CHIP population was statistically significantly lower than the MY 2023 measure score; therefore, HSAG recommends that UHC focus **quality of care** improvement efforts on the **Rating of Health Plan** measure.

To improve CAHPS rates related to **quality of care**, UHC could consider including information about the CAHPS survey results in provider communications, including reminders about the importance of improving communication with patients from different cultures, handling challenging patient encounters, and emphasizing patient-centered communication for members.

HEDIS

IS Review Results

Table 4-16 identifies the key elements used by UHC while conducting its MY 2024 HEDIS Compliance Audit. These key elements were reviewed by HSAG during validation activities. A checkmark in Table 4-16 indicates that the LO reviewed the HEDIS activities, which confirmed that HEDIS methodology was being followed. Some activities are identified as being compliant by inserting the name of the company with which UHC contracted to perform the required tasks.

Table 4-16—Validation Activities for UHC

Licensed Organization	Attest Health Care Advisors
Pre-on-site Visit Call/Meeting	✓
Roadmap Review	✓
Software Vendor	Not Reported
Source Code/HEDIS Certified Measures Review	✓
Survey Vendor	Press Ganey
CAHPS Sample Frame Validation	✓
Supplemental Data Validation	✓
Medical Record Review	✓
IDSS Review	✓

In addition to ensuring that data were captured, reported, and presented in a uniform manner, HSAG evaluated UHC's IS capabilities for accurate HEDIS reporting. HSAG reviewed UHC's FAR for its LO's assessment of IS capabilities, specifically focused on those aspects of UHC's system that could have impacted reporting on HEDIS performance measures.

The LO evaluated UHC's compliance with IS standards outlined in the **HEDIS MY 2024 Volume 5 HEDIS Compliance Audit: Standards, Policies and Procedures**. These standards detail the minimum requirements that UHC's information systems should meet to report HEDIS performance measures. For circumstances in which a particular IS standard was not met, the LO rated the impact on HEDIS reporting capabilities and, specifically, any measure that could be impacted.

Table 4-17 provides a summary of UHC's key findings for each IS standard as noted in its FAR.

Table 4-17—Summary of Compliance With IS Standards for UHC

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2024 FARs Review
IS R—Data Management and Reporting • IS R1—The organization's data management enables measurement. • IS R2—Data extraction and loads are complete and accurate. • IS R3—Data transformation and integration is accurate and valid. • IS R4—Data quality and governance are components of the organization's data management. • IS R5—Oversight and controls ensure correct implementation of measure reporting software. • IS R6—Cybersecurity practices are in place to promote protection and resiliency of the systems and data use for measurement.	• UHC was compliant with IS Standard R for Data Management and Reporting. • The LO determined that UHC had procedures in place so that all data elements required for HEDIS reporting were adequately captured. • The LO determined that the MCO had policies and procedures in place for validation of data extraction, transformation, and integration. • The LO determined that UHC was compliant for the standard for oversight and controls that ensure correct implementation of measure reporting software. • The LO determined that UHC had practices in place to promote protection and resiliency of systems and data. • Adequate validation processes were in place, ensuring data accuracy.
IS C—Clinical and Care Delivery Data • IS C1—Data capture is complete. • IS C2—Data conform with industry standards. • IS C3—Transaction file data are accurate. • IS C4—Organization confirms ingested data meet expectations for data quality.	• UHC was compliant with IS Standard C for Clinical and Care Delivery Data. • The LO determined that UHC had policies and procedures in place for submitted data that conform with industry standards. • Adequate validation processes were in place, ensuring data accuracy and quality.
IS M—Medical Record Review Processes • IS M1—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).	• UHC was compliant with IS Standard M for MRR Processes. • The LO determined that the data collection tool used by the MCO was able to capture all data fields necessary for HEDIS reporting. • Sufficient validation processes were in place to ensure data accuracy.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2024 FARs Review
• IS M2—Retrieval and abstraction of data from medical records is reliably and accurately performed. • IS M3—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 M4—The organization continually assesses data completeness and takes steps to improve performance. • IS M5—The organization regularly monitors vendor performance against expected performance standards.	
IS A—Administrative Data • IS A1—Data conform with industry standards and measure requirements. • IS A2—Data are complete and accurate. • IS A3—Membership information system enables measurement.	• UHC was compliant with IS Standard A for Administrative Data. • The LO determined that the MCO appropriately validated that data conform with industry standards and measure requirements. • The LO reviewed the membership information system to ensure that it appropriately enables measurement. • Sufficient validation processes were in place to ensure that data are accurate and complete.

HEDIS Results—Medicaid Population

Table 4-18 presents UHC's rates on HEDIS performance measures specified in TennCare's Quality Strategy and indicates whether the reported rate is below the MY 2024 NCQA Quality Compass National 25th percentile benchmark, between the 25th percentile and 75th percentile benchmarks, or above the 75th percentile benchmark.

Table 4-18—HEDIS MY 2024 Medicaid Plan-Specific Results on Measures Included in TennCare's Quality Strategy

Color Designation	National Percentile Achieved	Additional Comments
Green Shading+	Greater than 75th percentile	No additional comments
No Shading	25th to 75th percentile	No additional comments
Red Shading^	Less than 25th percentile	No additional comments
Gray Shading○	No rating available	Benchmarking data not available

Measure	UHC
Effectiveness of Care: Prevention and Screening	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	
BMI Percentile Documentation	
3–11 Years	81.18%
12–17 Years	76.28%^
Total	**79.32%**
Counseling for Nutrition	
3–11 Years	59.61%^
12–17 Years	47.44%^
Total	**54.99%^**
Counseling for Physical Activity	
3–11 Years	52.94%^
12–17 Years	43.59%^
Total	**49.39%^**
Childhood Immunization Status (CIS)	
DTaP	74.21%
IPV	87.83%
MMR	84.43%
HiB	84.43%
HepB	88.81%
VZV	85.16%
PCV	73.97%
HepA	84.67%
RV	71.53%
Influenza	32.12%
Combination 3	70.56%
Combination 7	62.04%
Combination 10	26.28%
Immunizations for Adolescents (IMA)	
Meningococcal	74.21%^
Tdap	84.43%
HPV	34.79%

Measure	UHC
Combination 1	73.72%^
Combination 2	34.55%
Cervical Cancer Screening (CCS)	
Cervical Cancer Screening	54.01%
Effectiveness of Care: Respiratory Conditions	
Asthma Medication Ratio (AMR)	
5–11 Years	73.44%
12–18 Years	69.50%
19–50 Years	59.58%
51–64 Years	52.58%^
Total	**67.00%**
Effectiveness of Care: Cardiovascular Conditions	
Controlling High Blood Pressure (CBP)	
Controlling High Blood Pressure	68.61%
Effectiveness of Care: Diabetes	
Eye Exam for Patients With Diabetes (EED)	
Eye Exam for Patients With Diabetes	60.83%
Blood Pressure Control (<140/90 mmHg) for Patients With Diabetes (BPD)	
Blood Pressure Control (<140/90 mmHg) for Patients With Diabetes	72.99%
Kidney Health Evaluation for Patients With Diabetes (KED)	
18–64 Years	39.84%
65–75 Years	51.54%
76–85 Years	53.46%
Total	**42.10%**
Effectiveness of Care: Behavioral Health	
Follow-Up After Hospitalization for Mental Illness (FUH)	
7-Day Follow-Up	
6–17 Years	53.78%
18–64 Years	38.07%
65 Years and Older	28.21%
Total	**42.04%**

Measure	UHC
30-Day Follow-Up	
6–17 Years	77.71%
18–64 Years	59.81%
65 Years and Older	44.44%
Total	**64.21%**
Access/Availability of Care	
Adults' Access to Preventive/Ambulatory Health Services (AAP)	
20–44 Years	80.48%
45–64 Years	88.46%+
65 Years and Older	96.00%+
Total	**84.76%+**
Prenatal and Postpartum Care (PPC)	
Postpartum Care	80.78%
Utilization and Risk-Adjusted Utilization	
Well-Child Visits in the First 30 Months of Life (W30)	
First 15 Months	70.51%+
Child and Adolescent Well-Care Visits (WCV)	
3–11 Years	66.75%
12–17 Years	57.02%
18–21 Years	31.68%
Total	**59.63%**
Electronic Clinical Data Systems (ECDS)	
Breast Cancer Screening (BCS-E)	
Breast Cancer Screening	53.86%
Long-Term Services and Supports (LTSS)	
Comprehensive Assessment and Update (LTSS-CAU)	
Assessment of Core Elements	91.97%
Assessment of Supplemental Elements	91.00%
Comprehensive Care Plan and Update (LTSS-CPU)	
Care Plan With Core Elements Documented	90.75%
Care Plan With Supplemental Elements Documented	90.51%

Measure	UHC
Reassessment/Care Plan Update After Inpatient Discharge (LTSS-RAC)	
Reassessment After Inpatient Discharge	51.58%
Reassessment and Care Plan Update After Inpatient Discharge	49.15%
Shared Care Plan With Primary Care Practitioner (LTSS-SCP)	
Shared Care Plan With Primary Care Practitioner	85.64%

The following HEDIS performance measures were a strength for UHC in MY 2024:

- UHC's MY 2024 rates on the **Adults' Access to Preventive/Ambulatory Health Services (AAP)** measure were above the MY 2024 Quality Compass national 75th percentile benchmark for two of the three age stratifications specified: **45–64 Years and 65 Years and Older**. These results suggest that UHC ensured that its adult members had timely access to preventive healthcare services to reduce the potential for adverse healthcare events. [**Timeliness, Access**]
- UHC's MY 2024 rate on the **Well-Child Visits in the First 30 Months of Life (W30)—First 15 Months** measure indicator was above the MY 2024 Quality Compass national 75th percentile benchmark. This result suggests that UHC effectively monitored the health of members during the first 15 months of life by ensuring regular well-child visits with PCPs. [**Quality, Access**]

Based on MY 2024 results, opportunities existed for UHC to improve its performance on the following HEDIS measures:

- UHC's MY 2024 rates on the **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)** measure fell below the MY 2024 Quality Compass national 25th percentile benchmark for the following indicators: all age stratifications associated with **Counseling for Nutrition**, all age stratifications associated with **Counseling for Physical Activity**, and the **12–17 Years** stratification for **BMI Percentile Documentation**. These results suggest that few child and adolescent members enrolled with UHC received the guidance and services needed to prevent adverse healthcare outcomes. HSAG recommends that UHC educate members to help them understand the importance of receiving preventive care and screenings. UHC should remind providers to review preventive care measures for every patient, including children and adolescents, at every visit to ensure that Medicaid members receive timely preventive health screenings. UHC also could inform Medicaid members through newsletters about the importance of weight assessment, counseling for nutrition, and physical activity for children and adolescents. [**Quality**]
- UHC's MY 2024 rates on the **Immunizations for Adolescents (IMA)—Meningococcal** and **Combination 1** measure indicators fell below the MY 2024 Quality Compass national 25th percentile benchmark. These results suggest that few adolescent members enrolled with UHC received essential immunizations to protect against preventable diseases. HSAG recommends that UHC educate members to help them understand the importance of receiving preventive care and screenings. UHC should remind providers to review preventive care measures for every patient,

including children and adolescents, at every visit to ensure that members receive timely preventive health screenings. UHC also could inform members through newsletters about the importance of timely immunizations for adolescents. Best practices that UHC may consider piloting to improve immunization rates include offering member incentives, such as gift cards, for accessing timely preventive and immunization services. [**Quality**]

- UHC's MY 2024 rate on the **Asthma Medication Ratio (AMR)—51–64 Years** measure indicator fell below the MY 2024 Quality Compass national 25th percentile benchmark. This result suggests that the UHC did not effectively manage persistent asthma in adult members with appropriate medication. HSAG recommends that UHC work with providers to identify and address circumstances or conditions preventing members from accessing the medication they need to effectively manage their persistent asthma. [**Quality**]

HEDIS Results—CHIP Population

Table 4-19 presents UHC's rates on HEDIS performance measures specified in TennCare's Quality Strategy and indicates whether the reported rate is below the MY 2024 NCQA Quality Compass National 25th percentile benchmark, between the 25th percentile and 75th percentile benchmarks, or above the 75th percentile benchmark. Rates for HEDIS measures that do not have a national benchmark are shaded gray.

Table 4-19—HEDIS MY 2024 CHIP Plan-Specific Results on Measures Included in TennCare's Quality Strategy

Color Designation	National Percentile Achieved	Additional Comments
Green Shading+	Greater than 75th percentile	No additional comments
No Shading	25th to 75th percentile	No additional comments
Red Shading^	Less than 25th percentile	No additional comments
Gray Shading○	No rating available	Benchmarking data not available

Measure	UHC
Effectiveness of Care: Prevention and Screening	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	
BMI Percentile Documentation	
3–11 Years	80.24%
12–17 Years	76.07%^
Total	**78.59%**
Counseling for Nutrition	
3–11 Years	58.47%^
12–17 Years	44.17%^
Total	**52.80%^**

Measure	UHC
Counseling for Physical Activity	
3–11 Years	48.79%^
12–17 Years	41.10%^
Total	**45.74%^**
Childhood Immunization Status (CIS)	
DTaP	77.48%+
IPV	89.40%
MMR	87.42%
HiB	88.08%
HepB	89.40%
VZV	86.75%
PCV	76.82%
HepA	88.08%+
RV	76.16%+
Influenza	36.42%
Combination 3	72.19%+
Combination 7	66.89%+
Combination 10	30.46%
Immunizations for Adolescents (IMA)	
Meningococcal	69.41%^
Tdap	81.23%^
HPV	25.96%^
Combination 1	69.41%^
Combination 2	25.45%^
Cervical Cancer Screening (CCS)	
Cervical Cancer Screening	70.98%+
Effectiveness of Care: Respiratory Conditions	
Asthma Medication Ratio (AMR)	
5–11 Years	86.00%+
12–18 Years	78.00%+
19–50 Years	NA

Measure	UHC
51–64 Years	—
Total	**81.19%+**
Effectiveness of Care: Cardiovascular Conditions	
Controlling High Blood Pressure (CBP)	
Controlling High Blood Pressure	NA
Effectiveness of Care: Diabetes	
Eye Exam for Patients With Diabetes (EED)	
Eye Exam for Patients With Diabetes	NA
Blood Pressure Control (<140/90 mmHg) for Patients With Diabetes (BPD)	
Blood Pressure Control (<140/90 mmHg) for Patients With Diabetes	NA
Kidney Health Evaluation for Patients With Diabetes (KED)	
18–64 Years	NA
65–75 Years	—
76–85 Years	—
Total	**NA**
Effectiveness of Care: Behavioral Health	
Follow-Up After Hospitalization for Mental Illness (FUH)	
7-Day Follow-Up	
6–17 Years	60.00%+
18–64 Years	NA
65 Years and Older	—
Total	**59.38%+**
30-Day Follow-Up	
6–17 Years	80.00%+
18–64 Years	NA
65 Years and Older	—
Total	**81.25%+**
Access/Availability of Care	
Adults' Access to Preventive/Ambulatory Health Services (AAP)	
20–44 Years	82.80%+
45–64 Years	—

Measure	UHC
65 Years and Older	—
Total	**82.80%**
Prenatal and Postpartum Care (PPC)	
Postpartum Care	82.00%
Utilization and Risk-Adjusted Utilization	
Well-Child Visits in the First 30 Months of Life (W30)	
First 15 Months	76.15%+
Child and Adolescent Well-Care Visits (WCV)	
3–11 Years	65.28%
12–17 Years	53.41%
18–21 Years	34.51%
Total	**58.36%**
Electronic Clinical Data Systems (ECDS)	
Breast Cancer Screening (BCS-E)	
Breast Cancer Screening	—

NA indicates that the MCO followed the specifications for the measure indicator, but the denominator was too small (<30) to report a valid rate.
— Indicates that the MCO reported a rate of zero or did not report a rate for the measure indicator.

The following HEDIS performance measures were a strength for UHC in MY 2024:

- UHC's MY 2024 rates were above the MY 2024 Quality Compass national 75th percentile benchmark for the following **Childhood Immunization Status (CIS)** measure indicators: **DTaP**, **HepA**, **RV**, **Combination 3**, and **Combination 7.** Additionally, UHC's MY 2024 rates on the remaining **CIS** indicators were between the national 25th and 75th percentile benchmarks. These results suggest that UHC ensured that its CHIP members had access to essential immunizations to protect against preventable diseases. [**Quality, Access**]
- UHC's MY 2024 rate was above the MY 2024 Quality Compass national 75th percentile benchmark for the **Cervical Cancer Screening (CCS)** measure. These results suggest that UHC ensured that its CHIP members had access to screenings to enable the detection and treatment of cervical cancer. [**Quality**]
- UHC's MY 2024 rates were above the MY 2024 Quality Compass national 75th percentile benchmark for the following **Asthma Medication Ratio (AMR)** age stratifications: **5–11 Years**, **12–18 Years**, and **Total**. These results suggest that UHC effectively managed persistent asthma in enrolled CHIP members with the appropriate medications. [**Quality**]
- UHC's MY 2024 rates were above the MY 2024 Quality Compass national 75th percentile benchmark for the following **Follow-Up After Hospitalization for Mental Illness (FUH)** measure indicators: **7-Day Follow-Up—6–17 Years** and **Total**, **30-Day Follow-Up—6–17 Years** and **Total**.

These results suggest that UHC ensured that enrolled CHIP members received timely follow-up care after a mental health-related hospital inpatient stay. [**Quality, Timeliness, Access**]

- UHC's MY 2024 rate was above the MY 2024 Quality Compass national 75th percentile benchmark for the **Adults' Access to Preventive/Ambulatory Health Services (AAP)—20–44 Years** measure indicator. Additionally, UHC had a MY 2024 rate that was between the national 25th and 75th percentile benchmarks for the **AAP—Total** indicator. These results suggest that UHC ensured that CHIP members had access to preventive services to reduce the potential for adverse healthcare events. [**Timeliness, Access**]
- UHC's MY 2024 rate was above the MY 2024 Quality Compass national 75th percentile benchmark for the **Well-Child Visits in the First 30 Months of Life (W30)—First 15 Months** measure indicator. This result suggests that UHC effectively monitored the health of CHIP members during their first 15 months of life by ensuring regular well-child visits with PCPs. [**Quality, Access**]

Based on MY 2024 results, opportunities existed for UHC to improve its performance on the following HEDIS measures:

- UHC's MY 2024 rates fell below the MY 2024 Quality Compass national 25th percentile benchmark for the following **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)** measure indicators: **BMI Percentile Documentation—12–17 Years**; **Counseling for Nutrition—3–11 Years**, **12–17 Years**, and **Total**; and **Counseling for Physical Activity—3–11 Years**, **12–17 Years**, and **Total**. These results suggest that few child and adolescent CHIP members enrolled with UHC received the guidance and services needed to prevent adverse healthcare outcomes. HSAG recommends that UHC educate CHIP members to help them understand the importance of receiving preventive care and screenings. UHC should remind providers to review preventive care measures for every patient, including children and adolescents, at every visit to ensure that CHIP members receive timely preventive health screenings. UHC also could inform CHIP members through newsletters about the importance of weight assessment, counseling for nutrition, and physical activity for children and adolescents. [**Quality**]
- UHC's MY 2024 rates fell below the MY 2024 Quality Compass national 25th percentile benchmark for the following **Immunizations for Adolescents (IMA)** measure indicators: **Meningococcal**, **Tdap**, **HPV**, **Combination 1**, and **Combination 2.** These results suggest that few adolescent CHIP members enrolled with UHC were receiving important immunizations to prevent adverse healthcare events. HSAG recommends that UHC educate CHIP members to help them understand the importance of receiving preventive care and screenings. UHC should remind providers to review preventive care measures for every patient, including children and adolescents, at every visit to ensure that CHIP members receive timely preventive health screenings. UHC also could inform CHIP members through newsletters about the importance of timely immunizations for adolescents. Best practices that UHC may consider piloting to improve immunization rates include offering member incentives, such as gift cards, for accessing timely preventive and immunization services. [**Quality**]

PDV

Table 4-20 presents the overall rates HSAG reported for each data element reviewed for validation. Of note, cells highlighted in green with a + indicate that 2025 overall rates scored higher than 2024 overall rates, while cells highlighted in red with a ^ indicate that 2025 overall rates scored lower than 2024 overall rates.

Table 4-20—Overall Accuracy Results for UHC

Data Element	2025 Overall	2024 Overall
Active Contract Status	91.67%+	90.65%+
Provider Address	90.74%+	82.78%+
Provider Specialty/BH Service Code	74.45%^	89.79%^
Provider Panel Status	86.67%+	80.01%+
Routine Care Services	70.91%^	78.86%^
Urgent Care Services	55.71%^	71.11%^
Services for Children	62.63%^	86.59%^
Services for Adults	92.37%^	92.39%^
Primary Care Services	90.30%+	88.95%+
Prenatal Care Services	95.20%+	93.25%+

Strengths

For 2025, Active Contract Status, Provider Address, Services for Adults, Primary Care Services, and Prenatal Care Services resulted in overall rates greater than or equal to 90 percent.

Opportunities for Improvement

For 2025, Provider Specialty/BH Service Code, Provider Panel Status, Routine Care Services, Urgent Care Services, and Services for Children resulted in overall rates below 90 percent, indicating data **quality** concerns.

Recommendation

To address the provider data **quality** concerns, HSAG recommends that UHC utilize the case-level data files containing mismatched information between the PEFs and the provider office responses, and address the data deficiencies (e.g., provider specialty/BH Service Code, provider panel, or incorrect or disconnected telephone numbers that do not correspond to the sampled provider). Additionally, UHC should consider conducting outreach to providers to ensure the providers and/or their offices routinely

submit up-to-date information on all pertinent provider indicators (e.g., active contract status, updated contact information, and panel status).

Secret Shopper Survey

The following sections provide information concerning UHC's strengths identified during the Secret Shopper study and opportunities in addressing provider data **quality**, **timeliness**, and **access to care** concerns.

Strengths

Among the active provider cases reached for Q2 2025, 100 percent confirmed the address was correct, 95.24 percent offered the requested services and accepted new patients, and 90.48 percent offered appointments. Similarly, of the active provider cases that offered appointments in Q2 and Q3 2025, 100 percent of cases were compliant with the appointment wait time standard (i.e., 30 calendar days).

Opportunities for Improvement

Quarterly overall response rates for active and inactive providers ranged from 45.42 percent to 80.77 percent. With the exception of Q2 2025, quarterly overall provider data accuracy rates among active providers (i.e., provider locations with correct location and offering the requested services) ranged from 40.63 percent to 80.00 percent. Similarly, among the inactive provider cases reached, quarterly overall provider data accuracy rates (i.e., provider locations with correct location, offering the requested services, and accepting the requested insurance) ranged from 31.25 percent to 57.89 percent, indicating data **quality** and **access to care** concerns. With the exception of Q2 2025, new patient acceptance rates ranged from 31.25 to 73.02 percent. Similarly, with the exception of Q2 2025, appointment availability rates were below 38.00 percent. Overall appointment wait time compliance rates for active providers for Q1 2025 and Q4 2024 were 64.29 percent and 83.33 percent, respectively. Also, the overall appointment wait time compliance rate for inactive providers ranged from 37.50 percent to 85.71 percent.

WLP

AQS Compliance Review

The AQS review included a review of documents and interviews with WLP staff members to determine compliance with State and federal requirements. The extensive document review occurred pre-audit, during the audit, and post-audit to ensure that HSAG reviewed all available information to satisfy the audit requirements. Interviews with WLP staff members assisted in clarifying HSAG's outstanding questions and obtained information needed to assign scores for the review.

Table 4-21 displays the detailed scores for each of the standards included in WLP's 2025 AQS compliance review. The listing of total elements, total applicable elements (i.e., number of elements with the NA elements removed), **Met** elements, and **Not Met** elements provide details concerning the final score for each standard. Based on the overall score achieved by WLP, HSAG established a level of confidence rating for this year's compliance review as defined below:

- 90%–100%: High confidence in the MCO's compliance with State and federal requirements
- 80%–89%: Moderate confidence in the MCO's compliance with State and federal requirements
- 70%–79%: Low confidence in the MCO's compliance with State and federal requirements
- Under 70%: No confidence in the MCO's compliance with State and federal requirements

Table 4-21—2025 AQS Compliance Review Scores for WLP

Standard Name	Total Elements	Total Applicable Elements	Met	Partially Met	Not Met	Score*
Coordination and Continuity of Care	12	12	12	0	0	100%
Emergency and Poststabilization Services	9	9	9	0	0	100%
Practice Guidelines	6	6	6	0	0	100%
Health Information Systems	8	8	8	0	0	100%
Quality Assessment and Performance Improvement (QAPI) Program	6	6	6	0	0	100%
Enrollment and Disenrollment: Requirements and Limitations	12	12	12	0	0	100%
EPSDT	24	24	24	0	0	100%
Overall Score	**77**	**77**	**77**	**0**	**0**	**100%**
Confidence Level	**High**					

* A **Met** score equals 1.0 point, and a **Not Met** score equals 0.0 points.
Total Elements: The total number of elements in each standard.
Total Applicable Elements: The total number of elements within the standard, after removing nonapplicable elements.

WLP obtained 100 percent compliance on every standard included in the 2025 AQS compliance review and achieved a level of **High Confidence**. HSAG commends WLP for achieving 100 percent compliance on the seven standards and 77 elements included in the 2025 AQS compliance review. The MCO submitted written documentation to support the State and federal requirements, and interviews with staff members confirmed their understanding and correct implementation of those requirements. Achieving 100 percent compliance with the AQS compliance review standards improved the **quality**, **timeliness**, and **access to care** for members.

WLP achieved 100 percent compliance with the Transition of CHOICES Members Between MCOs and CHOICES Annual LOC Assessments file reviews. Achieving 100 percent compliance in these areas improved the **quality**, **timeliness**, and **accessibility of care** for CHOICES members. Table 4-22 shows the detailed scores for the 2025 AQS File Reviews.

Table 4-22—Scores Achieved in the File Reviews Included in the CY 2025 AQS Compliance Review

File Review	Total Files Requested/ Reviewed	Total Applicable Elements	Number of Files Containing Required Element		Score[2]
			Met[1]	Not Met[1]	
Transition of CHOICES Members Between MCOs	10/10	25	25	0	100%
CHOICES Annual LOC Assessment	10/10	20	20	0	100%
Overall File Review Score	**20/20**	**45**	**45**	**0**	**100%**

[1] A **Met** score equals 1.0 point, and a **Not Met** score equals 0.0 points.
[2] The overall score is the number of **Met** elements divided by the number of total applicable elements.

TennCare required the MCCs to submit a CAP for any element in the AQS that received a score of less than 100 percent. Because WLP achieved 100 percent compliance with the standards and file reviews, the MCO was not required to submit a CAP.

PIPs

For CY 2025, WLP submitted the following PIPs: **Improve HPV Vaccination of Adolescents by Their 13th Birthday (EPSDT)**, **Improve Diabetic Retinal Eye Exam Screenings in the PCMH Clinical Setting**, and **Improve Timeliness of Reassessment and Care Plan Update for LTSS Members**. WLP received **Met** validation scores for 100 percent of all applicable evaluation elements validated for both PIPs. HSAG did not identify any opportunities for improvement.

PMV

The review of WLP's FAR and IDSS reports confirms that WLP was audited in compliance with HEDIS requirements. WLP fully complied with HEDIS IS standards and used an NCQA-certified measure vendor to calculate its HEDIS measures for MY 2024. WLP received an **R** audit designation

for most of its HEDIS measures and did not offer the benefit necessary for reporting on the HEDIS measure **Oral Evaluation, Dental Services**.

NAV

For each evaluation item for each provider type, a performance score was determined by calculating the percentage of the actual point value that the MCO achieved based on the applicable CRA standard. Table 4-23 presents a high-level summary of the scores for the Network Adequacy portion of the ANA audit.

Table 4-23—Summary of Statewide Network Adequacy Scores for WLP

Evaluation Area	Total Items	Lowest Performance Score	Percentage Achieving 100% Score	Score[1]
PCPs	8	99.92%	87.50%	99.99%
SCPs[2]	36	100%	100%	100%
BH Providers	5	100%	100%	100%
Opioid Use Disorder Treatment Providers	1	100%	100%	100%
General Optometry and Hospitals	2	99.97%	0.00%	99.97%
Essential Hospital Services and COEs	7	100%	100%	100%
Health Promotion Strategies	1	100%	100%	100%
CHOICES Providers	11	46.32%	90.91%	95.12%
ECF CHOICES Providers	17	100%	100%	100%
Overall Network Adequacy Score	**88**	**46.32%**	**95.45%**	**99.39%**

[1]Average of the performance scores for items in each evaluation area.

[2] HSAG based the overall score on the combination of scores for Standard 1 (75 percent of members within 60 miles travel distance and ≤90 minutes travel time) and Standard 2 (100 percent of members within 90 miles travel distance and ≤120 minutes travel time). However, because Standard 1 is based on 75 percent of the non-dual members, HSAG adjusted, or weighted, the Standard 1 score to the total population. This adjusted score was combined with the Standard 2 score to obtain the overall score

Table 4-23 shows that WLP achieved total compliance with the availability and geographic accessibility standards, except for the PCP, General Optometry and Hospitals, and CHOICES Providers categories.

WLP received a score of 100 percent for all PCP provider types except for the Suburban/Rural OB/GYN provider type, for which UHC did not meet the standard for some members (less than 0.1 percent). WLP achieved compliance with the provider ratio standards for OB/GYNs. WLP also achieved 100 percent compliance with the OB/GYN travel distance and travel time standards for members with urban addresses.

WLP did not meet the standard for general optometry for 0.03 percent of members. Additionally, 0.02 percent of WLP's members did not have access to hospitals within the standard.

WLP received 100 percent scores in all CHOICES provider categories except Pest Control, which received a statewide score of 46.32 percent.

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 130 indicators for WLP. Of these indicators, 100 percent received ratings of **High Confidence.** Table 4-24 summarizes HSAG's validation results.

Table 4-24—Summary of WLP's Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Provider Capacity	100%	0%	0%	0%
Ratio Indicators	100%	0%	0%	0%
Time/Distance Indicators	100%	0%	0%	0%

HSAG evaluated and assessed the data methods used by WLP to calculate results generated for each network adequacy indicator in scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that WLP used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator. HSAG determined that data collection procedures and network adequacy methods in place at WLP and TennCare, and network adequacy results calculated by TennCare were **Acceptable**.

Recommendations

After reviewing materials submitted by WLP, the administrative data analyses (including distance analyses, ratio analyses, county analyses, and complaint analyses), HSAG concluded the following recommendations:

- WLP must ensure that all female members older than 13 years of age have access to an OB/GYN within the TennCare required travel distance and travel time standards.
- WLP must ensure that all members have access to hospitals within the TennCare required travel distance and travel time standards.
- WLP must ensure that all members have access to general optometry services within the TennCare required travel distance and travel time standards.
- WLP must ensure that all counties have access to at least two CHOICES pest control service providers. Based on the submitted data, only members in 44 of 95 counties (46.32 percent) have access to at least two pest control providers in their counties.

WLP demonstrated having thorough validation policies and procedures in place to ensure reporting accuracy for both member and provider data. WLP demonstrated a forward-thinking strategy by exploring the usage of QAS to monitor network development internally, identify provider gaps, and support outreach to nonparticipating providers. TennCare maintained robust processes for collecting and reviewing the provider data from WLP.

TennCare used sound and consistent methodologies to assess all network adequacy indicators. HSAG noted that TennCare used a manual process to populate the Spec Sheets with the Quest generated time/distance results, the provider ratio results, and the provider capacity results. HSAG recommends that TennCare continue to explore opportunities to streamline and automate the process of translating/transferring the network adequacy results into the Spec Sheets to mitigate inaccuracies in reporting.

ANA

This section presents the results of all ANA-related activities for WLP and includes requirements for members who receive services from the TennCare Medicaid program, CoverKids, CHOICES HCBS program, and the ECF CHOICES program.

The ANA activities included a summary of WLP's statewide network adequacy scores as previously presented in Table 4-23 in the NAV section of this report. In addition to the network adequacy review, the ANA activities also include a statewide benefit delivery score for WLP.

Table 4-25 presents the percentage scores for the six areas used to determine the effectiveness of the MCO's delivery of covered benefits. The overall Benefit Delivery score was the average score for the total of these six measures.

Table 4-25—Summary of WLP's Statewide Benefit Delivery Scores[1]

Measure	Score
Benefit Delivery—Accessibility: Member	100%
Benefit Delivery—Accessibility: Provider	100%
Network Availability and Accessibility	100%
Appointment Availability—MCO Complaints	99.85%
MCO Provider Contracts File Review Results—Quantity	100%
MCO Provider Contracts File Review Results—Quality	99.80%
Overall Benefit Delivery Score	**99.94%**

[1] HSAG obtained the information in this table from the analysis of policies and procedures, contracts, complaint files, member handbooks, provider manual, and virtual review interviews.

WLP achieved a rate of 99.94 percent on its overall benefit delivery score. The lowest score, 99.80 percent, represents quality elements of the provider contracts file review.

Recommendations

After reviewing materials submitted by WLP (including policies and procedures; newsletters; member handbooks; provider manuals; and a sample of provider contracts), administrative data analyses (including a travel distance and travel time analysis; ratio analysis; county analysis; and complaint

analysis), and interviews with WLP's staff members, HSAG made the following recommendations that could improve the **quality**, **timeliness**, and **access to care** for members:

- WLP must ensure that all provider contracts contain the provider and MCO signatures and signature dates.
- WLP must ensure that all female members older than 13 years of age have access to an OB/GYN within the TennCare required travel distance and travel time standards.
- WLP must ensure that all members have access to hospitals within the TennCare required travel distance and travel time standards.
- WLP must ensure that all members have access to general optometry services within the TennCare required travel distance and travel time standards.
- WLP must ensure that all counties have access to at least two CHOICES pest control service providers. Based on the submitted data, only members in 44 of 95 counties (46.32 percent) have access to at least two pest control providers in their counties.

CAHPS

None of the MY 2024 measure scores representing the **quality of care**, **timeliness of care**, and **access to care** domains for WLP's adult and child Medicaid and CHIP populations were statistically significantly lower than the MY 2023 measure scores; however, one measure score representing the **quality of care**, **timeliness of care**, and **access to care** domains (i.e., **Getting Care Quickly**) for WLP's CCC Medicaid population was statistically significantly higher than the MY 2023 measure score.

WLP should monitor performance to ensure significant decreases in measure rates representing the **quality of care**, **timeliness of care**, and **access to care** domains do not occur.

HEDIS

IS Review Results

Table 4-26 identifies the key elements used by WLP while conducting its MY 2024 HEDIS Compliance Audit. These key elements were reviewed by HSAG during validation activities. A checkmark in Table 4-26 indicates that the LO reviewed the HEDIS activities, which confirmed that HEDIS methodology was being followed. Some activities are identified as being compliant by inserting the name of the company with which WLP contracted to perform the required tasks.

Table 4-26—Validation Activities for WLP

Licensed Organization	Attest Health Care Advisors
Pre-on-site Visit Call/Meeting	✓
Roadmap Review	✓
Software Vendor	Not Reported

Licensed Organization	Attest Health Care Advisors
Source Code/HEDIS Certified Measures Review	✓
Survey Vendor	Center for the Study of Services (CSS)
CAHPS Sample Frame Validation	✓
Supplemental Data Validation	✓
Medical Record Review	✓
IDSS Review	✓

In addition to ensuring that data were captured, reported, and presented in a uniform manner, HSAG evaluated WLP's IS capabilities for accurate HEDIS reporting. HSAG reviewed WLP's FAR for its LO's assessment of IS capabilities, specifically focused on those aspects of WLP's system that could have impacted report on HEDIS performance measures.

The LO evaluated WLP's compliance with IS standards outlined in the **HEDIS MY 2024 Volume 5 HEDIS Compliance Audit: Standards, Policies and Procedures**. These standards detail the minimum requirements that WLP's information systems should meet to report HEDIS performance measures. For circumstances in which a particular IS standard was not met, the LO rated the impact on HEDIS reporting capabilities and, particularly, any measure that could be impacted. WLP may not be fully compliant with several of the IS standards but may still be able to report the selected measures.

Table 4-27 provides a summary of WLP's key findings for each IS standard as noted in its FAR.

Table 4-27—Summary of Compliance With IS Standards for WLP

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2024 FARs Review
IS R—Data Management and Reporting • IS R1—The organization's data management enables measurement. • IS R2—Data extraction and loads are complete and accurate. • IS R3—Data transformation and integration is accurate and valid. • IS R4—Data quality and governance are components of the organization's data management. • IS R5—Oversight and controls ensure correct implementation of measure reporting software. • IS R6—Cybersecurity practices are in place to promote protection and resiliency of the systems and data used for measurement.	• WLP was compliant with IS Standard R for Data Management and Reporting. • The LO determined that WLP had procedures in place so that all data elements required for HEDIS reporting were adequately captured. • The LO determined that the MCO had policies and procedures in place for validation of data extraction, transformation, and integration. • The LO determined that WLP was compliant for the standard for oversight and controls that ensure correct implementation of measure reporting software. • The LO determined that WLP had practices in place to promote protection and resiliency of systems and data.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2024 FARs Review
	• Adequate validation processes were in place, ensuring data accuracy.
IS C—Clinical and Care Delivery Data • IS C1—Data capture is complete. • IS C2—Data conform with industry standards. • IS C3—Transaction file data are accurate. • IS C4—Organization confirms ingested data meet expectations for data quality.	• WLP was compliant with IS Standard C for Clinical and Care Delivery Data. • The LO determined that WLP had policies and procedures in place for submitted data that conform with industry standards. • Adequate validation processes were in place, ensuring data accuracy and quality.
IS M—Medical Record Review Processes • IS M1—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 M2—Retrieval and abstraction of data from medical records is reliably and accurately performed. • IS M3—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 M4—The organization continually assesses data completeness and takes steps to improve performance. • IS M5—The organization regularly monitors vendor performance against expected performance standards.	• WLP was compliant with IS Standard M for MRR Processes. • The LO determined that the data collection tool used by the MCO was able to capture all data fields necessary for HEDIS reporting. • Sufficient validation processes were in place to ensure data accuracy.
IS A—Administrative Data • IS A1—Data conform with industry standards and measure requirements. • IS A2—Data are complete and accurate. • IS A3—Membership information system enables measurement.	• WLP was compliant with IS Standard A for Administrative Data. • The LO determined that the MCO appropriately validated that data conform with industry standards and measure requirements. • The LO reviewed the membership information system to ensure that it appropriately enables measurement. • Sufficient validation processes were in place to ensure that data are accurate and complete.

HEDIS Results—Medicaid Population

Table 4-28 presents WLP's rates on HEDIS performance measures specified in TennCare's Quality Strategy and indicates whether the reported rate is below the MY 2023 NCQA Quality Compass National 25th percentile benchmark, between the 25th percentile and 75th percentile benchmarks, or above the 75th percentile benchmark.

Table 4-28—HEDIS MY 2024 Medicaid Plan-Specific Results on Measures Included in TennCare's Quality Strategy

Color Designation	National Percentile Achieved	Additional Comments
Green Shading+	Greater than 75th percentile	No additional comments
No Shading	25th to 75th percentile	No additional comments
Red Shading^	Less than 25th percentile	No additional comments
Gray Shading○	No rating available	Benchmarking data not available

Measure	WLP
Effectiveness of Care: Prevention and Screening	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	
BMI Percentile Documentation	
3–11 Years	84.62%
12–17 Years	79.10%
Total	**82.24%**
Counseling for Nutrition	
3–11 Years	72.65%
12–17 Years	66.67%
Total	**70.07%**
Counseling for Physical Activity	
3–11 Years	67.09%
12–17 Years	64.97%
Total	**66.18%**
Childhood Immunization Status (CIS)	
DTaP	77.62%+
IPV	88.81%
MMR	84.91%
HiB	87.10%
HepB	89.29%

Measure	WLP
VZV	84.43%
PCV	76.16%
HepA	84.67%
RV	72.26%
Influenza	31.63%
Combination 3	72.02%
Combination 7	62.77%
Combination 10	26.28%
Immunizations for Adolescents (IMA)	
Meningococcal	69.83%^
Tdap	82.24%^
HPV	35.52%
Combination 1	69.83%^
Combination 2	35.28%
Cervical Cancer Screening (CCS)	
Cervical Cancer Screening	52.31%
Effectiveness of Care: Respiratory Conditions	
Asthma Medication Ratio (AMR)	
5–11 Years	69.62%
12–18 Years	71.43%
19–50 Years	64.36%
51–64 Years	62.76%
Total	**68.23%**
Effectiveness of Care: Cardiovascular Conditions	
Controlling High Blood Pressure (CBP)	
Controlling High Blood Pressure	66.67%
Effectiveness of Care: Diabetes	
Eye Exam for Patients With Diabetes (EED)	
Eye Exam for Patients With Diabetes	48.42%^
Blood Pressure Control (<140/90 mmHg) for Patients With Diabetes (BPD)	
Blood Pressure Control (<140/90 mmHg) for Patients With Diabetes	66.91%^

Measure	WLP
Kidney Health Evaluation for Patients With Diabetes (KED)	
18–64 Years	37.70%
65–75 Years	46.49%
76–85 Years	50.80%
Total	**38.77%**
Effectiveness of Care: Behavioral Health	
Follow-Up After Hospitalization for Mental Illness (FUH)	
7-Day Follow-Up	
6–17 Years	54.67%
18–64 Years	32.53%
65 Years and Older	20.27%^
Total	**38.79%**
30-Day Follow-Up	
6–17 Years	76.23%
18–64 Years	49.25%
65 Years and Older	36.49%^
Total	**56.92%**
Access/Availability of Care	
Adults' Access to Preventive/Ambulatory Health Services (AAP)	
20–44 Years	77.35%
45–64 Years	82.99%
65 Years and Older	90.76%+
Total	**79.67%**
Prenatal and Postpartum Care (PPC)	
Postpartum Care	78.59%
Utilization and Risk-Adjusted Utilization	
Well-Child Visits in the First 30 Months of Life (W30)	
First 15 Months	66.55%
Child and Adolescent Well-Care Visits (WCV)	
3–11 Years	64.20%
12–17 Years	53.10%

Measure	WLP
18–21 Years	28.79%
Total	**56.18%**
Electronic Clinical Data Systems (ECDS)	
Breast Cancer Screening (BCS-E)	
Breast Cancer Screening	44.18%^
Long-Term Services and Supports (LTSS)	
Comprehensive Assessment and Update (LTSS-CAU)	
Assessment of Core Elements	98.05%+
Assessment of Supplemental Elements	98.05%+
Comprehensive Care Plan and Update (LTSS-CPU)	
Care Plan With Core Elements Documented	98.54%+
Care Plan With Supplemental Elements Documented	98.54%+
Reassessment/Care Plan Update After Inpatient Discharge (LTSS-RAC)	
Reassessment After Inpatient Discharge	78.59%+
Reassessment and Care Plan Update After Inpatient Discharge	69.34%+
Shared Care Plan With Primary Care Practitioner (LTSS-SCP)	
Share Care Plan With Primary Care Practitioner	96.35%+

The following HEDIS performance measures were a strength for WLP in MY 2024:

- WLP's MY 2024 rates on the **Adults' Access to Preventive/Ambulatory Health Services (AAP)** measure were above the MY 2024 Quality Compass national 75th percentile benchmark for one age stratification (**65 Years and Older**) and between the national 25th and 75th percentile benchmarks for the remaining two age stratifications (**20–44 Years and 45–64 Years**). These results suggest that WLP ensured that its adult members had timely access to preventive healthcare services to reduce the potential for adverse healthcare events. [**Timeliness**, **Access**]
- WLP's MY 2024 rates on the following LTSS measures were above the MY 2024 Quality Compass national 75th percentile benchmark: **Comprehensive Assessment and Update (LTSS-CAU)**, **Comprehensive Care Plan and Update (LTSS-CPU)**, **Reassessment/Care Plan Update After Inpatient Discharge (LTSS-RAC)**, and **Shared Care Plan With Primary Care Practitioner (LTSS-SCP)**. These results suggest that WLP had effective processes in place to ensure that members' care plans reflected their current long-term support needs and to inform PCPs of any updates to members' care plans. [**Quality**]

Based on MY 2024 results, opportunities existed for WLP to improve its performance on the following HEDIS measures:

- WLP's MY 2024 rates on the **Immunizations for Adolescents (IMA)—Meningococcal**, **Tdap,** and **Combination 1** measure indicators fell below the MY 2024 Quality Compass national 25th percentile benchmark. These results suggest that few adolescent members enrolled with WLP received essential immunizations to protect against preventable diseases. HSAG recommends that WLP educate members to help them understand the importance of receiving preventive care and screenings. WLP should remind providers to review preventive care measures for every patient, including children and adolescents, at every visit to ensure that members receive timely preventive health screenings. WLP also could inform members through newsletters about the importance of timely immunizations for adolescents. Best practices that WLP may consider piloting to improve immunization rates include offering member incentives, such as gift cards, for accessing timely preventive and immunization services. [**Quality**]
- WLP's MY 2024 rates on the **Eye Exam for Patients With Diabetes (EED) and Blood Pressure Control for Patients With Diabetes (BPD)** measures fell below the MY 2024 Quality Compass national 25th percentile benchmark. These results suggest that WLP was not effective at monitoring and managing adult member's diabetes, as well as monitoring the health impacts of diabetes. HSAG recommends that WLP educate members to help them understand the importance of receiving preventive care and screenings. WLP should remind providers to review preventive care measures for every patient at every visit to ensure that members receive timely preventive health screenings. WLP also could consider targeted interventions based on identified disparities through ongoing data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code. [**Quality**]
- WLP's MY 2024 rates on the **Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up and 30-Day Follow-Up** measure indicators fell below the MY 2024 Quality Compass national 25th percentile benchmark for members in the **65 Years and Older** age group. These results suggest that few older adult members enrolled with WLP received timely follow-up care after a mental health-related hospital inpatient stay. HSAG recommends that WLP educate members about the importance of attending scheduled follow-up care visits to ensure the continuity of mental health-related treatment. WLP also could consider targeted interventions based on identified disparities through ongoing data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code. [**Quality, Timeliness, Access**]
- WLP's MY 2024 rate on the **Breast Cancer Screening (BCS-E)** measure fell below the MY 2024 Quality Compass national 25th percentile benchmark. This result suggests that few eligible members enrolled with WLP received the appropriate screening to enable early detection and successful treatment of breast cancer. HSAG recommends that WLP educate members to help them understand the importance of receiving preventive care and screenings. WLP should remind providers to review preventive care measures for every patient at every visit to ensure that Medicaid members receive timely preventive health screenings. WLP also could consider targeted interventions based on identified disparities through ongoing data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code. [**Quality**]

HEDIS Results—CHIP Population

Table 4-29 presents WLP's rates on HEDIS performance measures specified in TennCare's Quality Strategy and indicates whether the reported rate is below the MY 2024 NCQA Quality Compass National 25th percentile benchmark, between the 25th percentile and 75th percentile benchmarks, or above the 75th percentile benchmark.

Table 4-29—HEDIS MY 2024 CHIP Plan-Specific Results on Measures Included in TennCare's Quality Strategy

Color Designation	National Percentile Achieved	Additional Comments
Green Shading+	Greater than 75th percentile	No additional comments
No Shading	25th to 75th percentile	No additional comments
Red Shading^	Less than 25th percentile	No additional comments
Gray Shading○	No Rating Available	Benchmarking data not available

Measure	WLP
Effectiveness of Care: Prevention and Screening	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	
BMI Percentile Documentation	
3–11 Years	81.15%
12–17 Years	79.64%
Total	**80.54%**
Counseling for Nutrition	
3–11 Years	71.31%
12–17 Years	70.06%
Total	**70.80%**
Counseling for Physical Activity	
3–11 Years	68.03%
12–17 Years	71.26%
Total	**69.34%**
Childhood Immunization Status (CIS)	
DTaP	85.07%+
IPV	91.04%+
MMR	87.56%
HiB	90.55%+
HepB	92.04%+

Measure	WLP
VZV	87.56%
PCV	82.09%+
HepA	88.56%+
RV	82.09%+
Influenza	41.79%+
Combination 3	78.61%+
Combination 7	73.63%+
Combination 10	37.31%+
Immunizations for Adolescents (IMA)	
Meningococcal	73.95%^
Tdap	83.87%
HPV	27.05%^
Combination 1	73.45%^
Combination 2	26.55%^
Cervical Cancer Screening (CCS)	
Cervical Cancer Screening	67.20%+
Effectiveness of Care: Respiratory Conditions	
Asthma Medication Ratio (AMR)	
5–11 Years	81.25%+
12–18 Years	NA
19–50 Years	—
51–64 Years	—
Total	**81.63%+**
Effectiveness of Care: Cardiovascular Conditions	
Controlling High Blood Pressure (CBP)	
Controlling High Blood Pressure	NA
Effectiveness of Care: Diabetes	
Eye Exam for Patients With Diabetes (EED)	
Eye Exam for Patients With Diabetes	NA
Blood Pressure Control (<140/90 mmHg) for Patients With Diabetes (BPD)	
Blood Pressure Control (<140/90 mmHg) for Patients With Diabetes	NA

Measure	WLP
Kidney Health Evaluation for Patients With Diabetes (KED)	
18–64 Years	NA
65–75 Years	—
76–85 Years	—
Total	**NA**
Effectiveness of Care: Behavioral Health	
Follow-Up After Hospitalization for Mental Illness (FUH)	
7-Day Follow-Up	
6–17 Years	48.39%
18–64 Years	NA
65 Years and Older	—
Total	**50.00%+**
30-Day Follow-Up	
6–17 Years	90.32%+
18–64 Years	NA
65 Years and Older	—
Total	**88.89%+**
Access/Availability of Care	
Adults' Access to Preventive/Ambulatory Health Services (AAP)	
20–44 Years	85.84%+
45–64 Years	NA
65 Years and Older	—
Total	**85.53%+**
Prenatal and Postpartum Care (PPC)	
Postpartum Care	80.05%
Utilization and Risk-Adjusted Utilization	
Well-Child Visits in the First 30 Months of Life (W30)	
First 15 Months	72.57%+
Child and Adolescent Well-Care Visits (WCV)	
3–11 Years	62.85%
12–17 Years	52.82%

Measure	WLP
18–21 Years	36.30%
Total	**56.94%**
Electronic Clinical Data Systems (ECDS)	
Breast Cancer Screening (BCS-E)	
Breast Cancer Screening	—

NA indicates that the MCO followed the specifications for the measure indicator, but the denominator was too small (<30) to report a valid rate.
— Indicates that the MCO reported a rate of zero or did not report a rate for the measure indicator.

The following HEDIS performance measures were a strength for WLP in MY 2024:

- WLP's MY 2024 rates were above the MY 2024 Quality Compass national 75th percentile benchmark for the following **Childhood Immunization Status (CIS)** measure indicators: **DTaP**, **IPV**, **HiB**, **HepB**, **PCV**, **HepA**, **RV**, **Influenza**, **Combination 3**, **Combination 7**, and **Combination 10**. Additionally, WLP had MY 2024 rates between the national 25th and 75th percentile benchmarks for two indicators: **MMR** and **VZV**. These results suggest that WLP ensured that its CHIP members had access to essential immunizations to protect against preventable diseases. [**Quality, Access**]
- WLP's MY 2024 rates were above the MY 2024 Quality Compass national 75th percentile benchmark for the **Cervical Cancer Screening (CCS)** measure. These results suggest that WLP ensured that its CHIP members had access to screenings to enable the detection and treatment of cervical cancer. [**Quality**]
- WLP's MY 2024 rates were above the MY 2024 Quality Compass national 75th percentile benchmark for the following **Follow-Up After Hospitalization for Mental Illness (FUH)** measure indicators: **7-Day Follow-Up—Total** and **30-Day Follow-Up—6–17 Years** and **Total**. Additionally, WLP had a MY 2024 rate that was between the national 25th and 75th percentile benchmarks for the **7-Day Follow-Up—6–17 Years** indicator. These results suggest that WLP ensured that enrolled CHIP members received timely follow-up care after a mental health-related hospital inpatient stay. [**Quality, Timeliness, Access**]
- WLP's MY 2024 rates were above the MY 2024 Quality Compass national 75th percentile benchmark for the **Adults' Access to Preventive/Ambulatory Health Services (AAP)—20–44 Years** and **Total** measure indicators. These results suggest that WLP ensured that CHIP members had access to preventive services to reduce the potential for adverse healthcare events. [**Timeliness, Access**]
- WLP's MY 2024 rate was above the MY 2024 Quality Compass national 75th percentile benchmark for the **Well-Child Visits in the First 30 Months of Life (W30)—First 15 Months** measure indicator. This result suggests that WLP effectively monitored the health of CHIP members during their first 15 months of life by ensuring regular well-child visits with PCPs. [**Quality, Access**]

Based on MY 2024 results, opportunities existed for WLP to improve its performance on the following HEDIS measures:

- WLP's MY 2024 rates fell below the MY 2024 Quality Compass national 25th percentile benchmark for the following **Immunizations for Adolescents (IMA)** measure indicators: **Meningococcal**, **HPV**, **Combination 1**, and **Combination 2**. These results suggest that few adolescent CHIP members enrolled with WLP were receiving important immunizations to prevent adverse healthcare events. HSAG recommends that WLP educate CHIP members to help them understand the importance of receiving preventive care and screenings. WLP should remind providers to review preventive care measures for every patient, including children and adolescents, at every visit to ensure that CHIP members receive timely preventive health screenings. WLP also could inform CHIP members through newsletters about the importance of timely immunizations for adolescents. Best practices that WLP may consider piloting to improve immunization rates include offering member incentives, such as gift cards, for accessing timely preventive and immunization services. [**Quality**]

PDV

Table 4-30 presents the overall rates HSAG reported for each data element reviewed for validation. Of note, cells highlighted in green with a + indicate that 2025 overall rates scored higher than 2024 overall rates, while cells highlighted in red with a ^ indicate that 2025 overall rates scored lower than 2024 overall rates.

Table 4-30—Overall Accuracy Results for WLP

Data Element	2025 Overall	2024 Overall
Active Contract Status	85.41%^	86.38%^
Provider Address	91.23%+	76.87%+
Provider Specialty/BH Service Code	82.53%^	82.80%^
Provider Panel Status	81.43%^	85.26%^
Routine Care Services	67.80%^	77.81%^
Urgent Care Services	51.35%^	73.35%^
Services for Children	64.36%^	84.42%^
Services for Adults	87.82%^	88.17%^
Primary Care Services	82.95%^	86.46%^
Prenatal Care Services	91.24%^	92.71%^

Strengths

For 2025, Provider Address and Prenatal Care Services resulted in an overall rate greater than 90 percent.

Opportunities for Improvement

For 2025, Active Contract Status, Provider Specialty/BH Service Code, Provider Panel Status, Routine Care Services, Urgent Care Services, Services for Children, Services for Adults, and Primary Care Services resulted in overall rates below 90 percent, indicating data **quality** concerns.

Recommendation

To address the provider data quality concerns, HSAG recommends that WLP utilize the case-level data files containing mismatched information between the PEFs and the provider office responses, and address the data deficiencies (e.g., provider specialty/BH Service Code, provider panel, or incorrect or disconnected telephone numbers that do not correspond to the sampled provider). Additionally, WLP should consider conducting outreach to providers to ensure the providers and/or their offices routinely submit up-to-date information on all pertinent provider indicators (e.g., active contract status, updated contact information, and panel status).

Secret Shopper Survey

The following sections provide information concerning WLP's strengths identified during the Secret Shopper study and opportunities in addressing provider data **quality**, **timeliness**, **and access to care** concerns.

Strengths

Among the active provider cases that offered appointments in Q2 and Q3 2025, 100 percent of cases were compliant with the appointment wait time standard (i.e., 30 calendar days). Additionally, 100 percent of cases that offered an appointment with an inactive provider in Q2 2025 were compliant with the appointment wait time standard.

Opportunities for Improvement

Quarterly overall response rates for active and inactive providers ranged from 65.37 percent to 78.26 percent. Among the active provider cases reached, quarterly overall provider data accuracy rates (i.e., provider locations with correct location and offering the requested services) ranged from 41.07 percent to 88.89 percent. Similarly, among the inactive provider cases reached, quarterly overall provider data accuracy rates (i.e., provider locations with correct location, offering the requested services, and accepting the requested insurance) ranged from 29.73 percent to 50.56 percent, indicating data **quality** and **access to care** concerns. Additionally, quarterly overall new patient acceptance rates and appointment availability rates were below 73.00 percent. Among the appointments that were offered in

Q4 2024 and Q1 2025, overall appointment wait time compliance rates for active providers were 72.73 percent and 85.71 percent, respectively. Additionally, with the exception of Q2 2025, the overall appointment wait time compliance rate for inactive providers ranged from 44.12 percent to 69.23 percent.

TCS

AQS Compliance Review

The AQS review included a review of documents and interviews with TCS staff members to determine compliance with State and federal requirements. The extensive document review occurred pre-audit, during the audit, and post-audit to ensure that HSAG reviewed all available information to satisfy the audit requirements. Interviews with TCS staff members assisted in clarifying HSAG's outstanding questions and obtained information needed to assign scores for the review.

Table 4-31 displays the detailed scores for each of the standards included in TCS's 2025 AQS compliance review. The listing of total elements, total applicable elements (i.e., number of elements with the not applicable [NA] elements removed), **Met** elements, and **Not Met** elements provide details concerning the final score for each standard. Based on the overall score achieved by TCS, HSAG established a level of confidence rating for this year's compliance review as defined below:

- 90%–100%: High confidence in the PIHP's compliance with State and federal requirements
- 80%–89%: Moderate confidence in the PIHP's compliance with State and federal requirements
- 70%–79%: Low confidence in the PIHP's compliance with State and federal requirements
- Under 70%: No confidence in the PIHP s compliance with State and federal requirements

Table 4-31—2025 AQS Compliance Review Scores for TCS

Standard Name	Total Elements	Total Applicable Elements	Met	Partially Met	Not Met	Score*
Coordination and Continuity of Care	12	12	12	0	0	100%
Emergency and Poststabilization Services	9	9	9	0	0	100%
Practice Guidelines	6	6	6	0	0	100%
Health Information Systems	8	8	8	0	0	100%
Quality Assessment and Performance Improvement (QAPI) Program	6	6	6	0	0	100%
Enrollment and Disenrollment: Requirements and Limitations	12	12	12	0	0	100%
EPSDT	24	23	23	0	0	100%
Overall Score	**77**	**76**	**76**	**0**	**0**	**100%**
Confidence Level	**High**					

* A **Met** score equals 1.0 point, and a **Not Met** score equals 0.0 points.
Total Elements: The total number of elements in each standard.
Total Applicable Elements: The total number of elements within the standard, after removing nonapplicable elements.

TCS obtained 100 percent compliance on every standard included in the 2025 AQS compliance review and achieved a level of **High Confidence** for the review. HSAG commends TCS for achieving 100 percent compliance on the seven standards and 76 applicable elements included in the 2025 AQS compliance review. The PIHP submitted written documentation to support the State and federal requirements, and interviews with staff members confirmed their understanding and correct implementation of those requirements. Achieving 100 percent compliance with the standards improved the **quality**, **timeliness**, and **accessibility of care** for members.

TennCare required TCS to submit a CAP for any element in the AQS that received a score of less than 100 percent. Because TCS achieved 100 percent compliance with the 2025 AQS compliance review, the PIHP was not required to submit a CAP.

HSAG identified one suggestion concerning the EPSDT standard:

- EPSDT—Element #18 required that if a member under 16 years of age is seeking BH TennCare Kids services and the member's parent(s) or legally appointed representative is unable to accompany the member to the examination, the MCO shall require that its providers either contact the member's parent(s) or legally appointed representative to discuss the findings and inform the family of any other necessary healthcare, diagnostic services, treatment, or other measures recommended for the member or notify the MCO to contact the parent(s) or legally appointed representative with the results. HSAG suggests that TCS review internal documents to ensure that the process for monitoring provider compliance with the requirements is clearly outlined.

PIPs

For CY 2025, TCS submitted the following PIPs: **Improving Follow-Up After Hospitalization for Mental Illness 7-Day (FUH)**, **Improving Psychotropic Medication Management**, and **Improving EPSDT**. TCS received **Met** validation scores for 100 percent of all applicable evaluation elements validated for both PIPs. HSAG did not identify any opportunities for improvement.

PMV

The review of TCS's FAR and IDSS reports confirms that TCS was audited in compliance with HEDIS requirements. TCS fully complied with HEDIS IS standards and used an NCQA-certified measure vendor to calculate its HEDIS measures for MY 2024. TCS received an **R** audit designation for most of its HEDIS measures and did not offer the benefit necessary for reporting on the HEDIS measure **Oral Evaluation, Dental Services**.

NAV

For each evaluation item for each provider type, a performance score was determined by calculating the percentage of the actual point value that the PIHP achieved based on the applicable CRA standard. Table 4-32 presents a high-level summary of the scores for the Network Adequacy portion of the ANA audit.

Table 4-32—Summary of Statewide Network Adequacy Scores for TCS

Evaluation Area	Total Items	Lowest Performance Score	Percentage Achieving 100% Score	Score[1]
PCPs	8	100%	100%	100%
SCPs[2]	36	100%	100%	100%
BH Providers	5	100%	100%	100%
Opioid Use Disorder Treatment Providers	1	100%	100%	100%
General Optometry and Hospitals	2	100%	100%	100%
Essential Hospital Services and COEs	8	100%	100%	100%
Health Promotion Strategies	1	100%	100%	100%
Overall Network Adequacy Score	**61**	**100%**	**100%**	**100%**

[1]Average of the performance scores for items in each evaluation area.

[2] HSAG based the overall score on the combination of scores for Standard 1 (75 percent of members within 60 miles travel distance and ≤90 minutes travel time) and Standard 2 (100 percent of members within 90 miles travel distance and ≤120 minutes travel time). However, because Standard 1 is based on 75 percent of the non-dual members, HSAG adjusted, or weighted, the Standard 1 score to the total population. This adjusted score was combined with the Standard 2 score to obtain the overall score

Table 4-32 shows that TCS achieved total compliance with the availability and geographic accessibility standards.

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 53 indicators for TCS. Of these indicators, 100 percent received ratings of **High Confidence**. Table 4-33 summarizes HSAG's validation results.

Table 4-33—Summary of TCS's Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Ratio Indicators	100%	0%	0%	0%
Time/Distance Indicators	100%	0%	0%	0%

HSAG evaluated and assessed the data methods used by TCS to calculate results generated for each network adequacy indicator in scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that TCS used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator. HSAG determined that data collection procedures and network adequacy methods in place at TCS and TennCare, and network adequacy results calculated by TennCare were **Acceptable**.

Recommendations

After reviewing materials submitted by TCS, the administrative data analyses (including distance analyses, ratio analyses, county analyses, and complaint analyses), HSAG concluded the following recommendations:

- TCS must continue to ensure that all members have access within the TennCare required distance/time standards.

TCS established a robust process to maintain the accuracy and completeness of provider information through its attestation process, which included reminders sent to providers to update their information within the CAQH system. Additionally, all providers go through a review of credentialing every three years. TCS demonstrated strong oversight of their delegated entities by conducting quarterly reviews that included an evaluation of each of the delegated entities credentialing and recredentialing data and an audit of their systems. TennCare maintained robust processes for collecting and reviewing the provider data from TCS. HSAG did not identify specific opportunities for improvement related to the data collection and management processes TCS had in place to inform network adequacy reporting.

ANA

This section presents the results of all ANA-related activities for TCS and includes requirements for members who receive services from the TennCare Medicaid and Katie Beckett programs. The enrollment files received from TennCare for the TCS program included a small number of CHOICES members. Due to the small number, TDCI and TennCare agreed that the ANA report did not need to include CHOICES members.

The ANA activities included a summary of TCS's statewide network adequacy scores as previously presented in Table 4-32 in the NAV section of this report. In addition to the network adequacy review, the ANA activities also include a statewide benefit delivery score for TCS.

Table 4-34 presents the percentage scores for the six areas used to determine the effectiveness of the PIHP's delivery of covered benefits. The overall Benefit Delivery score was the average score for the total of these six measures.

Table 4-34—Summary of TCS's Statewide Benefit Delivery Scores[1]

Measure	Score
Benefit Delivery—Accessibility: Member	100%
Benefit Delivery—Accessibility: Provider	100%
Network Availability and Accessibility	100%
Appointment Availability—PIHP Complaints	99.98%
PIHP Provider Contracts File Review Results—Quantity	95.00%
PIHP Provider Contracts File Review Results—Quality	95.00%
Overall Benefits Delivery Score	**98.33%**

[1] HSAG obtained the information in this table from the analysis of policies and procedures, contracts, complaint files, member handbooks, provider manual, and virtual review interviews.

TCS achieved a rate of 98.33 percent on its overall benefit delivery score. The lowest score, 95.00 percent, represents quantity and quality elements of the provider contracts file reviews.

Recommendations

After reviewing materials submitted by TCS (including policies and procedures, newsletters, member handbooks, provider manuals, and a sample of provider contracts); administrative data analyses (including a travel distance and travel time analysis, ratio analysis, county analysis, and complaint analysis); and interviews with TCS's staff members, HSAG made the following recommendations that could improve the **quality**, **timeliness**, and **access to care** for members:

- TCS must ensure that provider files include the correct PCP designations since one file chosen for the primary care contract review was not a PCP file.

CAHPS

None of the MY 2024 measure scores representing the **quality of care**, **timeliness of care**, and **access to care** domains for TCS's adult and child Medicaid populations were statistically significantly higher or lower than the MY 2023 measure rates.

None of TCS's adult Medicaid rates met the minimum number of respondents to be reported as a CAHPS survey result. Therefore, TCS may want to explore oversampling the adult Medicaid population in future years to ensure the minimum of 100 respondents required for a measure to be reported as a CAHPS survey result is met. Additionally, TCS should monitor performance to ensure significant decreases in measure rates representing the **quality of care**, **timeliness of care**, and **access to care** domains do not occur.

HEDIS

IS Review Results

Table 4-35 identifies the key elements used by TCS while conducting its MY 2024 HEDIS Compliance Audit. These key elements were reviewed by HSAG during validation activities. A checkmark in Table 4-35 indicates that the LO reviewed the HEDIS activities, which confirmed that HEDIS methodology was being followed. Some activities are identified as being compliant by inserting the name of the company with which TCS contracted to perform the required tasks.

Table 4-35—Validation Activities for TCS

Licensed Organization	Dunwoody Technology Services Group, LLC
Pre-on-site Visit Call/Meeting	✓
Roadmap Review	✓
Software Vendor	Cotiviti, Inc.
Source Code/HEDIS Certified Measures Review	✓
Survey Vendor	Press Ganey
CAHPS Sample Frame Validation	✓
Supplemental Data Validation	✓
Medical Record Review	✓
IDSS Review	✓

In addition to ensuring that data were captured, reported, and presented in a uniform manner, HSAG evaluated TCS's IS capabilities for accurate HEDIS reporting. HSAG reviewed TCS's FAR for its LO's assessment of IS capabilities, specifically focused on those aspects of TCS's system that could have impacted reporting on HEDIS performance measures.

The LO evaluated TCS's compliance with IS standards outlined in the **HEDIS MY 2024 Volume 5 HEDIS Compliance Audit: Standards, Policies and Procedures**. These standards detail the minimum requirements that TCS's information systems should meet to report HEDIS performance measures. For circumstances in which a particular IS standard was not met, the LO rated the impact on HEDIS reporting capabilities and, specifically, any measure that could be impacted.

Table 4-36 provides a summary of TCS's key findings for each IS standard as noted in its FAR.

Table 4-36—Summary of Compliance With IS Standards for TCS

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2024 FARs Review
IS R—Data Management and Reporting • IS R1—The organization's data management enables measurement. • IS R2—Data extraction and loads are complete and accurate. • IS R3—Data transformation and integration is accurate and valid. • IS R4—Data quality and governance are components of the organization's data management. • IS R5—Oversight and controls ensure correct implementation of measure reporting software. • IS R6—Cybersecurity practices are in place to promote protection and resiliency of the systems and data used for measurement.	• TCS was compliant with IS Standard R for Data Management and Reporting. • The LO determined that TCS had procedures in place so that all data elements required for HEDIS reporting were adequately captured. • The LO determined that the PIHP had policies and procedures in place for validation of data extraction, transformation, and integration. • The LO determined that TCS was compliant for the standard for oversight and controls that ensure correct implementation of measure reporting software. • The LO determined that TCS had practices in place to promote protection and resiliency of systems and data. • Adequate validation processes were in place, ensuring data accuracy.
IS C—Clinical and Care Delivery Data • IS C1—Data capture is complete. • IS C2—Data conform with industry standards. • IS C3—Transaction file data are accurate. • IS C4—Organization confirms ingested data meet expectations for data quality.	• TCS was compliant with IS Standard C for Clinical and Care Delivery Data. • The LO determined that TCS had policies and procedures in place for submitted data that conform with industry standards. • Adequate validation processes were in place, ensuring data accuracy and quality.
IS M—Medical Record Review Processes • IS M1—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 M2—Retrieval and abstraction of data from medical records is reliably and accurately performed. • IS M3—Data entry processes are timely and accurate and include sufficient edit checks to	• TCS was compliant with IS Standard M for MRR Processes. • The LO determined that the data collection tool used by the PIHP was able to capture all data fields necessary for HEDIS reporting. • Sufficient validation processes were in place to ensure data accuracy.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2024 FARs Review
ensure accurate entry of submitted data in the files for measure reporting. • IS M4—The organization continually assesses data completeness and takes steps to improve performance. • IS M5—The organization regularly monitors vendor performance against expected performance standards.	
IS A—Administrative Data • IS A1—Data conform with industry standards and measure requirements. • IS A2—Data are complete and accurate. • IS A3—Membership information system enables measurement.	• TCS was compliant with IS Standard A for Administrative Data. • The LO determined that the PIHP appropriately validated that data conform with industry standards and measure requirements. • The LO reviewed the membership information system to ensure that it appropriately enables measurement. • Sufficient validation processes were in place to ensure that data are accurate and complete.

HEDIS Results—Medicaid Population

The TCS plan is administered by BC. TCS's HEDIS results are included in the statewide HEDIS results captured in BC's statewide IDSS report.

HEDIS Results—CHIP Population

The TCS plan did not manage healthcare benefits for the CHIP population.

PDV

Table 4-37 presents the overall rates HSAG reported for each data element reviewed for validation. Of note, cells highlighted in green with a + indicate that 2025 overall rates scored higher than 2024 overall rates, while cells highlighted in red with a ^ indicate that 2025 overall rates scored lower than 2024 overall rates.

Table 4-37—Overall Accuracy Results for TCS

Data Element	2025 Overall	2024 Overall
Active Contract Status	88.02%^	88.44%^
Provider Address	93.18%+	79.41%+

Data Element	2025 Overall	2024 Overall
Provider Specialty/BH Service Code	86.72%^	90.13%^
Provider Panel Status	89.39%+	87.90%+
Routine Care Services	58.00%^	79.35%^
Urgent Care Services	54.95%^	73.01%^
Services for Children	75.12%^	83.71%^
Services for Adults	93.34%+	91.05%+
Primary Care Services	89.45%^	92.96%^
Prenatal Care Services	96.26%^	96.84%^

Strengths

For 2025, Provider Address, Services for Adults, and Prenatal Care Services resulted in an overall rate greater than 90 percent.

Opportunities for Improvement

For 2025, Active Contract Status, Provider Specialty/BH Service Code, Provider Panel Status, Routine Care Services, Urgent Care Services, Services for Children, and Primary Care Services resulted in overall rates below 90 percent, indicating data **quality** concerns.

Recommendation

To address the provider data **quality** concerns, HSAG recommends that TCS utilize the case-level data files containing mismatched information between the PEFs and the provider office responses, and address the data deficiencies (e.g., provider specialty/BH Service Code, provider panel, or incorrect or disconnected telephone numbers that do not correspond to the sampled provider). Additionally, TCS should consider conducting outreach to providers to ensure the providers and/or their offices routinely submit up-to-date information on all pertinent provider indicators (e.g., active contract status, updated contact information, and panel status).

DQ

AQS Compliance Review

The AQS review included a review of documents and interviews with DQ staff members to determine compliance with State and federal requirements. The extensive document review occurred pre-audit, during the audit, and post-audit to ensure that HSAG reviewed all available information to satisfy the audit requirements. Interviews with DQ staff members assisted in clarifying HSAG's outstanding questions and obtained information needed to assign scores for the review.

Table 4-38 displays the detailed scores for each of the standards included in DQ's 2025 AQS compliance review. The listing of total elements, total applicable elements (i.e., number of elements with the not applicable [NA] elements removed), **Met** elements, and **Not Met** elements provide details concerning the final score for each standard. Based on the overall score achieved by DQ, HSAG established a level of confidence rating for this year's compliance review as defined below:

- 90%–100%: High confidence in the PAHP's compliance with State and federal requirements
- 80%–89%: Moderate confidence in the PAHP's compliance with State and federal requirements
- 70%–79%: Low confidence in the PAHP's compliance with State and federal requirements
- Under 70%: No confidence in the PAHP's compliance with State and federal requirements

Table 4-38—2025 AQS Compliance Review Scores for DQ

Standard Name	Total Elements	Total Applicable Elements	Met	Partially Met	Not Met*	Score**
Coordination and Continuity of Care	9	9	9	0	0	100%
Emergency and Poststabilization Services	3	3	3	0	0	100%
Practice Guidelines	6	6	6	0	0	100%
Health Information Systems	6	6	6	0	0	100%
Quality Assessment and Performance Improvement (QAPI) Program	5	5	5	0	0	100%
Enrollment and Disenrollment: Requirements and Limitations	12	12	12	0	0	100%
EPSDT	21	21	21	0	0	100%
Overall Score	**62**	**62**	**62**	**0**	**0**	**100%**
Confidence Level	**High**					

* **Not Met** elements were addressed in the CAP completed by DQ.
** A **Met** score equals 1.0 point and a **Not Met** score equals 0.0 points.
Total Elements: The total number of elements in each standard.
Total Applicable Elements: The total number of elements within the standard, after removing nonapplicable elements.

DQ obtained 100 percent compliance on every standard included in the 2025 AQS compliance review and achieved a level of **High Confidence** for the review. HSAG commends DQ for achieving 100 percent compliance on the seven standards and 62 elements included in the 2025 AQS compliance review. The DBM submitted written documentation to support the State and federal requirements, and interviews with staff members confirmed their understanding and correct implementation of those requirements. Achieving 100 percent compliance in these areas improved the **quality**, **timeliness**, and **access to care** for members.

TennCare required DQ to submit a CAP for any element in the AQS that received a score of less than 100 percent. Because DQ achieved 100 percent compliance on every standard included in the 2025 AQS compliance review, the DBM was not required to submit a CAP.

PIPs

For CY 2025, DQ submitted the following PIPs: **Oral Health Disparities** and **Pregnant & Postpartum Dental Utilization**. DQ received **Met** validation scores for 100 percent of all applicable evaluation elements validated for both PIPs. HSAG did not identify any opportunities for improvement.

PMV

The PMV results showed that DQ had robust processes in place to ensure the accuracy and completeness of the data needed to support reporting on TennCare-selected performance measures. DQ demonstrated engagement, partnership, and commitment to the PMV process by providing timely responses to HSAG's questions and supplying the follow-up information requested by HSAG auditors. The PMV results also showed that TennCare had robust processes in place to calculate and report valid rates on the performance measures in the scope of the PMV. TennCare demonstrated its experience with performance measure calculation during the PMV process. HSAG's review of DQ's and TennCare's IS and data processes did not identify any opportunities for improvement.

While trending was not possible for the **OEV-CH** measure due to changes in the measure specifications, HSAG was able to trend DQ's performance on the **SFM-CH** measure between MY 2023 and MY 2024. The TennCare-calculated rates on **SFM-CH** demonstrate that DQ improved its performance on this measure across the MYs for both the Medicaid and CoverKids populations. [**Quality, Timeliness, Access**]

NAV

For each evaluation item for each provider type, a performance score was determined by calculating the percentage of the actual point value that the PAHP achieved based on the applicable CRA standard. Table 4-39 presents a high-level summary of the scores for the Network Adequacy portion of the ANA audit.

Table 4-39—Summary of Statewide Network Adequacy Scores for DQ

Evaluation Area	Standard 1	% of Members (Standard 1)	Standard 2	% of Members (Standard 2)	Overall Score[1]
GDP Ratio for all non-ECF CHOICES members	2,500:1	100%			100%
GDP Distance for all non-ECF CHOICES members	30 miles travel distance or 45 minutes travel time	100%			100%
Oral Surgery Travel Distance for all non-ECF CHOICES members	60 miles travel distance or 60 minutes travel time	>99.99%			>99.99%
Orthodontic Services Travel Distance for all non-ECF CHOICES members	60 miles travel distance or 60 minutes travel time	>99.99%			>99.99%
Pediatric Dental Services Travel Distance for all non-ECF CHOICES members	70 miles travel distance or 70 minutes travel time	100%			100%
Dental Provider Travel Distance for ECF CHOICES members[2]	30 miles travel distance or 45 minutes travel time	99.47%	60 miles travel distance or 60 minutes travel time	100%	100%
Overall Network Adequacy Score		**99.91%**		**100%**	**>99.99%**

[1] The overall score is based on the combination of scores for Standard 1 (75 percent of members within 30 miles travel distance or 45 minutes travel time) and Standard 2 (100 percent of members within 60 miles travel distance or 60 minutes travel time). However, because Standard 1 is based on 75 percent of the members, the Standard 1 score is adjusted, or weighted, to the total population. This adjusted score is then combined with the Standard 2 score to obtain the overall score.

[2] The travel distance and travel time requirement is one provider within 30 miles travel distance or 45 minutes travel time for 75 percent of the members, and 60 miles travel distance or 60 minutes travel time for all ECF CHOICES members. Since greater than 75 percent of members had access within 30 miles for Standard 1, the Network Adequacy Score for this evaluation area is 100 percent. The ECF CHOICES travel distance and travel time requirements were calculated using all ECF members selecting dental benefits.

Table 4-39 shows that DQ achieved total compliance with the availability and geographic accessibility standards, except for oral surgery and orthodontist providers for all non-ECF CHOICES members. HSAG identified that 100 percent of members were within distance standards for GDPs and Pediatric Dental Services. For non-ECF CHOICES members, >99.99 percent had access to oral surgeons, >99.99 percent had access to orthodontists, and 100 percent had access to pediatric dentists within the travel distance and travel time standards.

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 9 indicators for DQ. Of these indicators, 100 percent received ratings of **High Confidence**. Table 4-40 summarizes HSAG's validation results.

Table 4-40—Summary of DQ's Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Time/Distance Indicators	100%	0%	0%	0%

HSAG evaluated and assessed the data methods used by DQ to calculate results generated for each network adequacy indicator in scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that DQ used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator. HSAG determined that data collection procedures and network adequacy methods in place at DQ and TennCare, and network adequacy results calculated by TennCare were **Acceptable**.

Recommendations

After reviewing materials submitted by DQ, the administrative data analyses (including distance analyses, ratio analyses, county analyses, and complaint analyses), HSAG concluded the following recommendations:

- DQ must ensure that all members have access to general orthodontists within the TennCare required travel distance and travel time standards.
- DQ must ensure that all members have access to oral surgeons within the TennCare required travel distance and travel time standards.

DQ maintained robust processes to maintain the accuracy and completeness of provider data through its multiple methods of identifying changes to provider information, such as the utilization of Provider Trust to routinely review provider data against state and federal databases and quarterly outreaches to providers to validate their demographic information. HSAG did not identify specific opportunities related to the data collection and management processes DQ had in place to inform network adequacy reporting.

ANA

The TennCare DBM contract between TennCare and DQ establishes minimum benefit and service requirements/limitations to be provided to members by the DBM. The contract also includes the provision that requires the DBM to ensure the availability and accessibility of primary and specialty dental care services.

The ANA activities included a summary of DQ's statewide network adequacy scores as previously presented in Table 4-39 in the NAV section of this report. In addition to the network adequacy review, the ANA activities also include a statewide benefit delivery score for DQ.

Table 4-41 presents the percentage scores for the six areas used to determine the effectiveness of the DBM's delivery of covered benefits. The average score for the total of these six measures resulted in the overall benefit delivery score.

Table 4-41—Summary of DQ's Statewide Benefit Delivery Scores[1]

Measure	Score
Benefit Delivery—Accessibility: Member	100%
Benefit Delivery—Accessibility: Provider	100%
Network Availability and Accessibility	100%
Appointment Availability—DBM Complaints	>99.99%
DBM Provider Contracts File Review Results—Quantity	100%
DBM Provider Contracts Files Review Results—Quality	100%
Overall Benefits Delivery Score	**>99.99%**

[1] The information in this table was obtained from the analysis of policies and procedures, contracts, complaint files, member handbooks, provider manual, newsletters, contracts, complaint files, and virtual review interviews.

DQ achieved a rate of >99.99 percent on its overall benefit delivery score. The lowest score, >99.99 percent, represents the rate for statewide complaints by comparing the total number of access and availability complaints to the total DQ population.

Recommendations

After reviewing materials submitted by DQ (including policies and procedures, newsletters, member handbooks, provider manuals, and a sample of provider contracts); administrative data analyses (including a travel distance and travel time analysis, ratio analysis, county analysis, and complaint analysis); and interviews with DQ's staff members, HSAG made the following recommendations that could improve the **quality**, **timeliness**, and **access to care** for members:

- DQ must ensure that all members have access to general orthodontists within the TennCare required travel distance and travel time standards.
- DQ must ensure that all members have access to oral surgeons within the TennCare required travel distance and travel time standards.

PDV

Table 4-42 presents the overall rates HSAG reported for each data element reviewed for validation. Of note, cells highlighted in green with a + indicate that 2025 overall rates scored higher than 2024 overall rates, while cells highlighted in red with a ^ indicate that 2025 overall rates scored lower than 2024 overall rates.

Table 4-42—Overall Accuracy Results for DQ

Data Element	2025 Overall	2024 Overall
Active Contract Status	86.89%^	90.54%^
Provider Address	95.12%+	94.75%+
Provider Specialty/BH Service Code	88.28%^	97.80%^
Provider Panel Status	92.44%+	88.04%+
Routine Care Services	67.54%^	83.26%^
Urgent Care Services	79.25%^	91.46%^
Services for Children	91.97%^	97.69%^
Services for Adults	68.48%^	72.37%^

Strengths

For 2025, Provider Address, Provider Panel Status, and Services for Children resulted in an overall rate greater than 90 percent.

Opportunities for Improvement

For 2025, Active Contract Status, Provider Specialty/BH Service Code, Routine Care Services, Urgent Care Services, and Services for Adults resulted in overall rates below 90 percent, indicating data **quality** concerns.

Recommendation

To address the provider data **quality** concerns, HSAG recommends that DQ utilize the case-level data files containing mismatched information between the PEFs and the provider office responses, and address the data deficiencies (e.g., provider specialty/BH Service Code, provider panel, or incorrect or disconnected telephone numbers that do not correspond to the sampled provider). Additionally, DQ should consider conducting outreach to providers to ensure the providers and/or their offices routinely submit up-to-date information on all pertinent provider indicators (e.g., active contract status and updated contact information).

ORx

AQS Compliance Review

The AQS review included a review of documents and interviews with ORx staff members to determine compliance with State and federal requirements. The extensive document review occurred pre-audit, during the audit, and post-audit to ensure that HSAG reviewed all available information to satisfy the audit requirements. Interviews with ORx's staff members assisted in clarifying HSAG's outstanding questions and obtained information needed to assign scores for the review.

Table 4-43 displays the detailed scores for each of the standards included in ORx's 2025 AQS compliance review. The listing of total elements, total applicable elements (i.e., number of elements with the not applicable [NA] elements removed), **Met** elements, and **Not Met** elements provide details concerning the final score for each standard. Based on the overall score achieved by ORx, HSAG established a level of confidence rating for this year's compliance review as defined below:

- 90%–100%: High confidence in the PAHP's compliance with State and federal requirements
- 80%–89%: Moderate confidence in the PAHP's compliance with State and federal requirements
- 70%–79%: Low confidence in the PAHP's compliance with State and federal requirements
- Under 70%: No confidence in the PAHP's compliance with State and federal requirements

Table 4-43—2025 AQS Compliance Review Scores for ORx

Standard Name	Total Elements	Total Applicable Elements	Met	Partially Met	Not Met*	Score**
Coordination and Continuity of Care	2	2	2	0	0	100%
Practice Guidelines	4	4	3	1	0	87.50%
Health Information Systems	4	4	4	0	0	100%
Quality Assessment and Performance Improvement (QAPI) Program	5	5	4	1	0	90.00%
Emergency and Poststabilization Services	6	6	4	2	0	83.33%
Enrollment and Disenrollment Requirements and Limitations	9	9	7	0	2	77.78%
Overall Score	**30**	**30**	**24**	**4**	**2**	**86.67%**
Confidence Level	**Moderate**					

* **Not Met** elements were addressed in the CAP completed by ORx.
** A **Met** score equals 1.0 point and a **Not Met** score equals 0.0 points.
Total Elements: The total number of elements in each standard.
Total Applicable Elements: The total number of elements within the standard, after removing nonapplicable elements.

ORx obtained an overall compliance score of 86.67 percent across all standards included in the 2025 AQS compliance review and achieved a level of **Moderate Confidence** for the review. HSAG

commends ORx for achieving 100 percent compliance on the Coordination and Continuity of Care and Health Information Systems standards included in the 2025 AQS compliance review. The DBM submitted written documentation to support the State and federal requirements, and interviews with staff members confirmed their understanding and correct implementation of those requirements. Achieving 100 percent compliance in these areas improved the **quality**, **timeliness**, and **access to care** for members.

Opportunities for Improvement

TennCare required ORx to submit a CAP for each element within a standard identified as an AON. An AON resulted for any element in the AQS compliance review that received a score of less than 100 percent and presented opportunities for improvement. ORx received a score of less than 100 percent in four of the standards included in the 2025 AQS compliance review. HSAG and TennCare worked with ORx to resolve the CAP.

Required CAPs for ORx's AONs are identified below and include the necessary evidence to achieve compliance with the standard.

Practice Guidelines

- ORx must have evidence of periodically reviewing and updating its practice guidelines as appropriate.

QAPI Program

- ORx must establish and implement a comprehensive QAPI Program that addresses quality initiatives, monitoring activities, and activities to improve the quality of care and services for its members.

Emergency and Poststabilization Services

- ORx must demonstrate and provide evidence of oversight of the pharmacy provider network to ensure enforcement of the 72-hour emergency supply override process.
- ORx must provide evidence that the PBM utilized corrective action for pharmacies that failed to comply with the 72-hour emergency supply rule.

Enrollment and Disenrollment: Requirements and Limitations

- ORx must develop and implement mechanisms to ensure staff members understand the reasons that TennCare will not disenroll a member.
- ORx must inform its Tennessee staff members and ensure their understanding of the causes for disenrollment.

PIPs

For CY 2025, ORx submitted the following PIPs: **Schizophrenia Medication Compliance Improvement Plan** and **Reducing Rejected Claims**. ORx received **Met** validation scores for 100 percent of all applicable evaluation elements validated for the **Reducing Rejected Claims** PIP and received a **High Confidence** level rating for the overall confidence of adherence to acceptable methodology for all phases of the PIP completed. For the **Schizophrenia Medication Compliance Improvement Plan** PIP, ORx received a **High Confidence** level rating for the overall confidence of adherence to acceptable methodology for all phases of the PIP, and a **Moderate Confidence** level rating for the overall confidence that the PIP achieved significant improvement. HSAG did not identify any opportunities for improvement.

PMV

The PMV results showed the ORx had robust processes in place to ensure the accuracy and completeness of the data needed to support reporting on TennCare-selected performance measures. ORx demonstrated engagement, partnership, and commitment to the PMV process by providing timely responses to HSAG's questions and supplying the follow-up information requested by HSAG auditors. The PMV results also showed that TennCare had robust processes in place to calculate and report valid rates on various performance measures, including the measures in scope for ORx. HSAG's review of TennCare's source code for MYs 2023 and 2024 confirmed that the calculation of ORx measures was conducted according to the **FFY 2024** and **FFY 2025 Adult Core Set Specifications**. HSAG's review of ORx's and TennCare's IS and data processes did not identify any opportunities for improvement.

When trending ORx's performance on the **COB-AD** and OUD-AD measures between MY 2023 and MY 2024, the TennCare-calculated rates on these measures show little change in ORx's performance across the MYs. [**Quality**]

NAV

For each evaluation item for each provider type, a performance score was determined by calculating the percentage of the actual point value that the PAHP achieved based on the applicable CRA standard. Table 4-44 presents a high-level summary of the scores for the Network Adequacy portion of the ANA audit.

Table 4-44—Summary of Statewide Network Adequacy Scores for ORx

Evaluation Area	Standard 1	% of Members (Standard 1)	Overall Score
Transport distance and travel time to pharmacy providers: Urban areas	3 miles and 15 minutes	99.96%	99.96%
Transport distance and travel time to pharmacy providers: Suburban areas	10 miles and 20 minutes	100%	100%

Evaluation Area	Standard 1	% of Members (Standard 1)	Overall Score
Transport distance and travel time to pharmacy providers: Rural areas	25 miles and 30 minutes	100%	100%
Network Adequacy Score		**99.99%**	**99.99%**

[1]Average of the performance scores for items in each evaluation area.

Table 4-44 shows that ORx achieved total compliance for the availability and geographic accessibility standards for transport distance and travel time to suburban and rural pharmacy providers. However, ORx did not meet the standard for transport distance and time to urban pharmacy providers for 0.04 percent of members.

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of three indicators for ORx. Of these indicators, 100 percent received ratings of **High Confidence**. Table 4-45 summarizes HSAG's validation results.

Table 4-45—Summary of ORx's Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Time/Distance Indicators	100%	0%	0%	0%

HSAG evaluated and assessed the data methods used by ORx to calculate results generated for each network adequacy indicator in scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that ORx used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator. HSAG determined that data collection procedures and network adequacy methods in place at ORx and TennCare, and network adequacy results calculated by TennCare were **Acceptable**.

Recommendations

After reviewing materials submitted by ORx, the administrative data analyses (including distance analyses, ratio analyses, county analyses, and complaint analyses), HSAG concluded the following recommendations:

- ORx must ensure that all members in urban areas have access to pharmacy providers within the TennCare required distance/time standards.
- ORx demonstrated the ability to maintain complete member data by implementing procedures such as validating member counts weekly. TennCare maintained robust processes for collecting and reviewing the provider data from ORx. TennCare also used sound and consistent methodologies to assess all network adequacy indicators. ORx did not have any validation processes in place to ensure provider data identified in the National Council for Prescription Drug Programs (NCPDP) were accurate and complete data for the provider. HSAG recommends ORx implement processes to validate provider data received through the NCPDP, to ensure accurate data for network adequacy reporting.

ANA

The PBM contract between TennCare and ORx establishes minimum benefit and service requirements/limitations to be provided to members by the PBM. The contract also includes the provision that the PBM is required to ensure the availability and accessibility of pharmacy services.

The ANA activities included a summary of ORx's statewide network adequacy scores as previously presented in Table 4-44 in the NAV section of this report. In addition to the network adequacy review, the ANA activities also include a statewide overall appointment availability score for ORx.

Table 4-46 presents the percentage scores for the two areas used to determine the accuracy of the PBM's policies and procedures regarding appointment availability and member complaints received concerning access to pharmacy services. The average score for the total of these two measures resulted in the overall benefit delivery score.

Table 4-46—Summary of ORx's Statewide Overall Appointment Availability Score[1]

Measure	Score
Network Availability and Accessibility	93.75%
Appointment Availability—PBM Complaints	>99.99%
Overall Appointment Availability Score	**96.87%**

[1] The information in this table was obtained from the analysis of policies and procedures, complaint files, and virtual interviews.

ORx scored 96.87 percent for the overall appointment availability review. The lowest score, 93.75 percent, represents network availability and accessibility elements that did not meet compliance requirements.

Recommendations

After reviewing materials submitted by ORx (including policies and procedures; newsletters; member handbooks; provider manuals; and a sample of provider contracts), administrative data analyses (including a travel distance and travel time analysis; ratio analysis; county analysis; and complaint analysis), and interviews with ORx's staff members, HSAG made the following recommendations that could improve the **quality**, **timeliness**, and **access to care** for members:

- ORx must take corrective action if a pharmacy fails to comply with established access requirements.
- ORx must implement a mechanism to ensure that network pharmacies provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.
- ORx must ensure that members living in urban areas have access to pharmacies within the TennCare required travel distance and travel time standards.

5. TennCare Quality Strategy Effectiveness Evaluation

Background

TennCare developed the 2024 Quality Assessment and Performance Improvement Strategy Update, dated December 2024, as required by 42 CFR §438.340 and §457.1240(e). CMS, Department of Health and Human Services, issued the final rules concerning the requirements for states' quality strategy in the Federal Register on May 10, 2024. According to 42 CFR §438.340(b)(2) and (b)(3)(i), a state's quality strategy must include:

- The State's goals and objectives for continuous QI which must be measurable and take into consideration the health status of all populations in the State served by the MCO, PIHP, PAHP, and PCCM [Primary Care Case Management] entity….
- A description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, PAHP, and PCCM entity described in §438.310(c)(2) with which the State contracts, including but not limited to, the performance measures reported in accordance with §438.330(c). The State must identify which quality measures and performance outcomes the State will publish at least annually on the website.[30]

TennCare included the following statement concerning the rationale for selecting the performance goals included in the TennCare Quality Strategy:

> To provide high-quality care to enrollees that will improve health outcomes, TennCare will focus on improving the health and wellness of mothers and infants, increasing preventive services for the state's Medicaid and CHIP populations and improving chronic health conditions.[31]

TennCare originally established CHIP as a separate FFS program. In January 2021, however, Tennessee transitioned its separate CHIP from FFS to managed care. TennCare uses the same MCCs to provide care and services to Medicaid and CHIP beneficiaries, and the Quality Strategy defines performance goals to improve both programs. To set the performance goals, TennCare established statewide rates by comparing the current rate to national benchmarks (e.g., 50th, 75th, and 90th percentiles). If there were no national benchmarks available, TennCare established the performance target to indicate a 2 percent improvement.[32]

[30] National Archives and Records Administration. 2025. Electronic Code of Federal Regulations. Available at: eCFR :: 42 CFR 438.340 -- Managed care State quality strategy. Accessed on: Feb 9, 2026.
[31] TennCare. 2024. **TennCare 2024 Quality Strategy Updat**e. Available at: Historical - 2024 Update of Quality Improvement Strategy. Accessed on: Feb 9, 2026.
[32] Ibid.

Methodology

HSAG obtained the CY 2024 TennCare Quality Assessment and Performance Improvement Strategy Update and used the document to complete the review required by 42 CFR §438.364(a)(4) as shown below:

> The State must ensure that the EQR results in an annual detailed technical report that summarizes findings on access and quality of care, including … recommendations for improving the quality of health care services furnished by each MCO…including how the State could target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.[33]

The TennCare Quality Assessment and Performance Improvement Strategy Update included seven goals with associated quality metrics and performance targets:

- Goal 1: Improve the health and wellness of mothers and infants
- Goal 2: Increase use of preventive care services for all members to reduce risk of chronic health conditions
- Goal 3: Integrate patient-centered, holistic care including non-medical risk factors into population health coordination for all members
- Goal 4: Improve positive outcomes for members with LTSS needs
- Goal 5: Provide additional support and follow-up for patients with behavioral health care needs
- Goal 6: Maintain robust member access to health care services
- Goal 7: Maintain financial stewardship through increasing value-based payments and cost-effective care[34]

HSAG reviewed each goal and selected HEDIS measures to include in this year's evaluation of TennCare's Quality Strategy. The measures represent the following domains identified in the **HEDIS Measurement Year 2024 Volume 2: Technical Specifications for Health Plans**:[35]

- Access/Availability of Care
- Utilization and Risk Adjusted Utilization
- Effectiveness of Care:
  - Prevention and Screening
  - Diabetes

[33] National Archives and Records Administration. 2025. Electronic Code of Federal Regulations. Available at: eCFR :: 42 CFR 438.364 -- External quality review results. Accessed on: Feb 9, 2026.
[34] TennCare. 2024. **TennCare 2024 Quality Strategy Update**. Available at: Historical - 2024 Update of Quality Improvement Strategy. Accessed on Feb 9, 2026.
[35] National Committee for Quality Assurance. 2024. **HEDIS Measurement Year 2024 Volume 2: Technical Specifications for Health Plans**, Washington, DC; 2024.

  - Cardiovascular Conditions
  - Behavioral Health
  - Respiratory Conditions
- ECDS
- LTSS

Findings

TennCare established the baseline performance targets in 2019 and 2020. The comparison rates used in this report are the 2025 Statewide HEDIS rates (i.e., MY 2024). TennCare established goal rates to be achieved by 2025; therefore, the Performance Goal Met column indicates whether the goal rate was met or not met.

Table 5-1 presents the description of the measures found in the CY 2024 TennCare Quality Assessment and Performance Improvement Strategy Update, the associated HEDIS measure, TennCare's goal (i.e., 1–7) in the Quality Strategy, the baseline rate, the 2025 performance goal, the 2025 HEDIS rate, and whether the performance goal was met (i.e., yes/no).

Table 5-1—Achievement of the 2025 HEDIS Rates Compared to the 2025 Performance Goal Rates

Domain Measure Description	HEDIS Measure	Associated Goal	Statewide Baseline Rate/Date	Statewide 2025 Performance Goal	MY 2025 Rate	Performance Goal Met (Yes/No)
Access/Availability of Care						
Postpartum Care	**PPC**	Goal 1	69.4% (2019)	73.4%	80.40%	**Yes**
Adults' Access to Preventive/Ambulatory Health Services: Ages 20–44	**AAP**	Goal 6	79.0% (2019)	81.0%	79.99%	**No**
Adults' Access to Preventive/Ambulatory Health Services: Ages 45–64	**AAP**	Goal 6	87.7% (2019)	89.7%	86.76%	**No**
Utilization and Risk Adjusted Utilization						
Well-Child Visits in the First 15 Months of Life	**W30**	Goal 1	53.7% (2020)	56.7%	70.09%	**Yes**
Well-Child Visits in the First 30 Months of Life	**W30**	Goal 1	67.8% (2020)	70.8%	76.82%	**Yes**
Child and Adolescent Well-Care Visits: Ages 3–11	**WCV**	Goal 2	58.6% (2020)	60.6%	66.97%	**Yes**

Domain Measure Description	HEDIS Measure	Associated Goal	Statewide Baseline Rate/Date	Statewide 2025 Performance Goal	MY 2025 Rate	Performance Goal Met (Yes/No)
Child and Adolescent Well-Care Visits: Ages 12–17	**WCV**	Goal 2	49.9% (2020)	51.9%	56.17%	**Yes**
Child and Adolescent Well-Care Visits: Ages 18–21	**WCV**	Goal 2	25.9% (2020)	27.9%	31.89%	**Yes**
Effectiveness of Care: Prevention and Screening						
Childhood Immunization Status: Combination 10	**CIS**	Goal 2	36.7% (2019)	39.7%	27.48%	**No**
Immunizations for Adolescents: Combination 2	**IMA**	Goal 2	33.4% (2019)	36.4%	34.79%	**No**
Cervical Cancer Screening	**CCS**	Goal 2	64.2% (2019)	66.2%	56.20%	**No**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile—Ages 3–11	**WCC**	Goal 2	80.2% (2019)	83.2%	84.07%	**Yes**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile—Ages 12–17	**WCC**	Goal 2	76.5% (2019)	79.5%	79.89%	**Yes**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile—Total	**WCC**	Goal 2	79.0% (2019)	82.0%	82.43%	**Yes**
Effectiveness of Care: Diabetes						
Controlling High Blood Pressure	**BPD**	Goal 2	60.4% (2019)	63.4%	72.50%	**Yes**
Eye Exam for Patients with Diabetes	**EED**	Goal 2	52.0% (2019)	55.0%	55.27%	**Yes**
Kidney Health Evaluation for Patients With Diabetes: Total	**KED**	Goal 2	26.9% (2020)	28.9%	40.02%	**Yes**
Effectiveness of Care: Cardiovascular Conditions						
Controlling High Blood Pressure	**CBP**	Goal 2	64.2% (2019)	66.2%	70.59%	**Yes**

Domain Measure Description	HEDIS Measure	Associated Goal	Statewide Baseline Rate/Date	Statewide 2025 Performance Goal	MY 2025 Rate	Performance Goal Met (Yes/No)
Effectiveness of Care: Behavioral Health						
Follow-Up After Hospitalization for Mental Illness: 7-Day Rate—Adults Ages 18–64	**FUH**	Goal 5	33.5% (2019)	35.5%	36.27%	**Yes**
Follow-Up After Hospitalization for Mental Illness: 7-Day Rate—Children Ages 6–17	**FUH**	Goal 5	51.4% (2019)	53.4%	51.39%	**No**
Follow-Up After Hospitalization for Mental Illness: 30-Day Rate—Adults Ages 18–64	**FUH**	Goal 5	55.4% (2019)	57.4%	56.42%	**No**
Follow-Up After Hospitalization for Mental Illness: 30-Day Rate—Children Ages 6–17	**FUH**	Goal 5	73.3% (2019)	75.3%	73.58%	**No**
Pharmacotherapy for Opioid Use Disorder: Total	**POD**	Goal 5	32.4% (2019)	34.4%	29.82%	**No**
Effectiveness of Care: Respiratory Conditions						
Asthma Medication Ratio: Total	**AMR**	Goal 2	51.0% (2019)	54.0%	69.24%	**Yes**
Electronic Clinical Data Systems						
Breast Cancer Screening*	**BCS-E**	Goal 2	53.8% (2020)	56.8%	51.46%	**No**
Long-Term Services and Supports						
Long-Term Services and Supports Comprehensive Assessment and Update: Assessment of Core Elements	**LTSS-CAU**	Goal 4	78.0% (2019)	80.0%	96.19%	**Yes**
Long-Term Services and Supports Comprehensive Assessment and Update: Assessment of Supplemental Elements	**LTSS-CAU**	Goal 4	74.6% (2019)	76.6%	95.86%	**Yes**
Long-Term Services and Supports Comprehensive	**LTSS-CPU**	Goal 4	75.6% (2019)	77.6%	95.78%	**Yes**

Domain Measure Description	HEDIS Measure	Associated Goal	Statewide Baseline Rate/Date	Statewide 2025 Performance Goal	MY 2025 Rate	Performance Goal Met (Yes/No)
Care Plan and Update: Care Plan With Core Elements Documented						
Long-Term Services and Supports Comprehensive Care Plan and Update: Care Plan With Supplemental Elements Documented	**LTSS-CPU**	Goal 4	75.5% (2019)	77.5%	95.70%	**Yes**
Long-Term Services and Supports Shared Care Plan With Primary Care Practitioner	**LTSS-SCP**	Goal 4	53.7% (2019)	55.7%	90.92%	**Yes**
Long-Term Services and Supports Reassessment After Inpatient Discharge	**LTSS-RAC**	Goal 4	21.1% (2019)	23.1%	63.50%	**Yes**
Long-Term Services and Supports Reassessment/Care Plan Update After Inpatient Discharge	**LTSS-RAC**	Goal 4	16.6% (2019)	18.6%	57.99%	**Yes**

*TennCare established the original performance goal for **BCS**; however, the rate for **BCS-E** is currently the only HEDIS rate reported for that measure.

Evaluation

TennCare included seven goals with associated quality metrics and performance targets in the Quality Strategy. HSAG evaluated 32 HEDIS measures from Goals 1, 2, 4, 5, and 6. Goals 3 and 7 did not include any HEDIS measures for consideration.

The 32 measures included 22 (i.e., 68.75 percent) that met the performance goals and 10 (i.e., 31.25 percent) that did not meet the performance goals. The 32 measures include requirements that will improve the **quality of care**, **timeliness of care**, and **access to care** for TennCare members. From the 10 rates that did not meet the performance goals, seven were less than 5 percentage points from the performance goal as shown below:

- **Adults' Access to Preventive/Ambulatory Health Services: Ages 20–44**
- **Adults' Access to Preventive/Ambulatory Health Services: Ages 45–64**
- **Immunizations for Adolescents: Combination 2**

- **Follow-Up After Hospitalization for Mental Illness: 7-Day Rate—Adults Ages 6–17**
- **Follow-Up After Hospitalization for Mental Illness: 30-Day Rate—Adults Ages 6–17**
- **Follow-Up After Hospitalization for Mental Illness: 30-Day Rate—Adults Ages 18–64**
- **Pharmacotherapy for Opioid Use Disorder: Total**

Three rates were greater than 5 percentage points from the performance goal as shown below:

- **Childhood Immunizations—Combination 10 (CIS)**
- **Cervical Cancer Screening (CCS)**
- **Breast Cancer Screening (BCS-E)**

The current MY 2024 HEDIS rates for those three measures are below the baseline rate listed in the Quality Strategy. TennCare established the performance goals for the three measures in 2019, which was prior to or during the restrictions mandated by the coronavirus disease 2019 (COVID-19) pandemic. The Centers for Disease Control and Prevention declared the COVID-19 pandemic at the beginning of 2020, and the public health emergency (PHE) continued until May 2023. In MY 2021, many restrictions related to the PHE were lifted; however, the PHE may have impacted members' ability to schedule appointments with providers and their willingness to travel to provider appointments. Although the use of telemedicine increased during the pandemic, it was difficult to conduct a visit for the preventive care measures via telehealth (i.e., **CIS**, **CCS**, and **BCS-E**) due to the physical contact required for a physical examination, immunizations, or a screening test. Since the rates for these three preventive care measures remain below the baseline rate, the effects of the COVID-19 pandemic may have continued to impact those rates.

Recommendations

Research has found success with mobile health units in reducing barriers to healthcare (e.g., transportation and system complexity).[36] TennCare and the MCCs may consider exploring the feasibility of mobile intervention strategies to increase screenings and preventive care, especially for members in underserved communities. TennCare and the MCCs may consider collaborating with the Tennessee Mobile Servies Workgroup, a partnership between Tennessee's Department of Mental Health & Substance Abuse Services and Department of Health (DOH).[37] Even though this workgroup primarily focuses on BH services, MCOs could learn best practices and implementation strategies for mobile health units that could improve the rates for breast cancer screening, cervical cancer screening, and childhood immunizations.

[36] Malone NC, Williams MM, Smith Fawzi MC, et al. Mobile health clinics in the United States. **International Journal of Health Equity** 2020, 19, 40. Available at: Mobile health clinics in the United States - PubMed. Accessed on: Feb 9, 2026.

[37] Tennessee Department of Mental Health and Substance Abuse Services. TN Mobile Services Workgroup. Available at: TN Mobile Services Workgroup. Accessed on: Feb 9, 2026.

To improve children's health services, Tennessee has twice expanded the list of school-based services in recent years, a cost-effective approach that improves access to care for children.[38,39] A 2025 report from the Tennessee Advisory Commission on Intergovernmental Relations, however, reported barriers from school districts, including challenges with reimbursement, liability issues as potential concerns, and challenges with administrative workloads relating to documenting and filing claims.[40] Previously, TennCare has partnered with the MCOs to help alleviate these barriers by providing training and guidance to school districts.[41] Moving forward, TennCare and the MCOs should continue to provide further guidance, education, and technical assistance, potentially per quarter. It may also be advantageous for MCOs to partner with school districts to share best practices on improving processes within schools, potentially through webinars or newsletters.

Conclusions

HSAG evaluated the performance goals found in the CY 2024 TennCare Quality Assessment and Performance Improvement Strategy Update and compared those rates to the 2025 HEDIS rates from MY 2024. Of the 32 HEDIS measures evaluated, 22 (i.e., 68.75 percent) met the performance goals and 10 (i.e., 31.25 percent) did not meet the performance goals. Of the 10 measures that did not meet the performance goals, only three were below the performance goal by more than 5 percentage points.

TennCare is to be commended for setting realistic goals but encouraged to ensure that future HEDIS goals also include the relationship of those goals to national standards (e.g., NCQA's Quality Compass 50th, 75th, and 90th percentiles).

[38] Tennessee Department of Education. School-Based Medicaid. Available at: School-Based Medicaid. Accessed on: Feb 9, 2026.

[39] Tennessee Advisory Commission on Intergovernmental Relations. Contract Addendum Could Resolve Potential Issues for School Districts Seeking TennCare Reimbursements. 2025. Available at: Contract Addendum Could Resolve Potential Issues for School Districts Seeking TennCare Reimbursements. Accessed on: Feb 9, 2026.

[40] Ibid.

[41] Ibid.

6. Follow-Up on Prior Recommendations

The following section presents recommendations made by the previous EQRO, Qsource, in the prior year's EQR report (i.e., CY 2024 EQR Technical Report) and an assessment of the actions that the MCCs implemented to correct the areas needing improvement. Reported results include BC, UHC, WLP, TCS, DQ, and ORx.

Table 6-1—Prior Year's EQR Recommendations and Corrective Actions Completed for BC

Prior Recommendation	Actions
AQS Compliance Review	
CHOICES Recredentialing File Review	
BC must ensure it performs recredentialing of providers at least annually for ongoing CHOICES providers, at least every three years for all other CHOICES providers, and at least annually for ECF CHOICES providers.	BC maintained that the All Credentialing Tasks in Visual Cactus by Date Range error report monitoring will identify the following data points: Provider ID, National Provider Identifier (NPI), provider/facility name, due date, credentialing start date, credentialing finish date, and comments. BC will utilize the comments section to explain any discrepancies found and what action it will take to ensure timely recredentialing of ongoing CHOICES and ECF CHOICES providers at least annually, and at least every three years for all other CHOICES providers. **These actions satisfy the CAP.**

Table 6-2—Prior Year's EQR Recommendations and Corrective Actions Completed for UHC

Prior Recommendation	Actions
AQS Compliance Review	
File Reviews—Transition of CHOICES Members Between MCOs	
The MCO must ensure that services for transitioning members are implemented within the established time frame.	UHC presented three distinct actions and a concurrent monitoring/tracking process to address the AON, which included training and a tracking report. UHC will develop a mechanism for manager notification of MCO-to-MCO transitions. Qsource recommends monitoring (a minimum of three months or a set number of transitions) to determine if the actions resolve the identified concern. **The actions satisfy the CAP**.
File Reviews—UM Denials	
The MCO must ensure that all UM denials meet the time standard for notifications.	UHC established three separate actions to ensure UM denials consistently meet the time standards for notifications. Qsource recommends monitoring (a minimum of three months) to determine if the actions

Prior Recommendation	Actions
	resolve the identified concern. **The actions satisfy the CAP**.
CHOICES Credentialing File Review	
The MCO must ensure it maintains verification of the TennCare Medicaid number and licensure verification on all credentialing files.	UHC implemented an LTSS Validation of Credentialing and Recredentialing SOP and began conducting monthly audits of 100 percent of providers being credentialed or recredentialed. Focus areas of the audit included ensuring the inclusion of the TennCare Medicaid number and licensure verification within the credentialing/recredentialing provider file. UHC plans to conduct a six-month review of the process to evaluate/validate the success of the audits. **These actions satisfy the CAP**.
CHOICES Recredentialing File Review	
The MCO must ensure it obtains licensure verification on all recredentialing files.	UHC implemented an LTSS Validation of Credentialing and Recredentialing SOP and began conducting monthly audits of 100 percent of providers being credentialed or recredentialed. Focus areas of the audit include ensuring the inclusion of the TennCare Medicaid number and licensure verification within the credentialing/recredentialing provider file. UHC plans to conduct a six-month review of the process to evaluate/validate the success of the audits. **These actions satisfy the CAP**.

Table 6-3—Prior Year's EQR Recommendations and Corrective Actions Completed for WLP

Prior Recommendation	Actions
AQS Compliance Review	
BESMART	
WLP must ensure that the interrater reliability (IRR) procedure evaluates consistency and validity by measuring agreement between raters with the accepted BESMART Quality Review tool standards for a defined BESMART record.	WLP presented an updated BESMART Program Quality Review—TN policy and procedure that offered detailed information pertaining to the IRR process and emphasized the requirements for reviewers to complete the BESMART quality review tool independently for the same medical record to allow for evaluation of reviewer consistency. In addition, WLP presented the time frame for the next IRR as September 2024. **The actions satisfy the CAP**.
File Reviews—Grievances	
WLP must ensure that it completes timely grievance file reviews.	WLP identified the cause of the AON and established changes in the process for sending out resolution letters that included the assignment of Tennessee Carriers, Inc.

Prior Recommendation	Actions
	(TCI) cases to only one analyst, having backup analysts in case of emergency, and an outreach process to allow no more than five to 10 days for TCI to respond to a grievance. Since the implementation of process changes in October 2023, WLP's monitoring revealed progress, resulted in improved communication with TCI staff, created a more streamlined process with letters being sent out 24 to 48 hours after TCI's response to the MCC, and timely reporting of cases. **The actions satisfy the CAP**.

Table 6-4—Prior Year's EQR Recommendations and Corrective Actions Completed for TCS

Prior Recommendation	Actions
AQS Compliance Review	
File Reviews—Recredentialing File Review	
The MCO must ensure CHOICES providers are recredentialed within the established time frame.	TCS maintained that the All Credentialing Tasks in Visual Cactus by Date Range error report monitoring will identify the following data points: Provider ID, NPI, provider/facility name, due date, credentialing start date, credentialing finish date, and comments. TCS will utilize the comments section to explain any discrepancies found and what action it will take to ensure timely recredentialing of ongoing CHOICES and ECF CHOICES providers at least annually, and at least every three years for all other CHOICES providers. **These actions satisfy the CAP**.

Table 6-5—Prior Year's EQR Recommendations and Corrective Actions Completed for DQ

Prior Recommendation	Actions
PIPs	
Prenatal & Postpartum Dental Utilization	
Step 7. The DBM did not report the indicator title. Additionally, the DBM should add the time frames for the remeasurement periods. In the resubmission, the DBM included the indicator title, but it did not add the time frames for the remeasurement periods.	The DBM corrected Step 7 and included all dates in the PIP Submission Form.
Step 8. The DBM did not complete any portion of Step 8. In the resubmission, the DBM reported it will implement the targeted text message intervention on	The DBM corrected the Intervention Worksheet with additional intervention details to describe a more robust intervention and included methodologically sound measures.

Prior Recommendation	Actions
9/15/24. However, based on the documentation, this intervention has no reported member follow-up or interaction beyond providing information and links. Interventions that do not actively engage the member or provider are not recommended. Each intervention included for a PIP requires a robust evaluation of effectiveness measure. Text messages without the necessary engagement and tracking are not likely to improve indicator outcomes.	
Step 8. The DBM did not complete any portion of Step 8. In the resubmission, the DBM reported the PIP indicator as the intervention effectiveness measure. However, intervention effectiveness measures should be specific to the intervention and track the impact of the intervention. The DBM should develop a measure specific to the targeted text message campaign that is not the PIP indicator.	The DBM corrected the Intervention Worksheet and included methodologically sound intervention effectiveness measures.
Oral Health Disparities	
Step 1. The DBM selected a PIP topic that is focused on Black, non-Hispanic members ages 6–9 years and, as reported, based its selection of the specific race on a review of a study published in 2018. While the DBM provided the baseline rate for the population, 38.58 percent, it did not provide any comparison data for other ethnicities, nor did it report the rate for all Black, non-Hispanic members to show a specific opportunity for improvement within this narrowed age range. In the resubmission, the DBM provided more narrative to support the topic selection, citing additional sources. However, it did not provide plan-specific comparison data to provide evidence of an opportunity for improvement within the Black, non-Hispanic 6–9-year-old population compared to all Black, non-Hispanic members.	The DBM corrected Step 1 and included plan-specific data to support the narrowed focus in the PIP Submission Form.
Step 7. The DBM did not report the indicator title. Additionally, the DBM should add the time frames for the remeasurement periods. In the resubmission, the DBM included the indicator title, but it did not add the time frames for the remeasurement periods.	The DBM corrected Step 7 and included all dates in the PIP Submission Form.

Prior Recommendation	Actions
Step 8. The DBM did not complete any portion of Step 8. In the resubmission, the DBM reported a single intervention, "Targeted text message including information about why preventive dental care is important to overall health," and indicated it would address a transportation barrier allowing members to "contact their MCO to coordinate transportation to a dental appointment." However, based on the limited intervention details, it is unclear how this intervention will address this barrier when the text is about why preventive dental care is important. More details are needed. The DBM reported it will implement the targeted text message intervention on September 15, 2024. However, based on the documentation, this intervention has no reported member follow-up or interaction beyond providing information and links. Interventions that do not actively engage the members or providers are not recommended. Each intervention included for a PIP requires a robust evaluation of effectiveness measure. Text messages without the necessary engagement and tracking are not likely to improve indicator outcomes.	The DBM corrected the Intervention Worksheet with additional intervention details to describe a more robust intervention and included methodologically sound measures.
Step 8. The DBM did not complete any portion of Step 8. In the resubmission, the DBM reported the PIP indicator as the intervention effectiveness measure. However, intervention effectiveness measures should be specific to the intervention and track the impact of the intervention. The DBM should develop a measure specific to the targeted text message campaign that is not the PIP indicator.	The DBM corrected the Intervention Worksheet and included methodologically sound intervention effectiveness measures.
AQS Compliance Review	
PA File Reviews—UM	
The DBM must ensure that timely UM denials notifications are sent.	DQ's CAP identified the root cause, addressed the AON, implemented processes to prevent untimely UM denial notifications in the future, and continues to monitor for the effectiveness of the implemented processes. **The actions satisfy the CAP.**
PA File Reviews—Grievances	
The DBM must ensure that timely grievances are filed.	DQ presented interventions that addressed the identified AON. Specifically, the DBM restructured the complaint,

Prior Recommendation	Actions
	grievance, and appeal department. DQ hired three additional complaint and grievance specialists and initiated daily and weekly status reports to identify at-risk cases for follow-up with the specialists. **The actions satisfy the CAP.**

Table 6-6—Prior Year's EQR Recommendations and Corrective Actions Completed for ORx

Prior Recommendation	Actions
PIPs	
Schizophrenia Medication Compliance Improvement Program	
Step 5. The PBM should enter the Remeasurement 2 period dates. In addition, the PBM should change the dates in the denominator to "...during the remeasurement period." In the resubmission, the PBM did not make all the necessary corrections to address the feedback. The PBM did not document the Remeasurement 2 period dates.	The PBM corrected Step 5 and included all dates in the PIP Submission Form.
Step 8. The PBM described the intervention and did not document what QI tools it used to determine the barrier that the fax letter campaign addressed. The PBM did not clearly document the barrier in the Barrier Intervention table. The barrier description appeared to describe the intervention. The barrier should reflect what the PBM designed the intervention or RetroDUR letter campaign to address. The PBM documented that it had attached the fax letter. The PBM did not submit the fax letter with the submission. The PBM made most of the necessary corrections in the resubmission. The PBM did not include what QI tool it used to determine that there were adherence issues with atypical antipsychotic medications.	The PBM corrected Step 8 and included the QI tool it utilized in the PIP Submission Form.
Usage of Diagnosis Code Override by Providers for Preferred Atypical Antipsychotics	
Step 1. The PBM did not include plan-specific data in Step 1. The PBM should include pre-baseline data to support the selection of the PIP topic or include baseline data in Step 1. In the resubmission, the PBM did not make the necessary corrections.	The PBM corrected Step 1 in the PIP Submission Form.

Prior Recommendation	Actions
Step 8. The PBM used the Step 5 performance indicator as the intervention effectiveness measure. This would be accurate if every pharmacy provider in the network attended the Winter TPA [Third-Party Administrator] Meeting in February 2024 and received the provider education. Otherwise, the intervention effectiveness measure denominator would be "the total number of all preferred atypical antipsychotic claims received after February 2024 from the 202 pharmacy providers educated on the diagnosis code override list at the Winter TPA Meeting in February 2024." In the resubmission, the PBM did not make the necessary corrections. Instead, the PBM added three other interventions to the Winter TPA Meeting February 2024 intervention worksheet: monthly fax blasts, monthly provider newsletters, and quarterly TPA newsletters. If these interventions are ongoing SOPs, the PBM should not submit them as interventions tested for the PIP. If they are not SOP interventions, each of these added interventions should have their own intervention worksheet and intervention effectiveness measure. The PBM also deleted from the narrative the number (202) of pharmacy providers who trained in-person at the Winter TPA Meeting in February 2024. It was unclear why the PBM removed the number of in-person pharmacy providers educated in the February 2024 Winter TPA meeting.	The PBM corrected the Intervention Worksheet with accurate and methodologically sound intervention data.
AQS Compliance Review	
Grievance and Appeal Systems	
The PBM must ensure via documented policies or procedures that all information (comments, documents, records, and other information submitted by the member or representative) is considered during the review of an appeal or grievance.	ORx added specific language to the appeals and grievance manuals that addressed the identified AON. In addition, the PBM intends to engage the corporate compliance team to ensure timely delivery and consistency of documentation. **The actions satisfy the CAP**; however, Qsource recommends that the PBM inform all relevant staff of the manual updates and that all documents include the revision history.
Subcontractual Relationships and Delegation	
The PBM must ensure documentation indicates that the right to audit exists through 10 years from the	ORx presented the TennCare Program Regulatory Requirements Appendix which indicated that the right to audit exists through 10 years. Furthermore, ORx staff described efforts to improve the timely delivery of

Prior Recommendation	Actions
final date of the contract period or from the date of completion of any audit, whichever is later.	documents with the development of an internal compliance team. **The actions satisfy the CAP**.
Quality Assessment and Performance Improvement (QAPI) Program	
The PBM must develop documentation/processes that address/monitor call center outcomes and training, as needed and on demand.	ORx provided the Optum Quality Procedure: Telephone NCQA Accuracy document that described the monitoring process for the PBM's call center. The Optum High Level Training Overview—TennCare document addressed required customer service associate (CSA) training and retraining, if necessary. ORx presented additional documents and a 2023 report that included the average monthly sentiment score for Tennessee's call center, which confirmed positive customer experiences. **The actions satisfy the CAP**.
Non-Discrimination Compliance	
The PBM reported no alleged discrimination reports during 2023; however, the PBM must ensure a mechanism or policy and procedure exists to ensure that timely notification and assistance are provided to TennCare, and that corrective action is initiated if required.	ORx presented documentation in response to the identified AON. The ORx Complaint Discrimination Workflow described the steps the PBM takes when a caller wishes to report an action of alleged discrimination. Additionally, ORx indicated that the PBM is working to include corporate audit team participation to ensure delivery and consistency of the PBM's documentation. **The actions satisfy the CAP**; however, Qsource recommends that ORx include the specific time frame within which the PBM must provide the information to TennCare.
The PBM must ensure the Assurance of Nondiscrimination Compliance Questionnaire and Nondiscrimination Compliance Questionnaire are both provided and include the same signature date.	ORx presented documents that addressed the AON and explained corporate audit team involvement to ensure timely delivery and consistency of the documentation. **The actions satisfy the CAP**.

Appendix A. Methodologies for Conducting EQR Activities

The following sections include information concerning the objective of each activity included in this report, the technical methods of data collection and analysis, the description of data obtained, and how conclusions were drawn. The categorization of how HSAG expressed conclusions according to quality, timeliness of care, or access to care are based on the following definitions:

- **Quality**—CMS defines "quality" in the final rule at 42 CFR §438.320 as follows:

  Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, or PAHP, (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through (1) its structural and operational characteristics, (2) the provision of services that are consistent with current professional, evidence-based-knowledge, and (3) interventions for performance improvement.[42]

- **Timeliness**—NCQA defines "timeliness" relative to utilization decisions as follows:

  "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[43] NCQA further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to members and that require a timely response from the MCC (e.g., processing expedited member appeals and providing timely follow-up care).

- **Access**—CMS defines "access" in the final rule at 42 CFR §438.320 as follows:

  Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).[44]

AQS Compliance Review

Objectives

The purpose of the compliance reviews, one of the mandatory EQR activities defined in 42 CFR §438.358(b)(1)(iii),[45] is to evaluate the **quality of care**, **timeliness of care**, and **access to care** and services the MCOs, PIHPs, and PAHPs furnish to members. The evaluation includes determining the

[42] U. S. Government Publishing Office. (2024). **Electronic Code of Federal Regulations**. Available at: eCFR :: 42 CFR 438.320 -- Definitions. Accessed on: Feb 9, 2026.
[43] NCQA. **2023 Standards and Guidelines for the Accreditation of Health Plans**. Washington, DC: The NCQA; 2023: UM5.
[44] U. S. Government Publishing Office. (2024). **Electronic Code of Federal Regulations**. Available at: eCFR :: 42 CFR 438.320 -- Definitions. Accessed on: Feb 9, 2026.
[45] National Archives and Records Administration. (2025). Code of Federal Regulations. Available at: eCFR :: 42 CFR 438.358 -- Activities related to external quality review. Accessed on: Feb 9, 2026.

MCCs' compliance with 42 CFR §438 Subpart D, §438.56, §438.100, §438.114, and §438.330 of the BBA, and the State contractual requirements included in the MCCs' TennCare contracts.[46,47,48] HSAG follows the guidelines set forth in the CMS EQR Protocol 3 cited earlier in this report to create the process, tools, and interview questions used for the compliance reviews. The compliance review results assist in identifying, implementing, and monitoring interventions to drive performance improvement for the TennCare program.

42 CFR §438.358 requires the EQRO to perform the following mandatory activity:

> For each MCO, PIHP, or PAHP the following EQR-related activity must be performed in the 12 months preceding the finalization of the annual report: … A review, conducted within the previous 3-year period, to determine the MCO's, PIHP's, or PAHP's compliance with the standards set forth in subpart D of this part, the disenrollment requirements and limitations described in §438.56, the enrollee rights described in §438.100, the emergency and post-stabilization services requirements described in §438.114. and the quality assessment and performance improvement requirements described in §438.330.

Technical Methods of Data Collection and Analysis

The CMS EQR Protocol 3 defines the five activities included in the review of compliance with Medicaid and CHIP managed care regulations. Table A-1 displays the activities and indicates the process HSAG uses to ensure compliance with those requirements.

Table A-1—Protocol 3 Activities Performed for the Review of Compliance With Managed Care and State Regulations for AQS

Activity 1:	Establish Compliance Thresholds
	• Determine the timeline and agendas for conducting the compliance reviews with TennCare. • Begin developing the compliance review tool consistent with CMS protocols approximately six months prior to the review date. • Collect information from the State concerning state-specific requirements found in the TennCare contracts with the MCCs. • Define scoring mechanisms used as benchmarks to quantify results from the compliance activities. • Send draft compliance tool to TennCare for review and comment. • Receive approval of draft compliance tool from TennCare.

[46] State of Tennessee, Department of Finance and Administration, Division of Health Care Finance and Administration, Division of TennCare. (2024). Amendment #21 to the Statewide MCO Contract Risk Agreement. Available at: CONTRACTOR RISK AGREEMENT. Accessed on: Feb 9, 2026.
[47] National Archives and Records Administration. (2025). Code of Federal Regulations. Available at: eCFR :: 42 CFR Part 438 -- Managed Care. Accessed on: Feb 9, 2026.
[48] Centers for Medicare & Medicaid Services. (2018). Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care. Available at: 2020-24758.pdf. Accessed on: Feb 9, 2026.

Activity 1:	Establish Compliance Thresholds
	• Determine the point of contact for the compliance reviews from each MCC and schedule the review. • Send the compliance tool and additional pre-site documents to the MCCs with details concerning the preliminary data needed from the MCCs, the timeline for posting the information, and the secure website address for posting the information. • Conduct webinars with MCCs requesting additional information about the compliance review activities. • Respond to MCC questions concerning the requirements established to evaluate MCC performance during the compliance reviews.
Activity 2:	**Perform Preliminary Review**
	• Receive requested pre-site documents and data files from the MCCs. • Begin completing the compliance tool with information obtained from the pre-site documents. • Evaluate the MCCs' information to gain insight into their **quality of care**, **timeliness of care**, and **access to care**, and the organizations' structure, services, operations, and resources. • Determine preliminary findings before the site visit from documents submitted by the MCCs. • Specify areas and issues requiring further clarification or follow-up during the review to ensure receiving information concerning the identified gaps in the documentation sent with the pre-site information.
Activity 3:	**Conduct the Compliance Review**
	• Conduct an opening conference that includes introductions, an overview of the compliance review process and schedule, the MCC's overview of its structure and processes, and a discussion concerning any changes needed to the agenda and general logistical issues. • Conduct interviews with the MCC's staff to obtain complete information concerning the MCC's compliance with the federal Medicaid managed care regulations and associated State contract requirements, explore any issues not fully addressed in the pre-site documents, and increase the reviewers' overall understanding of the MCC's performance. • Collect additional documents required for the compliance review including, but not limited to, written policies and procedures, data, and reports across a broad range of areas. • Discuss the organization's IS data collection process and reporting capabilities related to the standards included in the review. • Summarize findings at a closing conference to provide the MCC's staff members and TennCare with a high-level summary of HSAG's preliminary findings. • Provide information concerning next steps and the projected date the MCCs will receive the draft compliance report.
Activity 4:	**Compile and Analyze Findings**
	• Complete compliance tools with findings from interviews and documents received during the site review.

Activity 4:	Compile and Analyze Findings
	• Evaluate and analyze the MCCs' performance complying with the requirements in each of the standards contained in the review tool. • Delineate findings and designate scores (e.g., **Met**, **Not Met**, or **Not Applicable**) to document the degree the MCCs comply with each of the requirements. • Calculate a percentage of compliance rate for each individual standard and an overall percentage of compliance score across all standards. • Determine a confidence level based on the MCCs' overall network adequacy scores when compared to the established compliance percentage parameters.
Activity 5:	**Report Results to the State**
	• Prepare a draft report describing HSAG's compliance review findings to include: – Scores assigned for each element within each standard. – Assessments of each MCC's strengths and areas requiring corrective action. – Identification of best practices to share with the MCCs and TennCare. – Suggestions to further enhance the MCCs' performance. • Forward the draft report to TennCare for review and comment. • Receive approval of the draft report from TennCare. • Send the draft report to the MCCs for comment. • Respond to any comments made by the MCCs. • Issue a final report that includes an appendix with the compliance tool and an appendix with elements included in the CAP. • Collaborate with the MCCs and TennCare to correct all elements scoring below 100 percent compliance until the revisions meet the requirements.

Description of Data Obtained

To assess the MCC's compliance with federal regulations, State rules, and contract requirements, HSAG obtains information from a wide range of written documents produced by the MCC, including, but not limited to, the following for the ANA review:

- Committee meeting agendas, minutes, and handouts
- Written policies, procedures, reports, program descriptions, and other plan documents with creation or revision dates prior to the end of the review period (i.e., December 31, 2024)
- Complete NCQA accreditation report
- The provider manuals, provider newsletters, and other MCO communication to providers/subcontractors
- The member handbooks, member newsletters, educational brochures, and other MCO communications to members
- The automated member website and provider portal

- Automated provider directory
- Documentation to support requirements for the health information systems
- Narrative and/or data reports across a broad range of performance and content areas

HSAG obtains additional information for the compliance review through interactive discussions and interviews with the MCC's key staff members during the site review.

How Conclusions Were Drawn

HSAG uses scores of **Met**, **Partially Met**, and **Not Met** to indicate the degree to which the MCCs' performance complies with the requirements. HSAG uses a designation of **NA** when a requirement is not applicable to the MCC during the period covered by HSAG's review. The scoring methodology is defined as follows:

Met indicates full compliance, defined as both of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Not Met indicates noncompliance, defined as either of the following:

- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For a provision with multiple components, key components of the provision could be identified and any findings of **Not Met** would result in an overall finding of noncompliance for the provision, regardless of the findings noted for the remaining components.

From the rates assigned for each of the requirements, HSAG calculates a total percentage-of-compliance rate for the standards and an overall percentage-of-compliance score across the standards. HSAG calculates the total score for each standard by adding the weighted value of the scores for each requirement in the standard—i.e., **Met** (value: 1.00 point), **Partially Met** (value: 0.50 points), **Not Met** (value: 0.00 points), and **Not Applicable** (value: 0.00 points)—and dividing the summed weighted scores by the total number of applicable requirements for that standard.

While the focus of an AQS review is to evaluate whether the MCCs correctly implement the required federal and State requirements, the results of the review can also determine areas of strength and weakness for the MCCs related to **quality of care**, **timeliness of care**, and **access to care**. Once HSAG calculates the scores for each standard, the reviewers evaluate each element scoring **Met** and **Not Met** to determine how the elements relate to the three domains as defined on page A-1. At that point, HSAG draws conclusions for each MCC concerning **quality of care**, **timeliness of care**, and **access to care** from the results of the compliance review.

HSAG determines the overall percentage-of-compliance score across the standards by following the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores and dividing the results by the total number of applicable requirements). HSAG also assists in reviewing the CAPs from the MCCs to determine, in collaboration with TennCare, if their proposed corrections will meet the intent of the requirements that were scored **Partially Met** or **Not Met.** The CAP continues until all items achieve a **Met** status.

Table A-2 displays the standards and rates BC achieved during the past three years in the annual compliance reviews.

Table A-2—Three-Year AQS Scores for BC

CFR	CMS Standard	Standard in TennCare Compliance Review	Scores Achieved		
			2023	2024	2025
§438.10*	Information Requirements	Information Requirements (tool includes cultural competence elements)	100%	100%	****
§438.54 §438.56	Enrollment and Disenrollment: Requirements and Limitations	Enrollment and Disenrollment: Requirements and Limitations	NA**	100%	100%
§438.100*	Enrollee Rights	Member Rights Requirements	100%	100%	****
§438.114	Emergency and Poststabilization Services	Emergency and Poststabilization Services	100%	100%	100%
§438.206*	Availability of Services	Availability of Services	100%	100%	****
§438.207*	Assurances of Adequate Capacity and Services	Assurances of Adequate Capacity and Services	100%	100%	****
§438.208	Coordination and Continuity of Care	Coordination and Continuity of Care	100%	100%	100%
§438.210*	Coverage and Authorization of Services	Coverage and Authorization of Services (with denials file review)	100%	100%	****
§438.214*	Provider Selection	Credentialing and Recredentialing Policies and Procedures	100%	100%	****
§438.224*	Confidentiality	Confidentiality	100%	100%	****

CFR	CMS Standard	Standard in TennCare Compliance Review	Scores Achieved		
			2023	2024	2025
§438.228*	Grievance and Appeals System	Grievances and Appeal Systems (with grievance and appeal file reviews)	100%	100%	****
§438.230*	Subcontractual Relationships and Delegation	Subcontractual Relationship and Delegation (with MCC subcontractor/delegate file review)	100%	100%	****
§438.236	Practice Guidelines	Practice Guidelines	100%	100%	100%
§438.242	Health Information Systems	Health Information Systems	100%	100%	100%
§438.330	Quality Assessment and Performance Improvement Program	Quality Assessment and Performance Improvement Program (QAPI)	100%	100%	100%
CRA***	Not Applicable (NA)	BESMART Program	100%	100%	NA
CRA***	NA	Non-discrimination Compliance	100%	100%	NA
§§441.50–441.61 CRA***	EPSDT (Individuals Under Age 21)	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	100%	100%	100%

*The AQS Compliance Review process changed to a staggered review of standards across a three-year period beginning in 2025.
**This standard was added to the AQS review in 2024.
***Requirements in the TennCare MCO Contract Risk Agreement were removed from the AQS Compliance Review in 2025.
****Standard will be reviewed in Year 2 or Year 3 of the three-year review cycle.

Table A-3 displays the standards and rates UHC achieved during the past three years in the annual compliance reviews.

Table A-3—Three-Year AQS Scores for UHC

CFR	CMS Standard	Standard in TennCare Compliance Review	Scores Achieved		
			2023	2024	2025
§438.10*	Information Requirements	Information Requirements (tool includes cultural competence elements)	100%	100%	****
§438.54 §438.56	Enrollment and Disenrollment: Requirements and Limitations	Enrollment and Disenrollment: Requirements and Limitations	NA**	100%	100%
§438.100*	Enrollee Rights	Member Rights Requirements	100%	100%	****
§438.114	Emergency and Poststabilization Services	Emergency and Poststabilization Services	100%	100%	100%
§438.206*	Availability of Services	Availability of Services	100%	100%	****
§438.207*	Assurances of Adequate Capacity and Services	Assurances of Adequate Capacity and Services	100%	100%	****
§438.208	Coordination and Continuity of Care	Coordination and Continuity of Care	100%	100%	100%
§438.210*	Coverage and Authorization of Services	Coverage and Authorization of Services (with denials file review)	100%	100%	****
§438.214*	Provider Selection	Credentialing and Recredentialing Policies and Procedures	100%	100%	****
§438.224*	Confidentiality	Confidentiality	100%	100%	****
§438.228*	Grievance and Appeals System	Grievances and Appeal Systems (with grievance and appeal file reviews)	100%	100%	****
§438.230*	Subcontractual Relationships and Delegation	Subcontractual Relationship and Delegation (with MCC subcontractor/delegate file review)	100%	100%	****
§438.236	Practice Guidelines	Practice Guidelines	100%	100%	100%

CFR	CMS Standard	Standard in TennCare Compliance Review	Scores Achieved		
			2023	2024	2025
§438.242	Health Information Systems	Health Information Systems	100%	100%	100%
§438.330	Quality Assessment and Performance Improvement Program	Quality Assessment and Performance Improvement Program (QAPI)	100%	100%	100%
CRA***	Not Applicable (NA)	BESMART Program	90.90%	100%	NA
CRA***	NA	Non-discrimination Compliance	100%	100%	NA
§§441.50–441.61 CRA	EPSDT (Individuals Under Age 21)	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	100%	100%	100%

* The AQS Compliance Review process changed to a staggered review of standards across a three-year period beginning in 2025.
**This standard was added to the AQS review in 2024.
***Requirements in the TennCare MCO Contract Risk Agreement were removed from the AQS Compliance Review in 2025.
****Standard will be reviewed in Year 2 or Year 3 of the three-year review cycle.

Table A-4 displays the standards and rates WLP achieved during the past three years in the annual compliance reviews.

Table A-4—Three-Year AQS Scores for WLP

CFR	CMS Standard	Standard in TennCare Compliance Review	Scores Achieved		
			2023	2024	2025
§438.10*	Information Requirements	Information Requirements (tool includes cultural competence elements)	100%	100%	****
§438.54 §438.56	Enrollment and Disenrollment: Requirements and Limitations	Enrollment and Disenrollment: Requirements and Limitations	NA**	100%	100%
§438.100*	Enrollee Rights	Member Rights Requirements	100%	100%	****
§438.114	Emergency and Poststabilization Services	Emergency and Poststabilization Services	100%	100%	100%
§438.206*	Availability of Services	Availability of Services	100%	100%	****
§438.207*	Assurances of Adequate Capacity and Services	Assurances of Adequate Capacity and Services	100%	100%	****

CFR	CMS Standard	Standard in TennCare Compliance Review	Scores Achieved		
			2023	2024	2025
§438.208	Coordination and Continuity of Care	Coordination and Continuity of Care	100%	100%	100%
§438.210*	Coverage and Authorization of Services	Coverage and Authorization of Services (with denials file review)	100%	100%	****
§438.214*	Provider Selection	Credentialing and Recredentialing Policies and Procedures	100%	100%	****
§438.224*	Confidentiality	Confidentiality	100%	100%	****
§438.228*	Grievance and Appeals System	Grievances and Appeal Systems (with grievance and appeal file reviews)	100%	100%	****
§438.230*	Subcontractual Relationships and Delegation	Subcontractual Relationship and Delegation (with MCC subcontractor/delegate file review)	100%	100%	****
§438.236	Practice Guidelines	Practice Guidelines	100%	100%	100%
§438.242	Health Information Systems	Health Information Systems	100%	100%	100%
§438.330	Quality Assessment and Performance Improvement Program	Quality Assessment and Performance Improvement Program (QAPI)	100%	100%	100%
CRA***	Not Applicable (NA)	BESMART Program	90.90%	97.90%	NA
CRA***	NA	Non-discrimination Compliance	100%	100%	NA
§§441.50–441.61 CRA	EPSDT (Individuals Under Age 21)	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	100%	100%	100%

* The AQS Compliance Review process changed to a staggered review of standards across a three-year period beginning in 2025.
**This standard was added to the AQS review in 2024.
***Requirements in the TennCare MCO Contract Risk Agreement were removed from the AQS Compliance Review in 2025.
****Standard will be reviewed in Year 2 or Year 3 of the three-year review cycle.

Table A-5 displays the standards and rates TCS achieved during the past three years in the annual compliance reviews.

Table A-5—Three-Year AQS Scores for TCS

CFR	CMS Standard	Standard in TennCare Compliance Review	Scores Achieved		
			2023	2024	2025
§438.10*	Information Requirements	Information Requirements (tool includes cultural competence elements)	100%	100%	****
§438.54 §438.56	Enrollment and Disenrollment: Requirements and Limitations	Enrollment and Disenrollment: Requirements and Limitations	NA**	100%	100%
§438.100*	Enrollee Rights	Member Rights Requirements	100%	100%	****
§438.114	Emergency and Poststabilization Services	Emergency and Poststabilization Services	100%	100%	100%
§438.206*	Availability of Services	Availability of Services	100%	100%	****
§438.207*	Assurances of Adequate Capacity and Services	Assurances of Adequate Capacity and Services	100%	100%	****
§438.208	Coordination and Continuity of Care	Coordination and Continuity of Care	100%	100%	100%
§438.210*	Coverage and Authorization of Services	Coverage and Authorization of Services (with denials file review)	100%	100%	****
§438.214*	Provider Selection	Credentialing and Recredentialing Policies and Procedures	100%	100%	****
§438.224*	Confidentiality	Confidentiality	100%	100%	****
§438.228*	Grievance and Appeals System	Grievances and Appeal Systems (with grievance and appeal file reviews)	100%	100%	****
§438.230*	Subcontractual Relationships and Delegation	Subcontractual Relationship and Delegation (with MCC subcontractor/delegate file review)	100%	100%	****
§438.236	Practice Guidelines	Practice Guidelines	100%	100%	100%

CFR	CMS Standard	Standard in TennCare Compliance Review	Scores Achieved		
			2023	2024	2025
§438.242	Health Information Systems	Health Information Systems	100%	100%	100%
§438.330	Quality Assessment and Performance Improvement Program	Quality Assessment and Performance Improvement Program (QAPI)	100%	100%	100%
CRA***	Not Applicable (NA)	BESMART Program	100%	100%	NA
CRA***	NA	Non-discrimination Compliance	100%	100%	NA
§§441.50–441.61 CRA	EPSDT (Individuals Under Age 21)	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	100%	100%	100%

*The AQS Compliance Review process changed to a staggered review of standards across a three-year period beginning in 2025.
**This standard was added to the AQS review in 2024.
***Requirements in the TennCare MCO Contract Risk Agreement were removed from the AQS Compliance Review in 2025.
****Standard will be reviewed in Year 2 or Year 3 of the three-year review cycle.

Table A-6 displays the standards and rates DQ achieved during the past three years in the annual compliance reviews.

Table A-6—Three-Year AQS Scores for DQ

CFR	CMS Standard	Standard in TennCare Compliance Review	Scores Achieved		
			2023	2024	2025
§438.10*	Information Requirements	Information Requirements (tool includes cultural competence elements)	100%	100%	****
§438.54 §438.56	Enrollment and Disenrollment: Requirements and Limitations	Enrollment and Disenrollment: Requirements and Limitations	NA**	100%	100%
§438.100*	Enrollee Rights	Member Rights Requirements	100%	100%	****
§438.114	Emergency and Poststabilization Services	Emergency and Poststabilization Services	100%	100%	100%
§438.206*	Availability of Services	Availability of Services	100%	100%	****

CFR	CMS Standard	Standard in TennCare Compliance Review	Scores Achieved		
			2023	2024	2025
§438.207*	Assurances of Adequate Capacity and Services	Assurances of Adequate Capacity and Services	50.00%	100%	****
§438.208	Coordination and Continuity of Care	Coordination and Continuity of Care	100%	100%	100%
§438.210*	Coverage and Authorization of Services	Coverage and Authorization of Services (with denials file review)	100%	100%	****
§438.214*	Provider Selection	Credentialing and Recredentialing Policies and Procedures	100%	100%	****
§438.224*	Confidentiality	Confidentiality	100%	100%	****
§438.228*	Grievance and Appeals System	Grievances and Appeal Systems (with grievance and appeal file reviews)	100%	100%	****
§438.230*	Subcontractual Relationships and Delegation	Subcontractual Relationship and Delegation (with MCC subcontractor/delegate file review)	100%	100%	****
§438.236	Practice Guidelines	Practice Guidelines	100%	100%	100%
§438.242	Health Information Systems	Health Information Systems	100%	100%	100%
§438.330	Quality Assessment and Performance Improvement Program	Quality Assessment and Performance Improvement Program (QAPI)	100%	100%	100%
CRA***	NA	Non-discrimination Compliance	100%	100%	NA
§§441.50–441.61 CRA	EPSDT (Individuals Under Age 21)	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	100%	100%	100%

*The AQS Compliance Review process changed to a staggered review of standards across a three-year period beginning in 2025.
**This standard was added to the AQS review in 2024.
***Requirements in the TennCare MCO Contract Risk Agreement were removed from the AQS Compliance Review in 2025.
****Standard will be reviewed in Year 2 or Year 3 of the three-year review cycle.

Table A-7 displays the standards and rates ORx achieved during the past three years in the annual compliance reviews.

Table A-7—Three-Year AQS Scores for ORx

CFR	CMS Standard	Standard in TennCare Compliance Review	Scores Achieved		
			2023	2024	2025
§438.10*	Information Requirements	Information Requirements (tool includes cultural competence elements)	100%	100%	****
§438.54 §438.56	Enrollment and Disenrollment: Requirements and Limitations	Enrollment and Disenrollment: Requirements and Limitations	NA**	100%	77.78%
§438.100*	Enrollee Rights	Member Rights Requirements	100%	100%	****
§438.114	Emergency and Poststabilization Services	Emergency and Poststabilization Services	100%	100%	83.33%
§438.206*	Availability of Services	Availability of Services	100%	100%	****
§438.207*	Assurances of Adequate Capacity and Services	Assurances of Adequate Capacity and Services	100%	100%	****
§438.208	Coordination and Continuity of Care	Coordination and Continuity of Care	100%	100%	100%
§438.210*	Coverage and Authorization of Services	Coverage and Authorization of Services (with denials file review)	93.75%	100%	****
§438.214*	Provider Selection	Credentialing and Recredentialing Policies and Procedures	100%	100%	****
§438.224*	Confidentiality	Confidentiality	100%	100%	****
§438.228*	Grievance and Appeals System	Grievances and Appeal Systems (with grievance and appeal file reviews)	70.45%	98.90%	****
§438.230*	Subcontractual Relationships and Delegation	Subcontractual Relationship and Delegation (with MCC subcontractor/delegate file review)	100%	91.67%	****
§438.236	Practice Guidelines	Practice Guidelines	100%	100%	87.50%

CFR	CMS Standard	Standard in TennCare Compliance Review	Scores Achieved		
			2023	2024	2025
§438.242	Health Information Systems	Health Information Systems	100%	100%	100%
§438.330	Quality Assessment and Performance Improvement Program	Quality Assessment and Performance Improvement Program (QAPI)	90.00%	90.00%	90.00%
CRA***	NA	Non-discrimination Compliance	87.50%	70.83%	NA

* The AQS Compliance Review process changed to a staggered review of standards across a three-year period beginning in 2025.
**This standard was added to the AQS review in 2024.
***Requirements in the TennCare MCO Contract Risk Agreement were removed from the AQS Compliance Review in 2025.
****Standard will be reviewed in Year 2 or Year 3 of the three-year review cycle.

The timeline for completing the CY 2024 AQS compliance reviews is displayed in Table A-8:

Table A-8—Timeline for the CY 2025 AQS Compliance Activity

MCC	Collecting Data	Conducting Review	Writing Report	Finalizing Report
BC	January–February 2025	February 18–20, 2025	February–May 2025	May 2025
UHC	January–February 2025	February 4–6, 2025	February–May 2025	May 2025
WLP	January–February 2025	February 11–13, 2025	February–May 2025	May 2025
TCS	January–February 2025	February 18–20, 2025	February–May 2025	May 2025
DQ	January–March 2025	March 4–6, 2025	March–May 2025	May 2025
ORx	January–March 2025	March 18–20, 2025	March–May 2025	May 2025

PIPs

Validating PIPs is one of the mandatory EQR activities described at 42 CFR §438.330(b)(1). In accordance with §438.330(d), MCCs are required to have a QAPI Program which includes PIPs that focus on both clinical and nonclinical areas. Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and must include the following:

- Measuring performance using objective quality indicators
- Implementing system interventions to achieve QI
- Evaluating effectiveness of the interventions
- Planning and initiating activities for increasing and sustaining improvement

For this year's annual PIP validation, HSAG used the CMS EQR Protocol 1 cited earlier in this report. HSAG's validation of PIPs includes two key components of the QI process:

1. HSAG evaluates the technical structure of the PIP to ensure that the MCC's design, conduct, and report the PIPs in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (i.e., Aim statement, population, performance indicator(s), sampling methods, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that the reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, the MCC's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the MCCs improve rates through implementation of effective processes (i.e., barriers analyses, intervention design, and evaluation results).

Technical Methods of Data Collection and Analysis

The HSAG PIP team consisted of, at a minimum, an analyst with expertise in statistics and study design and a clinician with expertise in performance improvement processes. Each MCC completed the PIP Submission Form and submitted it to HSAG for review. The PIP Submission Form standardized the process for submitting information regarding the PIPs and ensured that all CMS EQR Protocol 1 requirements were addressed.

For the MCC PIPs, HSAG developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS EQR Protocol 1, which identifies nine steps that should be validated for each PIP:

Protocol Steps	
Step Number	**Description**
1	Review the Selected PIP Topic
2	Review the PIP Aim Statement
3	Review the Identified PIP Population
4	Review the Sampling Method
5	Review the Selected Performance Indicator(s)
6	Review the Data Collection Procedures
7	Review the Data Analysis and Interpretation of PIP Results
8	Assess the Improvement Strategies
9	Assess the Likelihood that Significant and Sustained Improvement Occurred

HSAG used the following methodology to evaluate the PIPs conducted by the MCCs to determine whether a PIP was valid and to assess the percentage of compliance with the CMS EQR Protocol 1 for conducting PIPs.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as **Met**, **Partially Met**, **Not Met**, **Not Applicable**, or **Not Assessed**. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be **Met**.

In alignment with the CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. One validation rating reflects HSAG's confidence that the MCC adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. The second validation rating is only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP Validation Tool. For each applicable validation rating, HSAG reports the percentage of applicable evaluation elements that received a **Met** validation score and the corresponding confidence level: **High Confidence**, **Moderate Confidence**, **Low Confidence**, or **No Confidence**. The confidence level definitions for each validation rating are as follows:

1. **Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP**
   - **High Confidence**: High confidence in reported PIP results. All critical evaluation elements were **Met**, and 90 percent to 100 percent of all evaluation elements were **Met** across all steps.
   - **Moderate Confidence**: Moderate confidence in reported PIP results. All critical evaluation elements were **Met**, and 80 percent to 89 percent of all evaluation elements were **Met** across all steps.
   - **Low Confidence**: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were **Met**; or one or more critical evaluation elements were **Partially Met**.
   - **No Confidence**: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were **Met**; or one or more critical evaluation elements were **Not Met**.
2. **Overall Confidence That the PIP Achieved Significant Improvement**
   - **High Confidence**: All performance indicators demonstrated **statistically significant** improvement over the baseline.
   - **Moderate Confidence**: One of the three scenarios below occurred:
     - All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated **statistically significant** improvement over the baseline.
     - All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated **statistically significant** improvement over the baseline.

  - Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated **statistically significant** improvement over baseline.
- **Low Confidence**: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated **statistically significant** improvement over the baseline.
- **No Confidence**: The remeasurement methodology was not the same as the baseline methodology for all performance indicators **or** none of the performance indicators demonstrated improvement over the baseline.

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from the MCC's PIP Submission Form. Following HSAG's PIP validation process, the MCC submits each PIP Submission Form according to the approved timeline. Following the initial validation of each PIP, HSAG provides feedback in the validation tools. If validation criteria are not achieved, the MCC can seek technical assistance from HSAG and can resubmit the submission form for a final validation.

For all PIP topics, the six MCCs used claims data or data warehouse data specific to the performance indicators. The numerators are divided by the denominators to produce the percentages or ratios reported.

Table A-9—Timeline for the CY 2025 PIP Activity

MCC	Collecting Data	Conducting Review	Writing Report	Finalizing Report
BC	PIP Indicator Data: January–December 2024 Intervention Data: July 2023–June 2024	6/30–10/1/25	9/2–10/1/25	9/2–10/31/25
UHC	PIP Indicator Data: January–December 2024 Intervention Data: July 2023–June 2024	6/30–10/1/25	9/2–10/1/25	9/2–10/31/25
WLP	PIP Indicator Data: January–December 2024 Intervention Data: July 2023–June 2024	6/30–10/1/25	9/2–10/1/25	9/2–10/31/25
TCS	PIP Indicator Data: January–December 2024 Intervention Data: July 2023–June 2024	6/30–10/1/25	9/2–10/1/25	9/2–10/31/25
DQ	PIP Indicator Data: January–December 2024 Intervention Data: June 2023–May 2024	6/30–10/1/25	9/2–10/1/25	9/2–10/31/25
ORx	PIP Indicator Data: January–December 2024 Intervention Data: July 2023–June 2024	6/30–10/1/25	9/2–10/1/25	9/2–10/31/25

PMV

Overview

TennCare contracted with HSAG to conduct PMV of MCOs, the PBM, and the DBM (collectively described in Tennessee as MCCs). The primary objectives of the PMV process were to:

- Confirm that the MCOs and PIHP were audited in compliance with HEDIS requirements.
- Evaluate the accuracy of the performance measure data collected by the PBM and DBM.
- Determine the extent to which the specific performance measures calculated by TennCare, on behalf of the PBM and DBM, followed the specifications established for calculation of the performance measures.
- Identify overall strengths and areas for improvement in the performance measure process.

Table A-10 below establishes the timeline of each PMV activity HSAG conducted for TennCare during CY 2024.

Table A-10—Timeline for the CY 2024 PMV Activity

MCC	Collecting Data	Conducting Review	Writing Report	Finalizing Report
BC	June 2025–July 2025	July 2025	July 2025–August 2025	August 2025
UHC	June 2025–July 2025	July 2025	July 2025–August 2025	August 2025
WLP	June 2025–July 2025	July 2025	July 2025–August 2025	August 2025
TCS	June 2025–July 2025	July 2025	July 2025–August 2025	August 2025
DQ	February 2025–April 2025	April 2025–May 2025	May 2025–July 2025	August 2025
TennCare	February 2025–April 2025	April 2025–May 2025	June 2025–July 2025	August 2025
ORx	February 2025–March 2025	March 2025–May 2025	May 2025–June 2025	July 2025

Technical Methods of Data Collection and Analysis

HSAG conducted PMV activities as outlined in the CMS EQR Protocol 2 cited earlier in this report.

HSAG followed the same process to conduct the PMV of each MCC, which included:

- Pre-virtual review activities such as the review of FARs and IDSS reports from MCOs and the PIHP; the review of Information Systems Capabilities Assessment Tools (ISCATs) and supporting documents completed by the PBM, DBM, and TennCare; and the review of TennCare-provided measure data and programming logic used to compile measure data for reporting.

- Virtual review activities such as interviews with key staff members from the PBM, DBM, and TennCare; the review of the PMB's, DBM's and TennCare's information systems and data processes; and primary source verification (PSV) using measure data provided by TennCare.
- Post-virtual review activities such as the review of follow-up items provided by the PBM, DBM, and TennCare, and the determination and reporting of PMV findings.

HSAG validated the PBM's, DBM's, and TennCare's information systems and data processes to ensure accurate reporting of performance measures selected by TennCare. HSAG's PMV team reviewed the PBM's and DBM's collection, validation, and transmission of member, provider, and service data, as well as TennCare's' data integration and measure calculation processes. If HSAG reviewers noted an AON with any validation component listed in the CMS EQR Protocol 2, they determined whether the issue resulted in significant, minimal, or no impact to the final reported rate on a selected performance measure.

Description of Data Obtained

HSAG used several sources of information to conduct the PMV of the PBM, DBM, and TennCare. These included:

- PBM/DBM/TennCare responses to the ISCAT.
- Documentation supporting the PBM's, DBM's, and TennCare's responses to ISCAT questions, such as file layouts, system flow diagrams, system log files, and policies and procedures.
- Source code, computer programming, and query language (if applicable) used by TennCare to calculate selected performance measures.
- TennCare-reported performance measure rates.
- Enrollment and service data for PBM and DBM members included in the numerator population for selected performance measures.
- Virtual interviews and demonstrations, when HSAG obtained information through interaction, discussion, and formal interviews with key contractor staff as well as through system demonstrations.

How Data Were Aggregated and Analyzed

HSAG performed a performance validation audit of the PBM, DBM, and TennCare for TennCare-selected measures. HSAG evaluated the PBM's and DBM's eligibility and enrollment data systems and medical services data systems, and evaluated TennCare's data integration process through an ISCAT, source code review, virtual review of the contractor, and PSV of a selected sample of measure data.

HSAG analyzed the quantitative results obtained from the above PMV activity to identify strengths and opportunities for improvement in each domain of **quality**, **timeliness**, and **access** to services furnished

by the PBM and DBM. HSAG then identified common themes and the salient patterns that emerged across the PBM, DBM, and TennCare related to the PMV activity conducted.

How Conclusions Were Drawn

Each of the performance measures HSAG validated received one of four possible validation finding designations identified in the CMS EQR Protocol 2. The designation is determined by the magnitude of errors detected for the validation elements, not by the number of validation elements determined to be noncompliant based on the PMV findings. Consequently, an error for a single validation element may result in a designation of Do Not Report (**DNR**) because the impact of the error biased the reported performance measure rate by more than 5 percentage points. Conversely, it is also possible that several validation element errors may have little impact on the reported rate, and the measure could be given a designation of **R**. Since TennCare required the PBM and DBM to report on the measures validated by HSAG, HSAG did not assign the designation of **NR** to any measure.

Table A-11 defines the designations HSAG assigned to each performance measure based on the PMV findings.

Table A-11—Designation Categories for Performance Measures Validated by HSAG

Report (R)	Measure was compliant with state specifications.
Do Not Report (DNR)	PBM/DBM rate was materially biased and should not be reported.
No Applicable (NA)	The PBM/DBM was not required to report the measure.
Not Reported (NR)	Measure was not reported because the PBM/DBM did not offer the required benefit.

NAV

For the 2025 ANA review covering the period of January 1 to December 31, 2024, HSAG staff conducted analyses of the distribution, availability, and assignment of providers to TennCare members.

Administrative Data Analyses

HSAG requested various types of data files from the MCO, TennCare, and TDCI and conducted analyses to evaluate each MCC's performance in meeting access and availability standards as described in their contracts with TennCare. Prior to any administrative data analyses, HSAG conducted preliminary file review and standard data cleaning processes on both the member and provider data files.

HSAG obtained TennCare eligibility/enrollment data from TennCare's and imported the files into SAS[49] datasets for preliminary data review. HSAG performed the member eligibility data extractions in January 2025 to ensure that the TennCare eligibility files included the MCC's members eligible as of November 30, 2024.

HSAG also reviewed the member and provider addresses and used Quest Analytics software to ensure that the addresses could be geocoded to exact geographic locations in terms of latitude and longitude. If geographic coordinates could not be assigned using address-based coding, HSAG attempted geocoding using member and provider ZIP Codes. To obtain the most accurate estimates of network adequacy possible, the design of the Quest Analytics applications assisted in ensuring that HSAG counted:

- A single provider with multiple addresses once for each address.
- Multiple providers at the same address as distinct providers.
- A single provider with more than one specialty for each specialty.

After cleaning and geocoding the data, HSAG eliminated duplicates and used the files for all subsequent quantitative analyses to ensure internal consistency.

Ratio Analyses

HSAG performed statewide ratio analyses to calculate MCC-specific member-to-provider ratios and evaluated whether the ratios met the maximum ratio, as identified in the MCC contract. To calculate the member-to-provider ratios, HSAG divided the total number of members in the MCC by the total number of a specific provider type (e.g., PCPs and SCPs). HSAG determined the number of members in the MCC by extracting members from the TennCare enrollment and eligibility files who were active with the MCC as of November 30, 2024. To determine the number of providers for the MCC, HSAG extracted in-network providers from the MCC provider file who were active on November 30, 2024.

Travel Distance and Travel Time Analyses

HSAG used Quest Analytics software to calculate MCC-specific statewide results to evaluate the extent to which an MCC met the travel distance and travel time standards as identified in its contract. This software evaluated the physical distance and travel time between the addresses of members from the TennCare member demographic files and the addresses of their nearest providers (both PCPs and SCPs) and compared them to the TennCare standard for specific provider types as documented in the applicable MCC contracts. HSAG used the percentage of MCC members who were within a certain distance standard of their nearest providers to determine the level of MCC compliance with State requirements.

[49] HSAG generated the data normalization and analyses (i.e., provider-enrollee ratios, distance/time and quality measures) for this report using SAS software, Version 9.4 of the SAS System for Windows.

Complaints Analyses

Member complaints related to access and availability constitute another aspect of network adequacy. The MCCs and TDCI supplied the total number of member complaints during 2024 (January 1–November 30, 2024), including those related to access to care and appointment availability. HSAG reviewed the complaints to determine those related to access and availability and calculated the statewide ratio of member access-related complaints per total number of members.

County Analyses—CHOICES Provider Services

HSAG evaluated the MCO's compliance with CHOICES provider availability standards via county analyses and used the MCO-supplied CHOICES provider file to determine the percentage of counties with at least two providers per county.

County Analyses—ECF CHOICES Provider Services

HSAG evaluated the MCO's compliance with ECF CHOICES provider availability standards by using county analyses. HSAG reviewed the MCO-supplied ECF CHOICES provider file to determine the percentage of counties with at least two providers per county.

Results

The CRA includes various distance, ratio, county, and other network adequacy standards for the following provider types and services:

- PCPs (including OB/GYNs and TennCare Kids providers)
- SCPs
- BH providers
- General optometry and hospitals
- CHOICES providers
- ECF CHOICES providers

ISCA Methodology

Validation of network adequacy consists of several activities that fall into three phases of activities: (1) planning, (2) analysis, and (3) reporting, as outlined in the CMS EQR **Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity**, February 2023 (CMS EQR Protocol 4).[50]

[50] Department of Health and Human Services, Centers for Medicare & Medicaid Services. **Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity**, February 2023. Available at: CMS External Quality Review (EQR) Protocols. Accessed on: Feb 9, 2026.

To complete validation activities for the MCCs and TennCare, HSAG obtained all network adequacy standards and indicators that TennCare requires for validation.

HSAG prepared and submitted a document request packet to each MCC and TennCare outlining the activities that HSAG conducted during the validation process. The document request packet included a request for documentation to support HSAG's ability to assess the MCCs' information systems and processes, network adequacy indicator methodology, and accuracy in network adequacy reporting at the indicator level. Since TennCare calculates the network adequacy standards, HSAG reviewed TennCare's network adequacy indicator methodology and accuracy in network adequacy reporting. All findings are reported at the individual MCC level. Documents that HSAG requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with the MCCs to identify all data sources informing calculation and reporting at the network adequacy indicator level. HSAG obtained data and documentation from the MCCs, such as network data files or directories through a single documentation request packet that HSAG provided to each MCC. Additionally, HSAG obtained member enrollment data and network adequacy indicator results from TennCare.

HSAG hosted an MCC-wide webinar focused on providing technical assistance to the MCCs to develop a greater understanding of all activities associated with NAV, standards/indicators in the scope of validation, helpful tips on how to complete the ISCAT, and a detailed review of expected deliverables with associated timelines.

HSAG conducted validation activities via interactive virtual review, which this report refers to as "virtual review," as these activities are the same in both virtual and on-site formats.

Technical Methods of Data Collection and Analysis

The CMS EQR Protocol 4 identifies key activities and data sources needed for NAV. The following list describes the types of data collected and how HSAG conducted an analysis of these data:

- **Information systems underlying network adequacy monitoring**: HSAG conducted an ISCA by using each MCC's completed ISCAT and relevant supplemental documentation to understand the processes for maintaining and updating provider data, including how the MCC tracks providers over time, across multiple office locations, and through changes in participation in the MCC's network. HSAG used the ISCAT to assess the ability of the MCC's information systems to collect and report accurate data related to each network adequacy indicator. To do so, HSAG sought to understand the MCC's information technology system architecture, file structure, information flow, data processing procedures, and completeness and accuracy of data related to current provider networks. HSAG thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- **Validate network adequacy logic for calculation of network adequacy indicators**: HSAG required TennCare describe the process used to calculate the indicators and submit documented code, logic, or manual workflows for each indicator in the scope of the validation. HSAG identified

whether the required variables were in alignment with the indicators used to produce the TennCare's indicator calculations.

- **Validate network adequacy data and methods**: HSAG assessed data and documentation from TennCare that included, but was not limited to, network data files or directories and member enrollment data files. HSAG assessed all data files used for network adequacy calculation at the indicator level for validity and completeness.
- **Validate network adequacy results**: HSAG assessed the MCC's and TennCare's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support MCC and TennCare network adequacy monitoring results. HSAG validated network adequacy reporting against TennCare-defined indicators. HSAG assessed the validity, accuracy, and reliability of the results and the accuracy of the interpretation of the data.
- **Supporting documentation**: HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, data dictionaries, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

Virtual Review Validation Activities

HSAG conducted a virtual review with each MCC and TennCare. HSAG collected information using several methods, including interviews, system demonstrations, review of source data output files, observation of data processing, and review of final network adequacy indicator-level reports. The virtual review activities are described below:

- **Opening meeting:** The opening meeting included an introduction of the validation team and key MCC and TennCare staff members involved in the NAV activities, the review purpose, the required documentation, basic meeting logistics, and organization overview.
- **Review of the ISCAT and supporting documentation:** HSAG designed this session to be interactive with key MCC or TennCare staff members so that the validation team could obtain a complete picture of all steps taken to generate responses to the ISCAT and understand systems and processes for maintaining and updating provider data and assessing the MCC's information systems required for NAV. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and verified source data and processes used to inform data reliability and validity of network adequacy reporting.
- **Evaluation of underlying systems and processes:** HSAG evaluated the MCC's information systems, focusing on the MCC's processes for maintaining and updating provider data; integrity of the systems used to collect, store, and process data; MCC oversight of external information systems, processes, and data; and knowledge of the staff members involved in collecting, storing, and analyzing data. Throughout the evaluation, HSAG conducted interviews with key staff members familiar with the processing, monitoring, reporting, and calculation of network adequacy indicators. Key staff members included executive leadership, enrollment specialists, provider relations, business

analysts, data analytics staff, claims processors, and other front-line staff members familiar with network adequacy monitoring and reporting activities.

- **Overview of data collection, integration, methods, and control procedures:** The overview included discussion and observation of methods and logic used to calculate each network adequacy indicator. HSAG evaluated the integration and validation process across all source data and how TennCare produced the analytics files to inform network adequacy monitoring and calculation at the indicator level. HSAG also addressed control and security procedures during this session.

Network Adequacy Indicator Validation Rating Determinations

HSAG evaluated each MCC's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support MCC and TennCare network adequacy monitoring efforts.

HSAG used the CMS EQR Protocol 4 indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that the MCC used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated each network adequacy indicator's validation score by identifying the number of **Met** and **Not Met** elements recorded in the HSAG CMS EQR Protocol 4 Worksheet 4.6, noted in Table A-12.

Table A-12—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of **Met** elements
B. Total number of **Not Met** elements
Validation Score = A / (A + B) x 100
Number of **Not Met** elements determined to have significant bias on the results.

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed the validity, accuracy, and reliability of the network adequacy indicator results and the accuracy of the MCC's interpretation of data. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that the MCC used acceptable methodology for all phases of data collection, analysis, and interpretation of the network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, as shown in Table A-13. HSAG assigned a rating once it calculated the validation score for each indicator.

Table A-13—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	**High Confidence**
50.0% to 89.9%	**Moderate Confidence**

Validation Score	Validation Rating
10.0% to 49.9%	**Low confidence**
Less than 10% and/or any **Not Met** element has significant bias on the results	**No Confidence**

Table A-19 and Table A-20 present sample validation rating determinations. Table A-19 presents an example of a validation rating determination based solely on the validation score, as there were no **Not Met** elements that were determined to have significant bias on the results, whereas Table A-20 presents an example of a validation rating determination that includes a **Not Met** element that had significant bias on the results.

Table A-14—Example Validation Rating Determination—No Significant Bias

Worksheet 4.6 Summary	Worksheet 4.6 Result	Validation Rating Determination
A. Total number of **Met** elements	16	**Moderate Confidence**
B. Total number of **Not Met** elements	3	
Validation Score = A / (A + B) x 100%	84.2%	
Number of **Not Met** elements determined to have significant bias on the results	0	

Table A-15—Example Validation Rating Determination—Includes Significant Bias

Worksheet 4.6 Summary	Worksheet 4.6 Result	Validation Rating Determination
A. Total number of **Met** elements	15	**No Confidence**
B. Total number of **Not Met** elements	4	
Validation Score = A / (A + B) x 100%	78.9%	
Number of **Not Met** elements determined to have significant bias on the results	1	

HSAG determined significant bias based on the magnitude of errors detected and not solely based on the number of elements **Met** or **Not Met**. HSAG determined that a **Not Met** element had significant bias on the results by:

- Requesting that the MCC provide a root cause analysis of the finding.
- Working with the MCC to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- HSAG's NAV Oversight Review Committee reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact to determine the degree of bias.

- HSAG's NAV Oversight Review Committee finalizing a bias determination based on the following threshold:

The impact biased the reported network adequacy indicator result by more than five percentage points, the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from compliant to noncompliant or changed from noncompliant to compliant), or HSAG was unable to quantify the impact and therefore determined the potential for significant bias.

Table A-16 displays the timeline for the CY 2025 NAV activity.

Table A-16—Timeline for the CY 2025 NAV (CMS EQR Protocol 4) Activity

MCC	Collecting Data	Conducting Review	Writing Report	Finalizing Report
BC	January–April 2025	May–June 2025	June–July 2025	August 2025
UHC	January–April 2025	May–June 2025	June–July 2025	August 2025
WLP	January–April 2025	May–June 2025	June–July 2025	August 2025
TCS	January–April 2025	May–June 2025	June–July 2025	August 2025
DQ	January–April 2025	May–June 2025	June–July 2025	August 2025
ORx	January–April 2025	May–June 2025	June–July 2025	August 2025

ANA

Objectives

The purpose of the ANA is to evaluate the **timeliness of care** and **access to care** and services the MCCs furnish to members. The evaluation includes determining MCO compliance with 42 CFR §438.206, §438.207, and the State contractual requirements included in the TennCare contracts with the MCCs.[51,52,53] To create the process, tools, and interview questions used for the portion of the ANA review that evaluates the MCC's documentation, HSAG follows the guidelines set forth in the CMS EQR Protocol 3. The results of the documentation reviews assist in identifying, implementing, and monitoring interventions to drive improvement in **timeliness of care** and **access to care** for members in the TennCare program.

[51] Tennessee State Government. (2025). MCO Statewide Contract with Amendment 21. Available at: CONTRACTOR RISK AGREEMENT. Accessed on: Feb 9, 2026.
[52] Tennessee State Government. (2025). TennCare Dental Benefits Management (DBM) Programs. **TennCare Contracts**. DentaQuest, the DBM evaluated in the 2025 Annual External Quality Review Report, is no longer contracted with TennCare. The previous DentaQuest DBM contract is no longer publicly available. Effective 11/1/25, TennCare contracted with Renaissance to perform dental benefits management services. Current DBM program information is available at: TennCare Contracts. Accessed Feb 11, 2026.
[53] Tennessee State Government. (2025). TennCare Pharmacy Benefits Management (PBM) Services. **TennCare Contracts**. Available at: Optum3186500600.pdf. Accessed on: Feb 9, 2026.

Technical Methods of Data Collection and Analysis

The CMS EQR Protocol 3 cited earlier in the report defines the five activities included in the review of compliance with Medicaid and CHIP managed care regulations. Table A-17 displays the activities and indicates the process HSAG uses to ensure compliance with those requirements.

Table A-17—Regulations—Protocol 3 Activities Performed for the Review of Compliance With Managed Care Regulations and State Contract Requirements

Activity 1:	Establish Compliance Thresholds
	• Determine the timeline and agendas for conducting the compliance reviews with TDCI and TennCare. • Begin developing the compliance review tool consistent with CMS protocols approximately six months prior to the review date. • Collect information from the State concerning state-specific requirements found in the TennCare contracts with the MCCs. • Define scoring mechanisms used as benchmarks to quantify results from the compliance activities. • Send draft compliance tools to TDCI and TennCare for review and comment. • Receive approval of draft compliance tool from TDCI and TennCare. • Determine the point of contact for the compliance reviews from each MCC and schedule the review. • Send the compliance tools and additional pre-site documents to the MCCs with details concerning the preliminary data needed from the MCCs, the timeline for posting the information, and the secure website address for posting the information. • Conduct webinars with MCCs requesting additional information about the ANA compliance review activities. • Respond to MCC questions concerning the requirements established to evaluate MCC performance during the ANA reviews.
Activity 2:	**Perform Preliminary Review**
	• Receive requested pre-site documents and data files from the MCCs. • Begin completing the compliance tool with information obtained from the pre-site documents. • Evaluate the MCCs' information to gain insight into **timeliness of care** and **access to care**, and the organizations' structure, services, operations, and resources. • Determine preliminary findings before the site visit from documents submitted by the MCCs. • Specify areas and issues requiring further clarification or follow-up during the review to ensure receipt of information concerning the identified gaps in the documentation sent with the pre-site information.

Activity 3:	Conduct the Compliance Review
	• Conduct an opening conference that includes introductions, HSAG's overview of the compliance review process and schedule, the MCC's overview of its structure and processes, and a discussion concerning any changes needed to the agenda and general logistical issues. • Conduct interviews with the MCC's staff to obtain complete information concerning the MCC's compliance with the federal Medicaid managed care regulations and associated State contract requirements, explore any issues not fully addressed in the pre-site documents, and increase HSAG reviewers' overall understanding of MCC's performance. • Collect additional documents required for the compliance review including, but not limited to, written policies and procedures, data, and reports across a broad range of areas. • Discuss the organization's IS data collection process and reporting capabilities related to the standards included in the review. • Summarize findings at a closing conference to provide the MCC's staff members, TDCI, and TennCare with a high-level summary of HSAG's preliminary findings. • Provide information concerning next steps and the projected date the MCCs will receive the draft compliance report.
Activity 4:	**Compile and Analyze Findings**
	• Complete compliance tools with findings from interviews and documents received during the site review. • Evaluate and analyze the MCCs' performance complying with the requirements in each of the standards contained in the review tool. • Delineate findings and designate scores (e.g., **Met**, **Not Met**, or **Not Applicable**) to document the degree to which the MCCs comply with each of the requirements. • Calculate a percentage of compliance rate for each individual standard and an overall percentage of compliance score across all standards.
Activity 5:	**Report Results to the State**
	• Prepare a draft report describing HSAG's compliance review findings to include: – Scores assigned for each element within each standard. – Assessments of each MCC's strengths and areas requiring corrective action. – Identification of best practices to share with TDCI and TennCare. – Suggestions to further enhance the MCC's performance. • Forward the draft report to TDCI and TennCare for review and comment. • Receive approval of the draft report from TDCI and TennCare. • Send the draft report to the MCCs for comment. • Respond to any comments made by the MCCs.

Description of Data Obtained

To assess the MCC's compliance with federal regulations, State rules, and contract requirements, HSAG obtains information from a wide range of written documents produced by the MCC, including, but not limited to, the following for the ANA review:

- Written policies, procedures, and other plan documents with creation or revision dates prior to the end of the review period (i.e., 12/31/2024)
- The member handbook and additional documents sent to members
- The provider manual and other MCC communication to providers
- The automated member and provider portal
- Automated provider directory
- Narrative and/or data reports across a broad range of performance and content areas
- MCC questionnaire sent to the MCC with the pre-site documents

HSAG obtains additional information for the compliance review through interactive discussions and interviews with the MCC's key staff members.

How Conclusions Were Drawn

HSAG uses scores of **Met** and **Not Met** to indicate the degree to which the MCCs' performance complies with the requirements. HSAG uses a designation of **NA** when a requirement is not applicable to the MCC during the period covered by HSAG's review. The scoring methodology is defined as follows:

Met indicates full compliance, defined as both of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Partially Met indicates partial compliance, defined as either of the following:

- All documentation listed under a regulatory provision, or component thereof, is present; however, staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- Partial documentation listed under a regulatory provision, or component thereof, is not present; however, staff members are able to provide responses to reviewers that are consistent with each other and align with the regulatory requirements.

Not Met indicates noncompliance, defined as either of the following:

- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For a provision with multiple components, key components of the provision could be identified and any findings of **Not Met** would result in an overall finding of noncompliance for the provision, regardless of the findings noted for the remaining components.

From the rates assigned for each of the requirements, HSAG calculates a total percentage-of-compliance rate for the standards and an overall percentage-of-compliance score across the standards. HSAG calculates the total score for each standard by adding the weighted value of the scores for each requirement in the standard—i.e., **Met** (value: 1 point), **Partially Met** (value: 0.50 points), **Not Met** (value: 0.00 points), and **Not Applicable** (value: 0.00 points)—and dividing the summed weighted scores by the total number of applicable requirements for that standard.

While the focus of an ANA review is to evaluate whether the MCCs correctly implement the required federal and State requirements, the results of the review can also determine areas of strength and weakness for the MCCs related to **timeliness of care** or **access to care**. Once HSAG calculates the scores for each standard, the reviewers evaluate each element scoring **Met**, **Partially Met**, and **Not Met** to determine how the elements relate to the three domains as defined on page A-1. At that point, HSAG draws conclusions for each MCO concerning **timeliness of care** or **access to care** from the results of the compliance review.

Technical Methods of Data Collection and Analysis: ANA Administrative Data Analysis of Travel Distance and Travel Time and Ratio Requirements

HSAG requested various types of data files from the MCC, TennCare, and TDCI and conducted analyses to evaluate MCCs' performance in meeting access and availability standards as described in their contracts with TennCare. Prior to any administrative data analyses, HSAG conducted preliminary file review and standard data cleaning processes on both the member and provider data files.

HSAG obtained TennCare eligibility/enrollment data from HSAG via TennCare's Virtual Private Network site and imported the files into SAS[54] datasets for preliminary data review. HSAG performed the member eligibility data extractions in January 2025 to ensure that the TennCare eligibility files included members eligible as of November 30, 2024.

HSAG also reviewed the MCCs' member and provider addresses and used Quest Analytics software to ensure that the addresses could be geocoded to exact geographic locations in terms of latitude and longitude. If geographic coordinates could not be assigned using address-based coding, HSAG attempted geocoding using member and provider ZIP Codes. To obtain the most accurate estimates of

[54] HSAG generated the data normalization and analyses (i.e., provider-enrollee ratios, distance/time and quality measures) for this report using SAS software, Version 9.4 of the SAS System for Windows.

network adequacy possible, the design of the Quest Analytics applications assisted in ensuring that HSAG counted:

- A single provider with multiple addresses once for each address.
- Multiple providers at the same address as distinct providers.
- A single provider with more than one specialty for each specialty.

After cleaning and geocoding the data, HSAG eliminated duplicates and used the files for all subsequent quantitative analyses to ensure internal consistency.

Ratio Analyses

HSAG performed statewide ratio analyses to calculate MCO-specific member-to-provider ratios and evaluated whether the ratios met the maximum ratio, as identified in the MCO contract. To calculate the member-to-provider ratios, HSAG divided the total number of members in the MCO by the total number of a specific provider type (e.g., PCPs and SCPs). HSAG determined the number of members in the MCO by extracting members from the TennCare enrollment and eligibility files who were active with the MCO as of November 30, 2024. To determine the number of providers for the MCO, HSAG extracted in-network providers from the MCO provider file who were active on November 30, 2024. HSAG applied certain member restrictions when calculating the member-to-provider ratios for TennCare Kids and OB/GYNs. HSAG based the numerator for TennCare Kids providers on the number of members younger than 21 years of age as of November 30, 2024. The numerator for OB/GYNs included the number of female members older than 13 years of age as of November 30, 2024. HSAG conducted ratio analyses for four provider types: PCPs, TennCare Kids, OB/GYNs, and SCPs.

HSAG performed statewide ratio analyses to calculate DBM-specific member-to-provider ratios and evaluated whether the ratios met the maximum ratio, as identified in the DBM contract. HSAG calculated the member-to-provider ratio by dividing the total number of members in the DBM by the total number of a specific provider type (e.g., GDPs and SDPs). HSAG determined the number of members in the DBM by extracting members from the TennCare enrollment and eligibility files who were active with the DBM as of November 30, 2024. To determine the number of providers for the DBM, HSAG extracted in-network providers from the DBM provider file who were active on November 30, 2024. HSAG applied certain member restrictions when calculating the member-to-provider ratios for GDPs and based the numerator for GDPs on the number of non-dual members younger than 21 years of age as of November 30, 2024. HSAG conducted ratio analyses for GDPs.

Travel Distance and Time Analyses

HSAG used Quest Analytics software to calculate MCC-specific statewide results to evaluate the extent to which the MCCs met the distance and time standards as identified in its contract. This software evaluated the physical distance and travel time between the addresses of members from the TennCare member demographic files and the addresses of their nearest providers and compared them to the TennCare standard for specific provider types as documented in the applicable MCC contracts. HSAG

used the percentage of MCC members who were within a certain distance standard of their nearest providers to determine the level of MCC compliance with State requirements.

HSAG determines the overall percentage-of-compliance score across the standards by following the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores and dividing the results by the total number of applicable requirements).

Each year HSAG established a level of confidence rating for the compliance review based on the overall score as shown below:

- 90%–100%: High confidence in the MCO's compliance with State and federal requirements
- 80%–89%: Moderate confidence in the MCO's compliance with State and federal requirements
- 70%–79%: Low confidence in the MCO's compliance with State and federal requirements
- Under 70%: No confidence in the MCO's compliance with State and federal requirements

Table A-18—Overall Scores for Network Adequacy

Measure	Score					
	BC	UHC	WLP	TCS	DQ	ORx
Overall Network Adequacy Score	99.33%	99.25%	99.39%	100%	>99.99%	99.99%
Confidence Level	**High Confidence**					

All MCCs achieved **High Confidence** in their compliance with State and federal requirements for network adequacy from the scores achieved in the 2025 ANA Review.

Table A-19 includes the confidence ratings for the scores achieved by the MCOs and DBM in the 2024 ANA Review.

Table A-19—Overall Benefit Delivery Scores for the MCOs and DBM

Measure	Score				
	BC	UHC	WLP	TCS	DQ
Overall Benefit Delivery Score	>99.99%	98.33%	99.94%	98.33%	>99.99%
Confidence Level	**High Confidence**				

All the MCOs and the DBM achieved **High Confidence** in their compliance with State and federal requirements for overall benefit delivery from the scores achieved in the 2025 ANA Review.

Table A-20 includes the confidence rating for the score achieved by the PBM in the 2025 ANA Review.

Table A-20—Overall Appointment Availability Scores for the PBM

Measure	Score
	ORx
Overall Benefit Delivery Score	96.87%
Confidence Level	**High Confidence**

The PBM achieved **High Confidence** in its compliance with State and federal requirements for overall appointment availability from the scores achieved in the 2025 ANA Review.

Table A-21 displays the timeline for the 2025 ANA Reviews.

Table A-21—Timeline for the CY 2025 ANA Activity

MCC	Collecting Data	Conducting Review	Writing Report	Finalizing Report
BC	January–February 2025	February 18–20, 2025	February–May 2025	May 2025
UHC	January–February 2025	February 4–6, 2025	February–May 2025	May 2025
WLP	January–February 2025	February 11–13, 2025	February–May 2025	May 2025
TCS	January–February 2025	February 18–20, 2025	February–May 2025	May 2025
DQ	January–March 2025	March 4–6, 2025	March–May 2025	May 2025
ORx	January–February 2025	February 18–20, 2025	February–May 2025	May 2025

CAHPS

Objectives

The CAHPS surveys assess adult members' and parents/caretakers of child members' experience with healthcare and the quality of care they or their child receives. The surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. The CAHPS survey is recognized nationally as an industry standard for both commercial and public payers. The sampling and data collection procedures promote both the standardized administration of survey instruments and the comparability of the resulting data. BC, UHC, WLP, and TCS obtained a CAHPS vendor to administer CAHPS surveys for their adult, child Medicaid, and CHIP populations. Press Ganey Associates, an NCQA-certified HEDIS/CAHPS survey vendor, administered the 2025 CAHPS surveys for BC, TCS, and UHC, while the CSS, an NCQA-certified HEDIS/CAHPS survey vendor, administered the 2025 CAHPS surveys for WLP. The MCOs and the PIHP provided the CAHPS data to HSAG for inclusion of results within this report on June 16, 2025.

Table A-22—Timeline for the CY 2024 CAHPS Activity

MCO/PIHP	Collecting Data	Analyzing Data	Writing Report	Finalizing Report
BC	2/2025–5/2025	6/2025	7/2025	10/2025
UHC	2/2025–5/2025	6/2025	7/2025	10/2025
WLP	2/2025–5/2025	6/2025	7/2025	10/2025
TCS	2/2025–5/2025	6/2025	7/2025	10/2025

Technical Methods of Data Collection and Analysis

The MCOs and the PIHP accomplished the technical methods of data collection by administering the CAHPS 5.1H Adult Medicaid Health Plan Survey to the adult population, and the CAHPS 5.1H Child Medicaid Health Plan Survey (with the CCC measurement set) to the child Medicaid and CHIP populations. BC, UHC, WLP, and TCS used a mixed-mode methodology for data collection for the adult Medicaid, child Medicaid, and CHIP populations.[55] Adult members and parents/caretakers of child members completed the surveys in 2025, following NCQA's data collection protocol.

The CAHPS 5.1H Health Plan Surveys included a set of standardized items (39 items for the CAHPS 5.1H Adult Medicaid Health Plan Survey and 76 items for the CAHPS 5.1H Child Medicaid Health Plan Survey with CCC measurement set) that assessed adult members' and parents/caretakers of child members' experience with care. The survey categorized questions into measures of experience. These measures included four global ratings, four composite scores, three medical assistance with smoking and tobacco use cessation measure items (adult population only), and five CCC composite measures/items (CCC population only). The global ratings reflect adult members' and parents/caretakers of child members' overall experience with their/their child's personal doctor, specialist, health plan, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care (e.g., **Getting Needed Care** and **How Well Doctors Communicate**). The medical assistance with smoking and tobacco use cessation measure items assess the various aspects of providing assistance with smoking and tobacco use cessation to adults. The CCC composite measures/items evaluate the experience of families with children with chronic conditions accessing various services (e.g., specialized services, prescription medications).

For each of the four global ratings, HSAG calculated the percentage of respondents who chose a positive experience rating on a scale of 0 to 10. The definition of a positive response for the global ratings included a value of 9 or 10. For each of the four composite scores and CCC composite measures/items, HSAG calculated the percentage of respondents who chose a positive response. CAHPS composite question response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always" or (2) "No" or "Yes." A positive response for the composites included responses of "Usually/Always" or "Yes." For the medical assistance with smoking and tobacco use cessation measure items, responses of "Always/Usually/Sometimes" were used to determine if the respondent qualified for

[55] For the surveyed populations, BC, TCS, UHC, and WLP used a mixed-mode (i.e., mail, telephone, and Internet protocol) survey methodology pre-approved by NCQA.

inclusion in the numerator. The scores presented follow NCQA's methodology of calculating a rolling average using the current and prior year results. HSAG presented the positive rates in the report for BC, UHC, WLP, and TCS, which are based on the CAHPS survey results calculated by their CAHPS survey vendor. Each MCO and the PIHP provided HSAG with the requested CAHPS survey data to calculate top-box rates for each of the measures presented in this report.

When a minimum of 100 respondents for a measure was not achieved, the result of the measure was denoted as **NA**.

Arrows were used to note substantial differences. An MCO/PIHP that performed statistically significantly higher in MY 2024 than in MY 2023 was denoted with an upward arrow (↑). Conversely, an MCO/PIHP that performed statistically significantly lower in MY 2024 than in MY 2023 was denoted with a downward arrow (↓). An MCO/PIHP that did not perform statistically significantly higher or lower in MY 2024 than in MY 2023 was not denoted with an arrow.

Description of Data Obtained

The CAHPS surveys asks adult members or parents/caretakers to report on and to evaluate their/their child's experiences with healthcare. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. BC, UHC, WLP, and TCS contracted with a CAHPS vendor to administer the survey to adult members and parents/caretakers of child members. The CAHPS survey asks about members' experience with their health plan during the last six months of the measurement period (i.e., July through December 2024).

The MCOs' and PIHP's CAHPS vendors administered the surveys from February to May 2025. The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey received a disposition code of "completed" if at least three of the designated five questions were completed.[56] Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, did not meet the eligible population criteria, had a language barrier, or were mentally or physically incapacitated (adult population only). The survey also identified ineligible members during the process. The survey vendor recorded this information and provided it to HSAG.

How Conclusions Were Drawn

To draw conclusions for this report, HSAG used the information supplied by the MCOs and the PIHP to evaluate the results of the survey. HSAG compared the MCOs' and PIHP's adult Medicaid and child Medicaid MY 2024 CAHPS survey results to the MY 2023 CAHPS survey results to determine opportunities for improvement.

[56] A survey was assigned a disposition code of "completed" if at least three of the following five questions were completed for adult Medicaid: questions 3, 10, 19, 23, and 28. A survey was assigned a disposition code of "completed" if at least three of the following five questions were completed for child Medicaid: questions 3, 25, 40, 44, and 49.

To begin to draw conclusions from the data, HSAG categorized the rates as statistically significantly higher than the prior year's score, neither statistically significantly higher nor lower than the prior year's score, or statistically significantly lower than the prior year's score. HSAG concluded that MCOs and the PIHP could improve the measure rates that were lower than the prior year's score and encouraged the MCOs and the PIHP to focus on activities to assist in increasing measure rates higher than the prior year for subsequent surveys. HSAG drew conclusions concerning **quality of care**, **timeliness of care**, and/or **access to care** by evaluating the questions included in each of the measures presented in this report and relating the questions to the definitions of the three domains as noted on page A-1. This assignment to domains is depicted in Table A-23.

Table A-23—Assignment of CAHPS Measures to the Quality of, Timeliness of, and Access to Care Domains

CAHPS Topic	Quality	Timeliness	Access
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		
Advising Smokers and Tobacco Users to Quit (adult population only)	✓		
Discussing Cessation Medications (adult population only)	✓		
Discussing Cessation Strategies (adult population only)	✓		
Access to Specialized Services (CCC population only)	✓		✓
FCC: Personal Doctor Who Knows Child (CCC population only)	✓		
Coordination of Care for Children with Chronic Conditions (CCC population only)	✓		
Access to Prescription Medicines (CCC population only)	✓		✓
FCC: Getting Needed Information (CCC population only)	✓		

HEDIS

Overview

MCOs contracted by TennCare to manage healthcare benefits for Medicaid and CHIP beneficiaries are required to be accredited by the NCQA. To maintain their accreditation, TennCare MCOs must report on HEDIS performance measures and participate in an annual HEDIS Compliance Audit conducted by

an NCQA LO of their choice. HEDIS performance measures are developed and maintained by the NCQA and are broadly accepted in the managed care environment as an industry standard. For CY 2025, HSAG validated the results of each MCO's HEDIS Compliance Audit to ensure the validation activities were conducted as outlined in the CMS EQR Protocol 2 cited earlier in this report.

Technical Methods of Analysis

The HEDIS Compliance Audits of TennCare MCOs were conducted according the **HEDIS MY 2024 Volume 5 HEDIS Compliance Audit: Standards, Policies and Procedures**, and are consistent with the CMS EQR Protocol 2. Therefore, HSAG could review, validate, and eventually accept results from the HEDIS Compliance Audits as findings for the validation of performance measures to meet the managed care requirements.

Description of Data Obtained

The CMS EQR Protocol 2 identifies key types of data that should be reviewed by an EQRO. As part of the validation process, HSAG reviewed two primary sources of HEDIS data to determine if the LOs' audit processes met CMS requirements and to summarize the overall HEDIS reporting capabilities and functions for the MCOs: the IDSS data output reports and the FARs. The IDSS contained the final HEDIS rates that were verified, reviewed, and locked by the LOs. The auditor-locking mechanism in the IDSS tool ensured that no information could be changed without the consent of NCQA and the auditor. The IDSS review process allowed the LOs to assess the reasonability of the rates submitted by the MCOs. The FARs were prepared by the LOs and reported key elements from the HEDIS Compliance Audits, including information about the audited organization, information about the audit team, the survey sample frame, supplemental data (if applicable), source code review (if applicable), medical record review validation (MRRV), compliance with HEDIS IS standards, and the final audit opinion.

How Conclusions Were Drawn

IS Standards

HSAG reviewed the FARs to determine whether the MCOs' information systems complied with the IS standards outlined in the **HEDIS MY 2024 Volume 5 HEDIS Compliance Audit: Standards, Policies, and Procedures**. NCQA's IS standards assess the quality of an organization's information systems by measuring how the organization captures, manages, integrates, and reports medical, member, practitioner, and vendor data. Additionally, IS standards specify the minimum requirements for information systems and criteria for data management and reporting. The IS standards established for MY 2024 are described below:

IS R—Data Management and Reporting (formerly IS 6.0 and 7.0)

- IS R1—The organization's data management enables measurement.

  - Data standards, information systems, and processes for transferring and integrating source files are fully documented.
  - File layouts, data models, and data dictionaries used by the organization for data management are complete.
  - Data source identifiers are clear and documented.
- IS R2—Data extraction and loads are complete and accurate.
  - Transfer protocols capture all data elements for measurement.
  - Referential integrity is maintained during transmission.
  - Organization ensures extraction, and loads do not result in unintended data modification, deletion, or generation.
- IS R3—Data transformation and integration is accurate and valid.
  - File conversions maintain referential and data integrity.
  - Information tagging to enable measurement is accurate and valid.
  - Modifications, normalizations, and mappings to conform with data models, coding systems, and measure requirements are documented and valid.
  - Processing and transformation do not result in inappropriate data modification, deletion, or generation.
- IS R4—Data quality and governance are components of the organization's data management.
  - The organization's design, implementation, and improvements to its data management approach supports complete, valid, accurate, and reliable measurement.
  - Internal governance structures include responsibilities for data quality and integrity.
- IS R5—Oversight and controls ensure correct implementation of measure reporting software.
  - Reporting protocols and arrangements with vendors allow inspection, auditing, correction, and resubmission of data.
  - Use of certified measure logic is confirmed.
  - Reports demonstrate that data and results from implementing measure reporting software are complete and accurate.
- IS R6—Cybersecurity practices are in place to promote protection and resiliency of the systems and data used for measurement.

IS C—Clinical and Care Delivery Data (formerly IS 5.0)

- IS C1—Data capture is complete.
  - Electronic standards, formats, and protocols ensure capture of all data elements.
  - Data entry processors enter all required data elements.
  - Organization ensures data are not modified, deleted, or generated during capture.
  - Reports indicate data completeness.

- IS C2—Data conform with industry standards.
  - Organization uses industry standard data models, coding systems, and layouts.
  - Nonstandard data models, coding systems, and layouts are fully documented.
  - Data modification, normalization, and mapping are appropriate and do not inappropriately impact measures.
  - Processing and transformation do not inappropriately modify, delete, or generate data.
- IS C3—Transaction file data are accurate.
  - Organization systems and protocols include edit checks and controls to confirm accuracy.
  - Comparison of a sample of transmitted files with source documents ensures data are accurate.
  - Reports indicate data source impact on results.
- IS C4—Organization confirms ingested data meet expectations for data quality.
  - Organization maintains standards and requirements for inbound data to ensure data quality.
  - Internal systems and processes identify data quality issues.
  - Controls are in place to evaluate and monitor quality of data used by the organization.

IS M—Medical Record Review Processes (formerly IS 4.0)

- IS M1—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).
  - Forms or tools used for MRR—including samples of completed forms, policies, procedures, and instructions for completing the forms—ensure:
    - All fields relevant to measure reporting are included.
    - Forms guide the reviewer to the medical record data elements.
  - Electronic file formats and protocols ensure all data fields are captured for each measure.
  - Policies, procedures, and program code for files used to transfer administrative data to the MRR tools are complete and available.
  - Policies and procedures for submission and transmission of electronic information show:
    - The organization effectively monitors the quality and accuracy of its electronic submissions.
    - Transmissions are properly controlled by logs, record count verification, redundancy checking receipts, retransmissions, and sign-offs.
- IS M2—Retrieval and abstraction of data from medical records is reliably and accurately performed.
  - Policies and procedures—including chase logic and chart retrieval—ensure accuracy and completeness and verify the organization has mechanisms for transferring information to the appropriate location within the organization.
  - IRR standards and results ensure MRR is accurate and complete.
- IS M3—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.

  - Standard monitoring reports for all data entry operations personnel verify the organization effectively monitors the quality, accuracy, timeliness, and productivity of its entry processes.
  - Flowcharts and timelines describe MRR processing from all sources.
  - Data entry processors enter all required data elements for each measure.
  - Data entry policies and procedures ensure accuracy and completeness.
  - MRR data entry screens have:
    - Proper edit checks for parity checks, field sizes, date ranges, crosschecks with claims/encounter and practitioner file, code ranges, and practitioner services by specialty.
    - All necessary data fields for each measure.
  - Data transaction files are accurate, including:
    - Comparison of a sample of data entry files with source documents to ensure that all data are entered, and that data are not changed or deleted during processing.
    - Comparison of a sample of electronically transmitted files with source documents to ensure that all data are transmitted, and that data are not changed or deleted during processing.
  - The convenience sample, if applicable, ensures that the MRR process begins accurately.
  - MRRV verifies that the MRR process worked as planned.
- IS M4—The organization continually assesses data completeness and takes steps to improve performance.
  - Tracking documents indicate the progress of the MRR and the number of numerator-compliant members and exclusions.
  - Policies and procedures and performance standards require:
    - Complete submission and entry of medical record data.
    - Transmissions to be properly controlled by logs, record count verification, redundancy checking receipts, retransmissions, and sign-offs.
- IS M5—The organization regularly monitors vendor performance against expected performance standards.
  - Contracts with vendors require data for measure reporting and provide inspection and auditing of data; correction and resubmission of data, and backlog control standards and procedures; and enforce quality standards.
  - Studies and reports show that:
    - Data from vendors are complete and accurate.
    - No data are lost or modified during transfer.

IS A—Administrative Data (formerly IS 1.0, IS 2.0, IS 3.0)

- IS A1—Data conform with industry standards and measure requirements.
  - Standard layouts and forms are used.

  - Medical service transaction files include industry standard codes (e.g., International Classification of Diseases, Tenth Revision, Clinical Modification [ICD-10-CM]; Healthcare Common Procedure Coding System [HCPCS]).
  - Nonstandard layouts, forms, and codes are documented, and mapping is appropriate.
  - Mapping and normalization of provider specialty comply with measure requirements.
- IS A2—Data are complete and accurate.
  - Electronic standards, formats, and protocols ensure capture of all data elements, required codes, and characters for the appropriate system.
  - Organization ensures data are not modified, deleted, or generated during capture.
  - Organization ensures data processing, transformation, or reconciliation produces the intended result.
  - Reports indicate data completeness and impact on reporting.
- IS A3—Membership information system enables measurement.
  - Organization's membership system can accommodate:
    - Changes to product line.
    - Changes to product.
    - Methods for defining coverage start and end.
    - Methods for identifying dual enrollment.
    - Multiple changes to membership status.
  - Processing and transformation of membership information does not inappropriately modify, delete, or generate data.

Performance Measures

HSAG reviewed the IDSS reports to obtain MCOs' validated rates on HEDIS performance measures for MY 2024. For this report, HSAG limited its review to HEDIS measures specified in TennCare's Quality Strategy. HSAG assigned each reviewed HEDIS measure to one or more of three domains, as depicted in Table A-24, to draw conclusions about the quality of care, timeliness of care, and/or access to care for Medicaid and CHIP beneficiaries enrolled with each MCO.

Table A-24—HEDIS MY 2023 Measures Included in TennCare's Quality Strategy

Performance Measures	Quality	Timeliness	Access
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	✓		
Childhood Immunization Status (CIS)	✓		✓
Immunizations for Adolescents (IMA)	✓		

Performance Measures	Quality	Timeliness	Access
Cervical Cancer Screening (CCS)	✓		
Effectiveness of Care: Respiratory Conditions			
Asthma Medication Ratio (AMR)	✓		
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)	✓	✓	
Effectiveness of Care: Diabetes			
Eye Exam for Patients With Diabetes (EED)	✓		
Blood Pressure Control (<140/90 mmHg) for Patients With Diabetes (BPD)	✓		
Kidney Health Evaluation for Patients With Diabetes (KED)	✓		
Effectiveness of Care: Behavioral Health			
Follow-Up After Hospitalization for Mental Illness (FUH)	✓	✓	✓
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP)		✓	✓
Prenatal and Postpartum Care (PPC)	✓	✓	✓
Utilization and Risk-Adjusted Utilization			
Well-Child Visits in the First 30 Months of Life (W30)	✓		✓
Child and Adolescent Well-Care Visits (WCV)	✓		✓
Electronic Clinical Data System (ECDS)			
Breast Cancer Screening (BCS-E)	✓		
Long-Term Services and Support (LTSS)			
Long-Term Services and Supports—Comprehensive Assessment and Update (LTSS-CAU)	✓		
Long-Term Services and Supports—Comprehensive Care Plan and Update (LTSS-CPU)	✓		
Long-Term Services and Supports—Reassessment/Care Plan Update After Inpatient Discharge (LTSS-RAC)	✓		
Long-Term Services and Supports—Shared Care Plan With Primary Care Practitioner (LTSS-SCP)	✓		

PDV

Objectives

As TennCare's EQRO, HSAG conducted quarterly PDV surveys. HSAG used the results of this activity to determine the accuracy of the provider data files submitted by the MCCs and help determine the extent to which providers are available to and accessible by Medicaid and CHIP members.

For this activity, Tennessee MCCs include statewide MCOs (BC, UHC, and WLP); the PIHP (TCS); and the DBM (DQ).

Table A-25—Timeline for the CY 2025 PDV Activity

MCC	Collecting Data	Conducting Review	Writing Report	Finalizing Report
BC	2024 Q4: October 2024 2025 Q1: January 2025 2025 Q2: April 2025 2025 Q3: July 2025	2024 Q4: October 28–November18, 2024 2025 Q1: January 30–February 21, 2025 2025 Q2: April 28–May 16, 2025 2025 Q3: July 28–August 15, 2025	2024 Q4: November–December 2024 2025 Q1: March 2025 2025 Q2: June 2025 2025 Q3: September 2025	2024 Q4: December 2024 2025 Q1: March 2025 2025 Q2: June 2025 2025 Q3: September 2025
UHC	2024 Q4: October 2024 2025 Q1: January 2025 2025 Q2: April 2025 2025 Q3: July 2025	2024 Q4: October 28–November18, 2024 2025 Q1: January 30–February 21, 2025 2025 Q2: April 28–May 16, 2025 2025 Q3: July 28–August 15, 2025	2024 Q4: November–December 2024 2025 Q1: March 2025 2025 Q2: June 2025 2025 Q3: September 2025	2024 Q4: December 2024 2025 Q1: March 2025 2025 Q2: June 2025 2025 Q3: September 2025
WLP	2024 Q4: October 2024 2025 Q1: January 2025 2025 Q2: April 2025 2025 Q3: July 2025	2024 Q4: October 28–November18, 2024 2025 Q1: January 30–February 21, 2025 2025 Q2: April 28–May 16, 2025 2025 Q3: July 28–August 15, 2025	2024 Q4: November–December 2024 2025 Q1: March 2025 2025 Q2: June 2025 2025 Q3: September 2025	2024 Q4: December 2024 2025 Q1: March 2025 2025 Q2: June 2025 2025 Q3: September 2025
TCS	2024 Q4: October 2024 2025 Q1: January 2025 2025 Q2: April 2025 2025 Q3: July 2025	2024 Q4: October 28–November18, 2024 2025 Q1: January 30–February 21, 2025 2025 Q2: April 28–May 16, 2025 2025 Q3: July 28–August 15, 2025	2024 Q4: November–December 2024 2025 Q1: March 2025 2025 Q2: June 2025 2025 Q3: September 2025	2024 Q4: December 2024 2025 Q1: March 2025 2025 Q2: June 2025 2025 Q3: September 2025
DQ	2024 Q4: October 2024 2025 Q1: January 2025 2025 Q2: April 2025 2025 Q3: July 2025	2024 Q4: October 28–November18, 2024 2025 Q1: January 30–February 21, 2025 2025 Q2: April 28–May 16, 2025 2025 Q3: July 28–August 15, 2025	2024 Q4: November–December 2024 2025 Q1: March 2025 2025 Q2: June 2025 2025 Q3: September 2025	2024 Q4: December 2024 2025 Q1: March 2025 2025 Q2: June 2025 2025 Q3: September 2025

Technical Methods of Data Collection and Analysis

For the quarterly surveys, HSAG received a provider data file for each MCC from the State via the TennCare Oversight Processing System (TOPS), used for secure online project management. HSAG then conducted quality checks to ensure the extraction accuracy and expected format of data fields prior to selecting samples.

HSAG included all valid records received in the sampling universe and selected one statistically valid sample for each plan. HSAG determined the sample size based on the universe of providers in each network with statistical limits set at $\alpha = 0.10$ and $1 - \beta = 0.80$, ensuring a minimum sample size of 269 records. Prior to selecting each sample, HSAG eliminated duplicate records from the sampling universe. HSAG defined duplicate records as those with the same plan ID, NPI, provider last name, and provider address. HSAG excluded providers selected in the previous quarter's sampling from the current sampling and excluded providers selected from Medicaid when selecting CHIP providers from the same MCC.

HSAG attempted to contact each provider up to three times by telephone to verify the information contained in the provider file. If HSAG selected a provider more than once using this independent sampling technique, HSAG captured data elements specific to each contracted location and validated them separately during a single telephone inquiry.

HSAG's trained interviewers collected survey responses using a standardized TennCare-approved script. Interviewers contacted each case, abstracting data into a web-based data collection tool. HSAG's interviewers made three call attempts to contact each survey case during standard business hours (i.e., 8:30 a.m.–4:00 p.m. Central Time).[57] If the interviewer was placed on hold at any point during the call, the interviewer waited on hold for five minutes before ending the call. If an answering service or voicemail answered a call attempt during normal business hours, the interviewer made a second or third call attempt on a different day and at a different time of day.

The PDV survey tool contained pre-populated data elements from the provider data file samples. HSAG interviewers entered any aberrations in the data elements into the discrepant data and comment fields. HSAG verified all data entries for accuracy before analysis. If HSAG identified any data-entry errors, HSAG retrained staff members.

Description of Data Obtained

Using the TennCare-approved survey script, HSAG collected the following information pertaining to provider data accuracy:

- Contract Status

[57] HSAG did not consider a call attempted when the interviewer reached an office outside of the office's usual business hours. For example, if the interviewer reached a recording that stated the office was closed for lunch, the call attempt did not count toward the three attempts to reach the office. The interviewer attempted to contact the office up to three times outside of the known lunch hour.

- Provider Status
- Provider Address
- Provider Credentialed Specialty/BH Service Code
- Provider Panel Status
- Care Service Data
  - Routine and Urgent Care Services
  - Services for Patients
    - Do you provide services to patients less than 21 years of age (<21)?
    - Do you provide services to adults 21 years of age and older (≥21)?
    - Do you provide services to children 18 years of age and younger (≤18)?
  - Primary and Prenatal Care Services

How Conclusions Were Drawn

For each PDV data element, HSAG evaluated accuracy based on the data in the plan's original file submission. The following data element definitions describe how HSAG tabulated each plan's accuracy during analysis of the responses captured in the PDV survey tool. Using the data element definitions, HSAG grouped the results by data type (Sampling, Provider Status, and Care Services).

Table A-26—Data Element Definitions

Data Element	Definition
Contract Status	HSAG verified the provider had an active contract status during the time period under validation.
Provider Address	HSAG verified if the provider had accurate address components—Address 1, Address 2, City, State, and ZIP Code.
Provider Credentialed Specialty/BH Service Code	HSAG validated accuracy of the provider's credentialed specialty based on the specialty/BH service code present for the provider in the originally submitted MCC data.
Provider Panel Status	HSAG determined panel status accuracy (open versus closed) by comparing data submitted by the MCC with responses to whether the provider accepted new patients during the time period under review.
Routine and Urgent Care Services	HSAG validated the availability of routine and urgent care services for all MCCs by inquiring provider offices whether they offered routine and/or urgent care during the time reported for validation.
Services for Patients	HSAG determined accuracy by comparing the reported responses with the youngest and oldest ages listed within each MCC's submitted data.

Data Element	Definition
Primary and Prenatal Care Services	HSAG interviewers asked provider offices whether they offered primary care and/or prenatal care services. HSAG compared responses to MCC-submitted data to determine accuracy rates.
Overall Rates	The average rate of all four quarters' results. 2025 overall rates consist of 2024 Q4 and 2025 Q1 to Q3 results. Additionally, 2024 overall rates consist of 2023 Q4 and 2024 Q1 to Q3.

Secret Shopper

Objectives

As the contracted EQRO for TennCare, HSAG, conducted quarterly secret shopper surveys among active and inactive providers.[58] The Secret Shopper Survey evaluated access and availability of providers contracted with the Medicaid MCOs to serve TennCare Medicaid members.

The goal of the Secret Shopper Survey was to determine the accuracy of the managed care network information supplied to TennCare Medicaid members using the MCOs' PEFs and to ensure the provider networks comply with appointment wait time standards. HSAG placed secret shopper telephone calls to a sample of provider locations to determine the accuracy of the data. A secret shopper is a person employed to pose as a client or patient to evaluate the quality of customer service or the validity of information (e.g., accurate location information). The Secret Shopper Survey allowed objective data collection from healthcare providers without potential bias introduced by knowing the identity of the surveyor. Specific survey objectives included the following:

- Determine the accuracy of service location information (i.e., phone number and service address).
- Determine whether service locations offered the requested services.
- Determine whether service locations accepted Medicaid patients enrolled with the requested MCO.[59]
- Determine whether service locations that accepted Medicaid patients for the requested MCO accepted new patients.
- Determine appointment availability and assess whether the appointments offered comply with the wait time standard.

HSAG used the results to determine the accuracy of the PEFs submitted to TennCare and providers' availability and accessibility to TennCare Medicaid members. HSAG assessed BC, UHC, and WLP in the secret shopper activity.

[58] TennCare defined "active providers" as providers who submitted 30 or more claims and "inactive providers" as providers who submitted less than 30 claims.
[59] MCO acceptance was evaluated for inactive providers only.

Technical Methods of Data Collection and Analysis

The eligible population included service locations that are contracted with the MCO at the time the PEF is created, to serve individuals enrolled in the TennCare Medicaid program. HSAG conducted quarterly surveys throughout the contract year based on the following specialties:

Quarter/Year	Specialty/Provider Types
Q4 2024	Cardiology and Neurology
Q1 2025	Hematology and Ophthalmology
Q2 2025	Chiropractic and Neurosurgery
Q3 2025	General Surgery, Gastroenterology, Nephrology

TennCare provided the PEFs submitted by the MCOs, which included active and inactive providers potentially eligible for survey inclusion. The data elements for each provider included provider name, Medicaid identification (ID), NPI, provider specialty, claims information, physical (practice) address, telephone number, provider taxonomy code, and the status for accepting new patients. Upon receipt of the PEFs, HSAG assessed the data to ensure alignment with the data file format, data field contents, and logical consistency between data elements. HSAG also assessed the distribution of provider specialty data values present in each MCO's data to determine which data values will be attributed to each provider domain.

HSAG determined a statistically valid number of unique provider locations per MCO and specialty based on a 95.00 percent confidence level and ±5 percent margin of error with a minimum sample size of at least 150 unique providers. HSAG sampled all eligible providers if the minimum sample size could not be reached.

Description of Data Obtained

HSAG's secret shopper callers collected survey responses using a standardized script approved by TennCare. The script instructed callers to conduct the survey as though they were moving to the area and trying to arrange an appointment for themselves. Survey callers requested appointment availability for only the sampled location. Due to the secret shopper nature of the calls, callers improvised during actual calls as needed. The script directed callers not to leave voicemail messages or schedule appointments. Additionally, HSAG used TennCare-provided mock member IDs for the sampled location's reference when a member ID was required to access the scheduling calendar or to verify that the location accepted TennCare Medicaid.

Staff made three attempts to contact each survey case during standard business hours (i.e., 8:30 a.m. to 5:00 p.m. Central Time or Eastern Time).[60] If placed on hold at any point, the caller waited on hold for

[60] HSAG did not consider a call attempted when the interviewer reached an office outside of the office's usual business hours. For example, if the interviewer reached a recording that stated the office was closed for lunch, the call attempt did not count toward the three attempts to reach the office. The interviewer attempted to contact the office up to three times outside of the known lunch hour.

five minutes before ending the call. If the caller received an answering service or voicemail during normal business hours, the caller made a second and/or third call attempt on a different day and at a different time of day.

Interviewers completed project-specific training with a dedicated HSAG analytics manager to standardize the call procedure and data collection process. HSAG recorded the survey responses in an electronic data collection tool. Prior to analyzing the results, HSAG reviewed the responses to ensure complete and accurate data entry.

How Conclusions Were Drawn

HSAG classified survey indicators into two domains: provider data accuracy and access-related information. HSAG evaluated provider data accuracy on whether demographic information from the PEF matched survey responses. For data collected on the first available appointment, HSAG calculated the average wait time based on the date of the completed secret shopper call and the earliest appointment date. Additionally, HSAG assessed whether appointments offered were compliant with the wait time standards.[61]

HSAG collected the following information pertaining to provider data accuracy:

- Telephone number
- Address
- Provider specialty
- Provider affiliation with Medicaid for the requested MCO[62]

HSAG collected the following access-related information when calling sampled cases:

- Information concerning whether the provider location currently accepted new patients
- Next available appointment with any practitioner at the sampled location with the requested MCO
- Any limitations to accepting new patients or scheduling an appointment

Study Limitations

Due to the nature of the secret shopper survey, TennCare should consider the following limitations when generalizing survey results.

- HSAG conducted the survey calls at least three to five weeks after receiving the MCOs' PEFs, resulting in the possibility that provider locations updated their contact information with the MCO prior to HSAG's survey calls.
- Wait times were based on the first available appointment at the sampled location only. HSAG counted cases offering an appointment at a different location as being unable to offer an

[61] Routine specialist appointments should be scheduled within 30 calendar days.
[62] HSAG evaluated MCO acceptance for inactive providers only.

appointment. As such, survey results may underrepresent timely appointments for situations in which TennCare Medicaid members are willing to travel to an alternate location.

- Survey findings are based on the self-reported responses of office personnel. Therefore, survey responses may vary from information obtained at other times or using other data sources (e.g., online portals, speaking to a different representative at the provider's office).
- To maintain the secret nature of the survey and to ensure consistent data collection across cases, callers used a standardized survey script and posed as members who were not existing patients at the sampled provider locations. As such, survey results may not represent appointment timeliness among members who are existing patients or who may be willing to navigate scenarios outside of the survey script (e.g., leaving voicemails for an office or obtaining an appointment through an Internet-based scheduling portal).
- The survey script did not address specific clinical conditions that may have resulted in more timely appointments or greater availability of services (e.g., a patient with a time-sensitive health condition or a referral from another provider).
- HSAG recommends reviewing the new patient rates with caution, given the limited number of cases that confirmed the accuracy of the provider data (i.e., phone number, location, service offered, and insurance acceptance).
- HSAG recommends exercising caution when drawing conclusions related to access and availability (i.e., wait times and compliance rates) given the limited number of cases that confirmed new patient acceptance and offered an appointment date.
- No active neurosurgeons were evaluated for WLP due to overlapping phone numbers among active neurosurgeons across all MCOs at the time of sampling. Overall, 10 active and 85 inactive neurosurgeons were sampled for the survey. TennCare should exercise caution when interpreting survey results for active neurosurgeons.
- The nature of the specialty surveyed also limited efforts to collect data on appointment availability. General surgery, oncology/hematology, neurosurgery, gastroenterology, and nephrology visits typically require a referral to ensure that a PCP or specialist has determined that such care is appropriate.

Table A-27 includes the timeline for completing the Q4 CY 2024 to Q3 CY 2025 Secret Shopper Activity for BC, UHC, and WLP.

Table A-27—Timeline for the Q4 CY 2024 to Q3 CY 2025 Secret Shopper Activity

Quarter	Collecting Data	Conducting Review	Writing Report	Finalizing Report
Q4 2024	9/10/24	10/1/24–10/31/24	11/1/24–12/18/24	1/8/25–1/15/25
Q1 2025	1/15/25	2/18/25–3/17/25	3/18/25–4/15/25	4/28/25–4/30/25
Q2 2025	4/4/25	5/19/25–6/13/25	6/16/25–7/15/25	7/28/25–7/31/25
Q3 2025	7/8/25	8/18/25–9/12/25	9/15/25–10/17/25	10/29/25–10/31/25

BESMART Provider Survey

Objectives

TennCare requested that the State's EQRO, HSAG, conduct a PDV survey of its network of MOUD providers. HSAG's subcontractor, Qsource, conducted the provider survey of the network, called BESMART. The PDV's purpose was to determine accuracy of specified data for BESMART providers serving TennCare members with opioid addiction using approved Schedule III, IV, and V opioid medications or combinations of these medications. President Biden signed the Consolidated Appropriations Act on December 29, 2022, which went into effect on January 12, 2023, removing the previously implemented and surveyed Drug Addiction Treatment Act of 2000 Waiver program. The results of this survey can help further determine the extent to which providers are available to and accessible by TennCare members.

Methodology

Qsource developed six specific survey questions in collaboration with TennCare to validate key data regarding BESMART network providers and network capacity. Qsource conducted the survey following rigorous quality control standards and within the guidelines of its organizational quality management system.

TennCare securely provided HSAG with BESMART provider data in July 2025, which HSAG transferred to Qsource via HSAG's Secure Access File Exchange (SAFE) site. TennCare contacted providers via email to explain the purpose of the validation, ensure that providers were aware of the State's contractual relationship with HSAG, and inform providers that Qsource, HSAG's subcontractor, would administer the survey. Due to the limited number of applicable providers, Qsource did not conduct any sampling. Qsource's healthcare data analyst performed quality checks on the data universe of eligible BESMART providers, eliminating duplicate records. Qsource defined "duplicate records" as records with the same provider first name, provider last name, and NPI. Once the analyst had deduplicated the records, Qsource sent the survey to the provider's credentialing email address, then documented received survey responses, comments, and/or reasons for excluding a record from analyses.

To facilitate the survey process, Qsource used a mixed methodology consisting of online tools and CSR telephone protocol. Qsource used the online service Microsoft Forms to develop the tool and tested it internally to improve the tool's usability to further diminish the burden on respondents. Qsource sent all three evites via Microsoft Outlook to counter system blocks. The email included information about the survey and a clickable link to the survey.

Qsource sent initial invitations to complete the survey on Thursday, August 7, 2025, requesting that providers respond to a five-minute BESMART survey. Following up on that email, Qsource sent a reminder invitation to nonrespondents on Wednesday, August 13, 2025, with a message to expect a call from a CSR if the nonrespondent did not complete the survey within the next five business days.

Qsource sent a third and final invitation on Tuesday, August 19, 2025. After the additional time period, Qsource's CSRs contacted remaining nonrespondents via telephone to complete the survey.

The CSRs followed a script to ask targeted providers the survey questions and recorded responses using the Web link survey via Microsoft Forms. CSRs attempted to contact each provider up to three times by telephone to verify the data contained in the provider's file. If three calls proved unsuccessful, Qsource recorded the provider as nonresponsive. At the end of the survey period, Qsource staff exported results from the survey tool, conducted the validation, and analyzed the data for reporting.

Technical Methods of Data Collection and Analysis

In collaboration with TennCare, Qsource developed close-ended survey questions and one open-ended question to validate key data regarding provider capacity with minimal administrative burden for providers. TennCare securely provided HSAG with BESMART provider data in July 2025, which HSAG transferred to Qsource via HSAG's SAFE site. TennCare contacted providers via email two days prior to the survey to explain the purpose of the validation; ensure provider awareness of the State's contractual relationship with HSAG; and inform providers that Qsource, HSAG's subcontractor, would administer the survey. Due to the limited number of applicable providers, Qsource did not conduct any sampling.

Following quality checks by Qsource's healthcare data analyst on the data universe of eligible BESMART providers, Qsource eliminated duplicate records and sent the survey to each provider's credentialing email address. Qsource initially sent the survey as a clickable Web link via Microsoft Outlook and used the same method to send the two reminder emails.

Qsource sent initial invitations to complete the survey on August 7, 2025, requesting that providers respond within five business days. Qsource sent a reminder invitation to nonrespondents (those who had not responded) on August 13, 2025, which included the message that CSRs would call anyone who did not complete the survey within the next five business days. Qsource sent a third and final invitation on August 19, 2025, to providers still deemed as nonrespondents.

Qsource's CSRs attempted to contact each provider up to three times by telephone. If three calls proved unsuccessful, Qsource recorded the provider as nonresponsive. During the telephone calls, the CSRs followed a script to ask targeted providers the survey questions and recorded responses using the Web link survey via Microsoft Forms. At the end of the survey period, Qsource exported results from the survey tool, conducted the validation, and refined the analyses for reporting.

Description of Data Obtained

Deduplication of the initial MCO files left 570 unique TennCare BESMART provider records. Of these, 285 providers completed all or part of the survey. Some of the responding providers offered invalid answers to some questions, which Qsource did not include in the analyses. Qsource also noted unavailable provider responses, which Table A-28 summarizes below.

Table A-28—Summary of Unavailable Provider Responses

Reason	Number
Provider changed practices, no longer employed by the practice, or deceased	40
CSR could not contact the provider by either email or telephone	171
Invalid provider telephone number	73
Not a BESMART Provider	1
Total Unavailable Provider Responses	**285**

Qsource obtained information from responding providers for the following questions:

- What is your BESMART prescriber network contract status with each TennCare MCO or health plan?
- Regarding current BESMART patients:
  - What is the number you are treating; and
  - What is the payer mix for those patients?
- Regarding your capacity to expand your BESMART practice:
  - Are you currently able to expand to reach your MOUD network maximum capacity?
  - If not, how many additional MOUD patients could you add today?
  - How many additional MOUD patient slots could be exclusively reserved for TennCare members?
- How many slots for BESMART services will be available to each TennCare MCO you are currently contracting with?
- Provide additional comments, as needed.

To facilitate the survey process, Qsource used a mixed methodology of online tools (e.g., Microsoft Forms) and the Qsource call center. If the call center contacted providers, the call center representatives entered the answers to the questions in Microsoft Forms. Qsource used the data from Microsoft Forms to calculate the responses for the survey.

How Conclusions Were Drawn

Qsource created a report showing the answers generated for each question in the survey. The information obtained from the study included the current number of BESMART patients being treated by the providers and an estimate of the number of slots available for additional BESMART patients by MCO/PIHP. Table A-29 displays the results of the BESMART survey:

Table A-29—BESMART Survey Results by MCO

MCO	Number of Providers Responding	Percentage of Slots Available for BESMART Patients			
		25.00% or less	25.01%–50.00%	50.01%–75.00%	75.01%–100%
BC	273	135	112	5	13
UHC	268	155	95	3	8
WLP	276	146	105	3	11
TCS	183	187	5	2	8
Total Available Slots		**623**	**317**	**13**	**40**

Note: For BC, 20 records had a missing or invalid response. For UHC, 24 records had a missing or invalid response. For WLP, 20 records had a missing or invalid response**.** For TCS, 83 records had a missing or invalid response.

Table A-30 displays the timeline for conducting the 2025 BESMART activity.

Table A-30—Timeline for the CY 2024 BESMART Activity

MCC	Collecting Data	Conducting Review	Writing Report	Finalizing Report
BC	August–September 2025	September–October 2025	October 2025–November 2025	November 2025
UHC	August–September 2025	September–October 2025	October 2025–November 2025	November 2025
WLP	August–September 2025	September–October 2025	October 2025–November 2025	November 2025
TCS	August–September 2025	September–October 2025	October 2025–November 2025	November 2025

Qsource developed survey questions in collaboration with TennCare to validate key data regarding the current BESMART network providers and network capacity. The results of this survey can help further determine the extent to which providers are available to and accessible by TennCare members who need medication-assisted recovery and treatment.