

# Tennessee External Quality Review Organization

October 2016

2016 Annual

# EQRO Technical Report

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## Acronyms and Initialisms

A.....	Administrative
ACA.....	<i>Patient Protection and Affordable Care Act</i> as amended by the <i>Health Care and Education Reconciliation Act of 2010</i> , also known as the <i>Affordable Care Act</i>
AGE/AGM/AGW .....	Amerigroup Community Care, Inc., d.b.a. Amerigroup in Tennessee's East, Middle and West Grand Regions
AMM.....	Antidepressant Medication Management
ANA.....	Annual Provider Network Adequacy and Benefit Delivery Review
AON .....	Area of Noncompliance
AQS.....	Annual Quality Survey
ASH.....	Abortion, Sterilization and Hysterectomy
BCE/BCM/BCW.....	Volunteer State Health Plan, Inc., d.b.a. BlueCare in Tennessee's East, Middle and West Grand Regions
BH.....	Behavioral Health
BSN.....	Bachelor of Science in Nursing
CAHPS .....	Consumer Assessment of Healthcare Providers and Systems
CAP .....	Children and Adolescents' Access to Primary Care Practitioners (HEDIS Measure)
CCMS .....	Care Communication Management System
CEO.....	Chief Executive Officer
CFR .....	<i>Code of Federal Regulations</i>
CLIA.....	<i>Clinical Laboratory Improvement Act</i>
CHL.....	Chlamydia Screening in Women (HEDIS Measure)
CMHC .....	Clinical Mental Health Counselor
CMO .....	Chief Medical Officer
CMS .....	Centers for Medicare & Medicaid Services
CPT .....	Current Procedural Terminology
COE.....	Centers of Excellence
CRA.....	Contractor Risk Agreement
CY.....	Calendar Year
d.b.a. ....	Doing Business As
DBM/DBMC.....	Dental Benefits Manager/DBM Contract
DEA.....	Drug Enforcement Agency
DQ .....	DentaQuest of Tennessee, LLC
DHHS .....	Department of Health and Human Services
DM .....	Disease Management
DRG .....	Diagnosis Related Group
D-SNPs .....	Dual-Eligible Special Needs Plans
E.....	Expedited
EHR.....	Electronic Health Record
EPSDT .....	Early and Periodic Screening, Diagnosis and Treatment (federal standard)
EQR/EQRO .....	External Quality Review/EQR Organization
EVV .....	Electronic Visit Verification

## Acronyms and Initialisms

E/W	East/West
F-to-F	Face-to-Face
FQHC	Federally Qualified Health Center
GDP	General Dental Practitioner
HCBS	Home and Community-Based Services
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	<i>Health Insurance Portability and Accountability Act</i>
HIPDB	Healthcare Integrity and Protection Data Bank
HRA	Health Risk Assessment
HSAG	Health Services Advisory Group, Inc.
ICD	International Classification of Diseases
IEP	Individual Education Plan
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
IS	Information System(s)
LEIE	List of Excluded Individuals/Entities
LOC	Level of Care
LTC	Long-Term Care
LTSS	Long Term Services and Supports
MCC	Managed Care Contractor
MCDM	Member Centric Decision Management
MCO	Managed Care Organization
MD	Doctor of Medicine
MR	Medical Record
MLTSS	Managed Long Term Services and Supports
N	No
NA	Not Applicable/Not Assessed
NCQA	National Committee for Quality Assurance
NEMT	Non-Emergency Medical Transportation
NR	Non-Reportable Rate
OB/GYN	Obstetrician/Gynecologist
OIG	Office of Inspector General
P	Partial
P&P	Policy and Procedure
PA	Performance Activity
PAF	Provider Attestation Form
PCP	Primary Care Physician/Provider
PH	Population Health
PERS	Personal Emergency Response System
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PMV	Performance Measure Validation

## Acronyms and Initialisms

PPC	Prenatal and Postpartum Care
QI	Quality Improvement
QMP	Quality Monitoring/Improvement Program
QP	Quality Process
QSI	Quality Spectrum Insight
Quality Strategy	Quality Assessment and Performance Improvement Strategy
R	Reportable Rate
Roadmap	Record of Administrative Data Management and Processes
S	Standard
SCHIP	State Children’s Health Insurance Program
SCP	Specialty Care Provider
SDP	Specialty Dental Provider
STN	Short-Term Nursing
TCA	Tennessee Code Annotated
TCS	Volunteer State Health Plan, Inc., d.b.a. <i>TennCareSelect</i> across all Grand Regions of Tennessee
TDC	<i>TennCare</i> Dental Benefit Manager Contract
TN	Tennessee
TSA	<i>TennCareSelect</i> Agreement
UHCCP	UnitedHealthcare Community Plan
UHCE/UHCM/UHCW	UnitedHealthcare Plan of the River Valley, Inc., d.b.a. UnitedHealthcare in Tennessee’s East, Middle and West Grand Regions
UM	Utilization Management
UPNN	United Provider News Network
Y	Yes

## Acknowledgements/Copyrights<sup>1</sup>

**CAHPS**<sup>®</sup> refers to the Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality.

**HEDIS**<sup>®</sup> refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA).

**NCQA HEDIS Compliance Audit**<sup>™</sup> is a trademark of NCQA.

**Qsource**<sup>®</sup> is a registered trademark.

**Million Hearts**<sup>®</sup> is a registered trademark of the Department of Health and Human Services.

**DataStar**<sup>®</sup> is a registered trademark of DataStar, Inc.

**MACPro**, the Medicaid and CHIP Program System, is a web-based system for the submission, review and management of Medicaid and CHIP initiatives.

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## Executive Summary

Qsource produced and delivered this *2016 Annual EQRO Technical Report* to summarize the quality, timeliness and accessibility of care furnished by the managed care contractors (MCCs) of the Tennessee Division of Health Care Finance and Administration (HCFA) to the members of the state's Medicaid program (TennCare). Results were determined by aggregating and analyzing data obtained through the three federally mandated external quality review (EQR) activities that Qsource conducted as the EQRO organization (EQRO) for TennCare:

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

During the period of review (January to December 2015), TennCare's MCCs included three managed care organizations (MCOs) operating in Tennessee's East, Middle and West Grand Regions; one statewide MCO available to certain TennCare members under age 21 enrolled by the State; and a statewide dental benefits manager (DBM). While HCFA also contracts with a health plan administrator and DBM for the State's Children's Health Insurance Program (CHIP) and with six Dual-Eligible Special Needs Plans (D-SNPs) for Medicare cost-sharing, EQRO reporting for both populations is separate from the Medicaid managed care population and, therefore, not included in this report. Upon completion of a new *Quality Assessment and Performance Improvement Strategy* (Quality Strategy), TennCare evaluates the measures selected for validation with respect to its goals and objectives.

To assist both EQROs and state Medicaid agencies, CMS supplemented the requirements of Title 42 *Code of Federal Regulations* (CFR) Section 438, part 364 (42 § 438.364) and provided guidelines for this *2016 Annual EQRO Technical Report*, which includes the following sections:

- ◆ An Overview of EQRO Activities
- ◆ MCC Best and Emerging Practices
- ◆ PMV
- ◆ PIP Validation
- ◆ ANA
- ◆ AQS
- ◆ Conclusions and Recommendations

## Executive Summary

### Assessment

Results from Qsource’s 2016 EQR activities show that TennCare’s MCCs continue to exhibit a strong commitment to members by delivering timely, accessible and high-quality care. Findings for each activity are summarized in this section.

In 2016, 11 MCCs operated in all three Grand Regions of Tennessee. This includes three new MCOs created as part of the statewide contracts implemented in 2015. The MCCs were **Amerigroup (AG)**, operating as **Amerigroup-East (AGE)**, **Amerigroup-Middle (AGM)** and **Amerigroup-West (AGW)**; **BlueCare (BC)**, operating as **BlueCare-East (BCE)**, **BlueCare-Middle (BCM)**, **BlueCare-West (BCW)**, and statewide as **TennCareSelect**; **UnitedHealthcare (UHC)**, operating as **UnitedHealthcare-East (UHCE)**, **UnitedHealthcare-Middle (UHCM)** and **UnitedHealthcare-West (UHCW)**; and **DentaQuest (DQ)**, the statewide DBM.

### Quality Care: PMV

As part of the required National Committee for Quality Assurance (NCQA) accreditation, all TennCare MCOs report a full set of measures from the Healthcare Effectiveness Data and Information Set (HEDIS). Select measures from this set are then validated for accurate results and to assess MCO compliance with reporting standards. The DBM is not required to report performance measures and, therefore, does not undergo PMV.

All MCOs were compliant with the HEDIS Information Systems Standards for the 2016 PMV. All MCOs continued to use NCQA-certified software vendors for HEDIS measure production and satisfied the HEDIS Determination Standards. For the 2016 validations, all MCOs were determined to be in full compliance with all standards, and received a Reportable Rate (R) designation for the two measures validated: Chlamydia Screening in Women (CHL) and Children and Adolescents’ Access to Primary Care Practitioners (CAP). **Table 1** shows both measures’ statewide weighted rate for the reported year. Individual MCO results and available trending are presented in the [PMV section](#) of this report; sample assessment tools can be found in [Appendix B](#).

Table 1. 2016 PMV Results			
Performance Measure	TN Weighted Rate		HEDIS 2015 Medicaid National Average
	2015	2016	
<b>Chlamydia Screening in Women (CHL)</b>			
16–20 years	48.88%	48.17%	51.27%
21–24 years	55.93%	54.61%	60.16%
<b>Total</b>	<b>52.03%</b>	<b>51.19%</b>	<b>54.63%</b>

Table 1. 2016 PMV Results			
Performance Measure	TN Weighted Rate		HEDIS 2015 Medicaid National Average
	2015	2016	
<b>Children and Adolescents' Access to Primary Care Practitioners (CAP)</b>			
12–24 months	94.22%	91.77%	95.50%
25 months–6 years	88.06%	85.15%	87.78%
7–11 years	93.55%	91.15%	90.95%
12–19 years	89.96%	87.78%	89.32%

### Quality Care: PIP Validation

Designed by MCCs and approved by TennCare, PIPs use objective quality indicators to identify gaps for targeted quality improvement (QI) interventions, measure the effectiveness of implemented interventions, and plan and initiate activities for increasing or sustaining improvement. For the year under review, MCCs were contractually required to conduct PIPs that aligned with both the Triple Aim and objectives set forth by TennCare. In 2015 and 2016, TennCare elected to have Qsource validate all of the MCCs' PIPs, which were at different stages of progress (i.e., from Baseline to Remeasurement 4).

The DBM was required to conduct at least one clinical and one non-clinical PIP. For the MCOs, the two clinical PIPs were required to include one study on behavioral health (BH) relevant to one of the Population Health (PH) programs for bipolar disorder, major depression or schizophrenia. The other must be in the area of child health or perinatal (prenatal/postpartum) health. Furthermore, one of the three non-clinical PIPs were required to be in the area of long-term care. All these specifications were met per the contract risk agreement (CRA) requirements this year.

**Table 2** summarizes PIP validation status by MCC. Of the 52 PIPs evaluated in 2016, 47 achieved a **Met** validation status. Individual MCC results and available trending are presented in the [PIP Validation section](#) of this report and in [Appendix A](#); sample assessment tools can be found in [Appendix B](#).

Table 2. 2016 PIP Validation Status			
MCC	PIPs Met/Submitted	MCC	PIPs Met/Submitted
AGE	5/5	TCS	6/6
AGM	5/5	UHCE	3/4
AGW	5/5	UHCM	3/4

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MCC	PIPs Met/Submitted	MCC	PIPs Met/Submitted
BCE	6/6	UHCW	3/4
BCM	5/5	DQ	0/2
BCW	6/6		

**Access, Timeliness and Quality: ANA**

**Table 3** shows each MCC's 2016 ANA evaluation scores. Network Adequacy includes an assessment of the number and type of providers in each MCC's provider network and the proximity of members to these providers. Benefit Delivery is an evaluation of each MCC's delivery of covered benefits (via handbooks, contracts and policies) to its members and providers.

Eight MCC Network Adequacy ratings were >99.9 percent or better, except for **AGE** (99.8 percent), **AGW** (99.5 percent) and **BCM** (99.9 percent). For Benefit Delivery, six MCCs achieved ratings of >99.9 percent or better, except for **BCE** (99.3 percent), **BCM** (99.3 percent), **BCW** (99.3 percent), **TCS** (99.0 percent) and **UHCE** (98.3 percent). Individual MCC results and available trending are presented in the [ANA section](#) of this report and in [Appendix A](#); sample assessment tools can be found in [Appendix B](#).

MCC	Network Adequacy	Benefit Delivery	MCC	Network Adequacy	Benefit Delivery
<b>AGE</b>	99.8%	>99.9%	<b>TCS</b>	>99.9%	99.0%
<b>AGM</b>	100%	>99.9%	<b>UHCE</b>	>99.9%	98.3%
<b>AGW</b>	99.5%	>99.9%	<b>UHCM</b>	>99.9%	>99.9%
<b>BCE</b>	>99.9%	99.3%	<b>UHCW</b>	>99.9%	>99.9%
<b>BCM</b>	99.9%	99.3%	<b>DQ</b>	100%	100%
<b>BCW</b>	100%	99.3%			

**Access, Timeliness and Quality: AQS**

For the AQS, MCCs were assessed for compliance with quality process (QP) standards and performance activities (PAs) based on contractual, regulatory, legislative and judicial requirements. If the CRA requirements are the same or less stringent than the NCQA standards for MCO accreditation, they are not included in the AQS to avoid duplication. The DBM, which is not subject to NCQA accreditation, was evaluated on a distinct set of criteria established from its contract with TennCare. All MCCs' credentialing and recredentialing policies and procedures (P&Ps) were assessed during the 2016 ANA. Those results, as well as results for the credentialing

and recredentialing file reviews, were included in the *2016 AQS Technical Papers* and *2016 AQS Summary Report* and are also included in this report's AQS sections.

As shown in **Table 4**, compliance was high overall during the 2016 AQS, with the exception of **AG** for Network: Contracting, Availability, Access and Documentation (0.0 percent). All MCOs achieved a compliance score of 100 percent for 6 of the 8 QP standards and 8 of the 13 PAs evaluated. The DBM achieved 100-percent compliance for 15 of 18 QP standards and all five PAs. The DBM's compliance scores ranged from 75.0 to 96.0 percent for the remaining QP standards.

MCC	Individual QP Standards Range	Individual PA Range
MCOs	0.0–100%	70.5–100%
DBM	75.0–100%	100%

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

## Systemwide Recommendations

MCC-specific recommendations can be found in each MCC's report for the federally mandated EQR activities. The following were noted as systemwide performance improvement needs:

- ◆ **PMV:** The MCOs should continue to investigate ways to automate the data transfer between credentialing/provider management and administrative software platforms.
- ◆ **PIP Validation:** For the 2016 PIPs, the MCCs should ensure they submit PIP studies in their entirety during initial submissions with all the necessary and relevant information completed in the PIP Summary Forms by topic and MCC to ensure clarity during the review process.
- ◆ **ANA:** MCOs could address the shortages of providers in the relative elements that did not achieve 100-percent compliance for the individual MCOs. While these shortages varied from MCO to MCO, this recommendation applies to all MCOs.
- ◆ **AQS:** MCOs could add more specific information in the Member Handbook regarding appropriate prescription drug usage and avoiding prescription drug abuse because such information was only included in the Member Newsletters. Also, although the Member Handbook included information about continuing active treatment plans during pregnancy and about switching from the current MCO to another MCO, it could clearly state that switching from one MCO to another invalidates prior authorizations granted under the previous MCO.

## Overview

This section provides a brief history of TennCare, its Quality Strategy, the guidelines for this report, and brief descriptions and objectives of the EQR activities conducted in 2016. Because the 2016 Quality Strategy was not available at publication time, this report refers to the 2015 Quality Strategy.

### History of Tennessee's Managed Care Programs

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

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

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

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

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

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## Overview

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

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

On January 1, 2015, new contracts took effect between the state and its existing MCOs—**AG**, **BC** and **UHC**—with full statewide implementation completed by the end of calendar year (CY) 2015, which meant the addition of Amerigroup coverage in the East and West Grand Regions and BlueCare in the Middle Grand Region, to ensure quality and accessibility across the state through three covering plans and a DBM.

While it did not expand Medicaid, TennCare demonstrated impressive numbers in multiple categories. The percentage above the federal poverty limit for the categories of eligible individuals covered—Children, Pregnant Women, Parents or Caretaker Relatives, Newborns, Medically Needy, Supplemental Security Income, Institutionalized Individuals, Women with Breast or Cervical Cancer and TennCare Standard (children <19 years old) mostly exceeded the *Patient Protection and Affordable Care Act* (ACA) goal (138 percent). HCFA supported additional coverage through its CHIP and Medicare Cost Sharing programs, which the EQRO evaluated in separate reporting through, respectively, the *Annual CoverKids EQRO Technical Report* (including ANA and AQS evaluations) and the *Annual HEDIS D-SNP Report*.

## State Quality Strategy Goals

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

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

- ◆ **Vision Statement:** "Setting the standard in health care management by delivering high quality, cost-effective care that results in improved health and quality of life for eligible Tennesseans."
- ◆ **Mission Statement:** "To maintain an exemplary system of high quality health care for eligible Tennesseans within a sustainable and predictable budget."

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

- ◆ **Commitment:** Ensuring that Tennessee taxpayers receive values for their tax dollars
- ◆ **Agility:** Be nimble when situations require change
- ◆ **Respect:** Treat everyone as we would like to be treated
- ◆ **Integrity:** Be truthful and accurate
- ◆ **New Approaches:** Identify innovative solutions
- ◆ **Great customer service:** Exceed expectations

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

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

Measures from the HEDIS audit and MCO PIPs are the primary mechanisms for assessing these goals, which apply to the integrated physical and behavioral services delivered by TennCare's MCOs. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program, as well as a member satisfaction survey administered by the University of Tennessee, is used to measure member satisfaction. For select measures, TennCare offers incentives to MCOs that demonstrate significant improvement from the previous reporting period as determined by established NCQA methodology.

Additional Quality Strategy objectives, assessed through LTSS measures, have been established based on the CHOICES program implemented in 2010. As the name suggests, CHOICES is

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designed to provide adults who are elderly or have physical disabilities with viable alternatives to institutional care. Quality assurance for these services focuses on the following:

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

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

## EQR Activity Descriptions and Objectives

EQR requires three mandated activities and can include five optional activities. Each state may also assign other responsibilities to its designated EQRO, such as the provision of ongoing technical assistance. This section summarizes the activities that Qsource performed for TennCare in 2016.

### EQR Mandatory Activities

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

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

Qsource is responsible for the creation and production of this *2016 Annual EQRO Technical Report*, which compiles the results of these EQR activities. Qsource's efforts are a primary means of assessing the quality, timeliness and accessibility of services provided by TennCare's MCCs.

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

- ◆ A brief description of the data collection, aggregation and analyses for each of the EQR compliance activities
- ◆ A summary of findings from each review (PMV, PIP validation, ANA and AQS)
- ◆ A summary of strengths and opportunities demonstrated by each MCC in providing healthcare services to TennCare members
- ◆ Recommendations for improving the quality of these services

The mandated EQR activity audit and review periods for TennCare MCCs are summarized in **Table 5**. Applicable trending results are presented in the activity sections of this report.

<b>Table 5. 2016 Survey and Review Periods for EQR Activities</b>		
<b>Activity</b>	<b>Audit Period</b>	<b>Period Under Review</b>
<b>PMV</b>	February–April 2016	1/1–12/31/2015
<b>PIP Validation</b>	August–September 2016	1/1–12/31/2015
<b>ANA</b>	February–March 2016	1/1–12/31/2015
<b>AQS</b>	February–April 2016	1/1–12/31/2015

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

- ◆ *2016 Annual PMV Reports* (individual MCC reports)
- ◆ *2016 PIP Validation Technical Papers* (individual MCC reports)
- ◆ *2016 PIP Validation Summary Report*
- ◆ *2016 ANA Reports* (individual MCC reports)
- ◆ *2016 AQS Technical Papers* (individual MCC reports)
- ◆ *2016 AQS Summary Report*

This *2016 Annual EQRO Technical Report* is based on detailed findings that can be examined in the MCC-specific and summary reports. Each EQR activity’s brief descriptions and objectives are described in the following paragraphs of this section.

### PMV

To evaluate performance levels, TennCare selected a process for an objective, comparative review of quality-of-care outcomes and performance measures. Its primary aims were to evaluate the accuracy of MCO-reported measures and to determine whether those measures were calculated according to required technical specifications. To satisfy CMS protocol for MCOs and to meet the requirements set forth in 42 CFR §438.240(b)(2), TennCare identified for validation the following two HEDIS measures, defined by the NCQA and validated through an NCQA HEDIS Compliance Audit: Chlamydia Screening in Women (CHL) and Children and Adolescents’ Access to Primary Care Practitioners (CAP). Trending and comparisons among MCOs are available in the [PMV section](#) of this report.

### PIP Validation

The primary objective of the EQRO’s PIP validation is to determine the compliance of each MCC with the requirements set forth in 42 CFR §438.240(b)(1). MCCs must conduct PIPs that are designed to achieve, through ongoing measurements and interventions, significant and sustained improvement in clinical and nonclinical care areas that are expected to have a favorable effect on

## Overview

health outcomes and member satisfaction. PIP study topics must reflect Medicaid enrollment in terms of demographic characteristics and, if applicable, in terms of the prevalence and potential consequences (risks) of disease. Each PIP must be completed in a reasonable timeframe to allow PIP success-related data in the aggregate to produce new information on quality of care every year.

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

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

The 2016 PIP validation process evaluated 52 PIPs spread across 10 MCOs and one DBM. Validation was performed only for ongoing and baseline PIPs that were already underway during the 12 months preceding review. The validation process included a review of each PIP's study design and approach, an evaluation of each PIP's compliance with the analysis plan and an assessment of the effectiveness of MCC interventions. The results of the validation process can be found in the [PIP section](#).

### ANA

Per 42 CFR §438.204(g) and 438.206 and their respective contracts, TennCare MCCs must ensure

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

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

### AQS

The AQS is bound by the same mandates as ANA reviews. AQS requirements are further defined by (1) 42 CFR §434 and 438; (2) each MCC's contract with the state; (3) the court-ordered provisions of the *Grier Revised Consent Decree*; and (4) additional quality standards established by the State. While the *John B. Consent Decree* has been vacated, the state remains dedicated to continued review of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

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

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

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

### **EQR Optional Activities**

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

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

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

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### Additional Contractual Activities

In addition to those mentioned, Qsource performs other activities as part of its EQRO contract with TennCare. These include the following 2016 deliverables, required annually unless otherwise noted:

- ◆ *EPSDT Summary Report*
- ◆ *HEDIS/CAHPS Report: Comparative Analysis of Audited Results from TennCare Managed Care Organizations*
- ◆ *Impact Analysis Report*
- ◆ *Relative Resource Use (RRU) Report*
- ◆ *Annual HEDIS D-SNPs Report*
- ◆ *CHOICES Long-Term Care Services Satisfaction Survey Report*
- ◆ *Provider Data Validation (PDV) Report (Quarterly)*
- ◆ *Annual Child Focus Study*
- ◆ *Abortion, Sterilization and Hysterectomy (ASH) Audit Report*
- ◆ *Provider Satisfaction Survey*

Qsource also conducts meetings three times a year that are attended by TennCare and its MCCs. The three 2016 meetings featured seminars about changes to Medicaid, innovations in member communication, and growing risks for patients improperly treated. Additional meeting information is presented in [Appendix C](#).

## Technical Report Guidelines

To assist both EQROs and state Medicaid agencies, CMS supplemented the requirements of 42 CFR §438.364 and provided guidelines for this *2016 Annual EQRO Technical Report*, which—in addition to the Executive Summary and this Overview—includes the following sections:

- ◆ MCC Best and Emerging Practices
- ◆ ANA
- ◆ PMV
- ◆ AQS
- ◆ PIP validation
- ◆ Conclusions and Recommendations

## State Utilization of the EQRO Technical Report

The *Annual EQRO Technical Report* provides TennCare with unbiased data for its MCCs. As mandated by 42 CFR §438.364, these data make it possible to benchmark performance statewide and nationally. The data also depict the healthcare landscape for the state’s Medicaid population, which assists TennCare in its collaborations with other state agencies to address common health issues—particularly those that are prevalent, chronic and preventable. TennCare can use these

data to measure progress toward goals and objectives of HCFA's Quality Strategy, identify areas where targeted QI interventions could be beneficial, and determine if new or restated goals are needed. Multiyear trending, a critical component for state assessment, is offered where possible and will continue to be evaluated annually.

## State Quality Initiatives

Each year TennCare assesses the effectiveness of its Quality Strategy and updates it to include any significant changes since the previous year's strategy regarding program structure, benefits and MCC changes. Updated evaluation data, interventions and activities are also considered. Because the 2016 Quality Strategy was not available at publication time, this report refers to the 2015 Quality Strategy.

TennCare has implemented several initiatives to support both QI among its contractors and the goals of its 2015 Quality Strategy. These include updates and developments to internal documents and templates for the Electronic Health Record (EHR) Incentive Program; a new position added to Quality Oversight to visit providers in their practices and evaluate their workflows and EHR implementation; a new reporting system known as MACpro application/portal for reporting of CMS-specified child and adult measures; and quarterly emergency department utilization case studies.

Quality Oversight also created a Million Hearts award to measure MCC performance regarding completed activities and interventions. Million Hearts is a national initiative by CMS with an ambitious goal to prevent one million heart attacks and strokes by 2017. In TennCare's first year as part of the program, all MCOs signed up to become Million Hearts partners and developed a wide range of member and provider outreach strategies aimed at increasing awareness of prevention.

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

- ◆ Healthy Lives—Improve the health of people in Tennessee.
- ◆ Access—People in Tennessee should have access to healthcare and the conditions to achieve optimal health.
- ◆ Economic Efficiencies—Health resources in Tennessee, including healthcare, should be developed to address the health of people in Tennessee while encouraging value and economic efficiencies.

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- ◆ Quality of Care—People in Tennessee should have confidence that the quality of care is continually monitored and standards are adhered to by providers.
- ◆ Workforce—The state should support the development, recruitment and retention of a sufficient and quality health workforce.

TennCare’s 2015 Quality Strategy helped determine the parameters of state Medicaid initiatives, of which Population Health, Satisfaction Surveys, Pay-for-Performance and PIP Validation were chosen for inclusion in this report due to the programs’ relevance to EQR activities. At TennCare’s request, a summary of the DBM Member Satisfaction Survey was also included. These do not represent all of TennCare’s efforts.

## Population Health

By July 1, 2013, TennCare required each MCC to replace the DM health management model with operationalized PH programs. By 2014, all MCCs had transitioned from DM to PH and all TennCare enrollees had been stratified into three PH levels.

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

PH programs are designed to help members self-manage their conditions and risk factors. TennCare emphasizes improving members’ self-management of two specific conditions, which are pregnancy and diabetes. Statewide collaborative working groups have been established with each MCC. To support those efforts, TennCare requires MCCs to offer the following PH programs:

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

Advantages of the PH model include the following:

- ◆ Targeting needs of all members across the continuum, with all eligible populations included
- ◆ Providing both proactive and reactive interventions
- ◆ Targeting interventions based on risk and lifestyle, not just disease
- ◆ Addressing multiple risks and comorbidities in a whole-person approach

- ◆ Addressing upstream causes of poor health such as nutrition, physical inactivity and substance abuse
- ◆ Mirroring the national trend

Additionally, TennCare coordinated collaborative work groups designed to encourage discussion, innovation and problem-solving among stakeholders. The TennCare Kids MCC Collaborative Work Group worked with MCCs to produce four quarterly teen newsletters with articles focused on primary, behavioral and dental health for 15-20 year olds and the Maternity Work Group developed a Provider Toolkit, which contained both provider and member educational materials. The goal of the toolkit was to disseminate educational materials to providers and members. Quality Oversight and the MCCs worked together to reassess the structure and functions of work groups to enhance collaborative efforts.

### **DBM Member Satisfaction Survey**

Per the DBMC, the Member Satisfaction Survey is a statewide report submitted annually no later than 90 days after the end of the calendar year. The survey, conducted by phone, focused on members ages 0 to 20. In 2016, the DBM obtained 216 completed surveys from those who saw a dentist in the previous 12 months and 200 completed surveys from those who had not seen a dentist in the previous 12 months. Qsource reviewed the report and agreed with the results.

Based on the responses received, the DBM was able to determine the following among those who had visited a dentist within the last 12 months of the survey period:

- ◆ The vast majority were satisfied with their dental care, dental plan, dental benefits and dentist, with satisfaction scores for these four measures above 95 percent.
- ◆ 90 percent indicated their teeth and gums were in very good or good condition and 81 percent indicated they had seen an improvement since the previous year.
- ◆ 70 percent indicated they received an appointment within 30 days and only 12 percent indicated they had to wait more than 45 minutes to begin treatment.
- ◆ 93 percent indicated that their dentist used appointment reminders and nearly all indicated these reminders were helpful.

Among those who had not visited a dentist in the last 12 months of the survey period, the DBM determined the following:

- ◆ 61 percent indicated they were aware of the DentaQuest benefits under the TennCare program.
- ◆ 85 percent indicated that their teeth and gums are in very good or good condition.
- ◆ 59 percent of those answering on behalf of a child and 75 percent of adults indicated it had been one to two years since their last dental visit.

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## Overview

- ◆ A significantly lower percentage than in 2014 indicated their child had never been to a dentist (29 percent compared to 76 percent in 2014).
- ◆ Additionally, among those responding on behalf of a child, 39 percent compared to 18 percent in 2014 mentioned schedule conflicts as the most common reason for not visiting a dentist.
- ◆ The majority of members indicated that appointment reminders might increase the likelihood of scheduling a dental appointment.

## Pay-for-Performance

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

The following MCO-specific measures were selected based on 2015 HEDIS rates in accordance with the greatest need for improvement:

- ◆ Chlamydia Screening in Women (CHL)
- ◆ Children and Adolescents' Access to Primary Care Practitioners (CAP)

## PIP Validation

This year, TennCare required the validation of a total of 52 PIPs conducted by its 11 MCCs, which include 10 MCOs and one DBM. Qsource validated these studies according to CMS's *EQR Protocol 3: Validating Performance Improvement Projects (PIPs), A Mandatory Protocol for External Quality Reviews (EQR)* (Version 2.0, September 2012).

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

# MCC Best and Emerging Practices

This section summarizes best and emerging practices of TennCare’s MCCs that are effective in demonstrating improvements in care or service or that generate high satisfaction survey results. General practices are listed first, followed by those that are specific to each EQR activity.

## General Quality Practices

Most TennCare MCCs continue to achieve high compliance in all EQRO-related activities. Systems and processes are routinely evaluated and improved across all aspects of health plan operations. Provider networks are adequate, and all MCCs have timely access to services. Additionally, member and provider satisfaction scores continue to be high. The MCCs remain focused on conducting thorough data analyses, providing documentation of processes, and providing consistent healthcare as it expanded service areas.

## Practices by Activity

Qsource has identified the following promising MCC practices from all 2016 EQR activities. When presented by TennCare to the MCCs, these practices could potentially promote exemplary performance and quality healthcare delivery.

### PMV

- ◆ **BC** expanded into the State’s Middle Grand Region. **BC**’s expansion to the Middle Grand Region was implemented without any issues as there were multiple readiness reviews conducted to ensure a smooth transition.
- ◆ **UHCE**, **UHCM** and **UHCW** were commended for their processes in IS 3.0 Practitioner Data—Data Capture, Transfer and Entry, and the processes are considered to be a best practice.

### PIP Validation

- ◆ **AGE**, **AGM** and **AGW** submitted thorough documentation for complaint database management that included complaint entry and assignment instructions, flowcharts, job descriptions and pre-transportation validation checks.
- ◆ **AGM** provided supporting documentation for statistical tests and results with all necessary data. It was also commended for conducting a thorough analysis that addressed survey completeness and respondent characteristics for each measurement period and for providing supporting DataStar documentation of z-tests. **AGM** also described the causal/barrier analysis process and subsequent development of the PIP interventions with explicit detail both within the PIP Summary Form and attachments.
- ◆ **BCE**, **BCM** and **BCW** selected a topic that showed strength in its potential to significantly impact the health of its members 18 years of age and older through its in-

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**MCC Best & Emerging Practices**

depth analysis of depression. The MCOs also conducted a thorough review of the topic through extensive literature review, research and data analysis.

- ◆ **BCE** and **BCW** provided a thorough analysis of Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) measure data to identify study area opportunities. The MCO drilled down through four years of data to identify two targeted subgroups of the population: emergency room patients and those admitted through an outpatient setting. **BCE** and **BCW** also created a dedicated work group used an effective Plan-Do-Study-Act (PDSA) strategy that enabled continual monitoring of PIP interventions through process change and root-cause/impact analysis, and support ongoing improvement efforts and follow-up opportunities relative to the study goals.
- ◆ **BCM** showed strength through its dissection of the IET measure data and identification of other study area opportunities. New in January 2015, the MCO did a thorough internal analysis of current IET data to identify the two major components of the denominator: emergency room patients and those admitted via outpatient setting.
- ◆ **BCE**, **BCM** and **BCW** conducted a complete thorough review of the topic through extensive literature review, research and data analysis, and **TCS** derived the PIP study topic from extensive literature review, data research and analysis.
- ◆ **BCE**, **BCM**, **BCW** and **TCS** included the background for topic selection. The MCO also provided supporting final analysis documentation of its data-collection strategy with corresponding final results compared to baseline.
- ◆ **TCS** selected a topic that showed a strength in its potential to significantly impact the health of its members ages 6-12 through its in-depth data collection and analysis. Also, the MCO engaged in data mining by conducting statistical analyses to test specific effects of each of the two interventions compared to a control group (no intervention). Although the z-tests did not result in statistically significant differences for either intervention, the results of this analysis can inform continued improvement efforts. The MCO also identified barriers that may explain the interventions' lack of impact. Additionally, **TCS** demonstrated a thorough understanding of the study topic by citing research, current evidence and statistics.
- ◆ **TCS** used extensive literature review, data research and analysis for its study topic selection.
- ◆ **DQ** reported using additional methods to focus intervention efforts. A survey was conducted to determine barriers to dental care from sample of adolescents from the target counties.

**ANA**

- ◆ **AG** expanded coverage into all three regions of Tennessee beginning in CY2015. **AG** received 5,310 initial credentialing applications from providers in 2015, but still achieved 96.5-percent compliance in processing initial credentialing files.

- ◆ **BC** and **TCS** conducted quarterly patient experience surveys to monitor member satisfaction with office wait times and the overall patient experience with the TennCare Program. **BC** and **TCS** presented the survey responses for the last five quarters so that recent quarter responses could be compared to the corresponding quarter responses from the prior calendar year and should both be commended for the ongoing monitoring of the members' experience of care.
- ◆ **UHC** compiled the information required to be in the provider contracts and created a separate document, the TennCare Regulatory Appendix. **UHC** should be commended for having one document that contains the State regulatory requirements facilitating the ANA review and assisting the providers in locating any Tennessee-specific regulations that govern their practice in the State.

## AQS

For 2016, the MCOs maintained 100-percent overall compliance for six QP standards assessed for the 2014, 2015 and 2016 AQS reviews: QI Activities, Clinical Criteria for Utilization Management (UM) Decisions, Member Rights and Responsibilities, EPSDT, *Grier Revised Consent Decree* and Non-Discrimination Compliance.

# Performance Measure Validation (PMV)

## Assessment Background

Qsource's PMV team consisted of members selected for their various skill sets, including statistics, analysis, managed care operations, clinical expertise, performance measure reporting, information systems (IS) assessments and computer programming capabilities. The PMV process includes IS standards used to assess the capture, transfer and entry of data (e.g., medical services, enrollment, practitioner and supplemental data). Medical services data are also assessed for sound coding methods. The training, sampling, abstraction and oversight of the medical record review process were also assessed, as was data integration—in particular, accurate reporting and control procedures to support data integrity.

## Technical Methods of Data Collection

For the MCOs, validation included the following basic steps:

1. **Pre-Review Activities:** In addition to scheduling the onsite reviews and developing the agenda, the team prepared a data collection tool based on established validation protocols. Additionally, each MCO was required to complete the Record of Administrative Data Management and Processes (Roadmap). Pre-onsite conference calls were held to follow up on any outstanding questions if necessary. The validation team conducted a review of the Roadmap and supportive documentation, including an evaluation of processes used for collecting, storing, validating and reporting the performance measure data.
2. **Onsite Reviews** lasted one day and included the following:
  - ◆ Opening meeting
  - ◆ Evaluation of system compliance, specifically the processing of claim, encounter, recipient and provider data where applicable
  - ◆ Overview of data integration and control procedures, including discussion and observation of source code logic where applicable
  - ◆ Review of how all data sources were combined and the method used to produce the analytical file for performance measures reporting
  - ◆ Interviews with MCO staff members involved with any aspect of the performance measure reporting
  - ◆ Closing conference summarizing preliminary findings and recommendations
3. **Validation Results:** Based on all validation activities, results were determined for each performance measure. For the MCOs, NCQA's HEDIS Compliance Audit protocol was followed. This entailed a report of preliminary findings, a review of the final rates and the

**PMV**

production of a final report stating whether the MCO had a **Reportable Rate (R)** or a **Non-Reportable Rate (NR)**.

**Description of Data Obtained**

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

- ◆ Roadmap provided background information on MCO policies, processes and data in preparation for the onsite validation activities.
- ◆ Source Code (Programming Language) for Performance Measures, obtained from each MCO, was used to determine compliance with the performance measure definitions if certified software was not used.
- ◆ Performance Measure Reports, prepared by each MCO, were reviewed, along with previous such reports, to assess trending patterns for any multiyear measures.
- ◆ Supportive Documentation included any additional information needed by the validation team to complete the validation process. This included file layouts, system flow diagrams, system-log files and data collection process descriptions.

**Comparative Findings****2016 Validated Measures**

For the 2015 measurement year, TennCare MCOs were required to report a full set of HEDIS measures for NCQA-accreditation purposes, two of which were validated by Qsource in 2016: Chlamydia Screening in Women (CHL) and Children and Adolescents' Access to Primary Care Practitioners (CAP). None of the MCOs demonstrated major process issues that affected reliable HEDIS reporting or that related to IS capabilities. **Table 6** provides an explanation of the audited measures.

<b>Table 6. 2016 PMV HEDIS Measures</b>	
<b>Measure</b>	<b>Description</b>
Chlamydia Screening in Women (CHL)	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. Reported as a total rate and two age stratifications: <ul style="list-style-type: none"> <li>◆ 16–20 years</li> <li>◆ 21–24 years</li> </ul>
Children and Adolescents' Access to Primary Care Practitioners (CAP)	The percentage of members 12 months–19 years of age who had a visit with a PCP. Four percentages are reported: <ul style="list-style-type: none"> <li>◆ Children 12–24 months who had a visit with a PCP during the measurement year</li> <li>◆ Children 25 months–6 years who had a visit with a PCP during the measurement year</li> <li>◆ Children 7–11 years who had a visit with a PCP during the</li> </ul>

**Table 6. 2016 PMV HEDIS Measures**

Measure	Description
	<p>measurement year or the year prior to the measurement year</p> <ul style="list-style-type: none"> <li>◆ Adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year</li> </ul>

### 2016 Validated Measures by MCO

The results for CHL are stratified across two age groups (16-20 years and 21-24 years) and the total percentage is provided in this report. The results for CAP are stratified across four age groups: 12-24 months, 25 months-6 years, 7-11 years and 12-19 years. MCO-specific results appear in [Table 7](#) and in [Charts 1 and 2](#). [Charts 3 and 4](#) compare data from 2015 and 2016. For CAP, two age groups for **AGW** were not applicable (NA). The MCO followed the specification, but the denominator was too small (<30) to report a valid rate; hence, results are not presented.

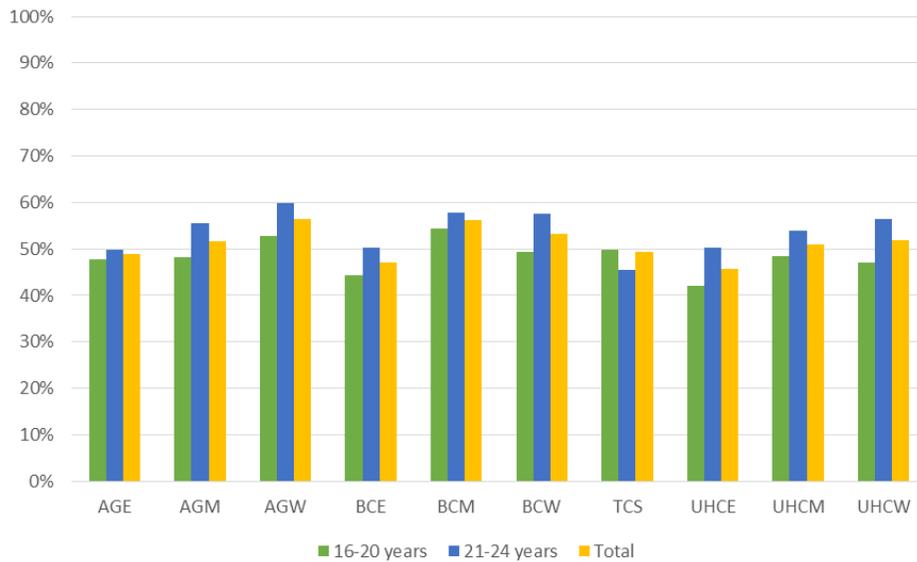
The MCOs calculated these results for CY2015 and reported them to TennCare. They were validated by Qsource's subcontractor, Health Services Advisory Group, Inc. (HSAG). No performance measures were selected for validation for **DQ**.

Table 7. 2016 PMV Results: MCOs

	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW	HEDIS 2015 Medicaid National Average
<b>Chlamydia Screening in Women (CHL)</b>											
16–20 years	47.80%	48.17%	52.78%	44.28%	54.31%	49.35%	49.82%	42.01%	48.51%	47.11%	51.27%
21–24 years	49.86%	55.52%	59.78%	50.31%	57.68%	57.60%	45.54%	50.36%	53.87%	56.33%	60.16%
<b>Total</b>	<b>48.87%</b>	<b>51.65%</b>	<b>56.46%</b>	<b>47.05%</b>	<b>56.10%</b>	<b>53.13%</b>	<b>49.43%</b>	<b>45.70%</b>	<b>50.94%</b>	<b>51.87%</b>	<b>54.63%</b>
<b>Children and Adolescents' Access to Primary Care Practitioners (CAP)</b>											
12–24 months	89.17%	92.84%	88.14%	96.02%	93.07%	94.01%	88.70%	90.27%	91.41%	88.15%	95.50%
25 months– 6 years	79.81%	85.50%	81.99%	88.36%	87.39%	84.61%	82.31%	84.45%	87.84%	83.74%	87.78%
7–11 years	81.36%	90.08%	NA*	93.24%	92.75%	92.24%	92.19%	88.72%	92.07%	89.35%	90.95%
12–19 years	67.16%	86.15%	NA*	90.44%	90.38%	89.07%	88.12%	85.67%	89.37%	84.83%	89.32%

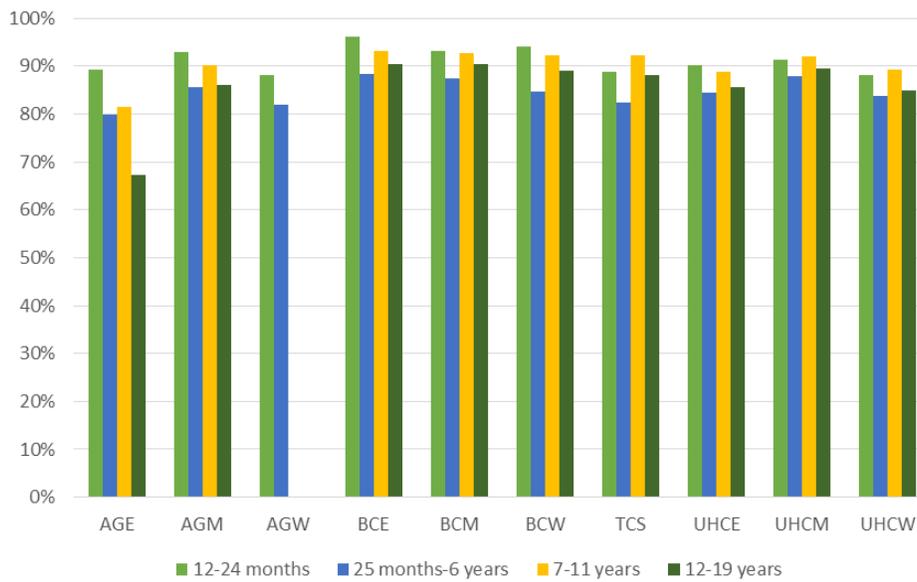
\* NA – Not Applicable; There was a small denominator, i.e., the MCO followed the specification, but the denominator was too small (<30) to report a valid rate; hence, results are not presented.

**Chart 1. HEDIS 2016 Rate by MCO: CHL**



Note: CHL is the HEDIS measure Chlamydia Screening in Women

**Chart 2. HEDIS 2016 Rate by MCO: CAP**

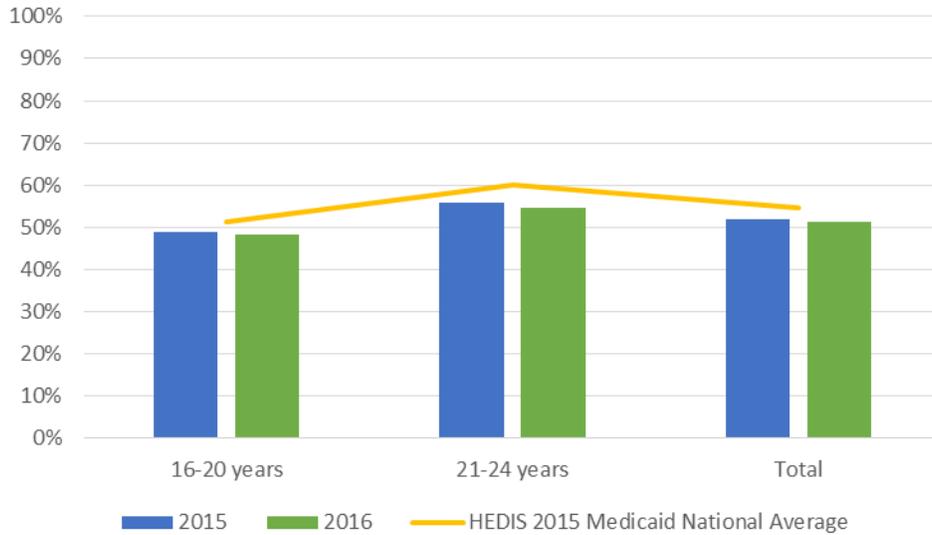


Note: CAP is the HEDIS measure Children and Adolescents' Access to Primary Care Practitioners; AGW received NAs for the 7-11 years and 12-19 years due to a denominator too small (<30) to report a valid rate.

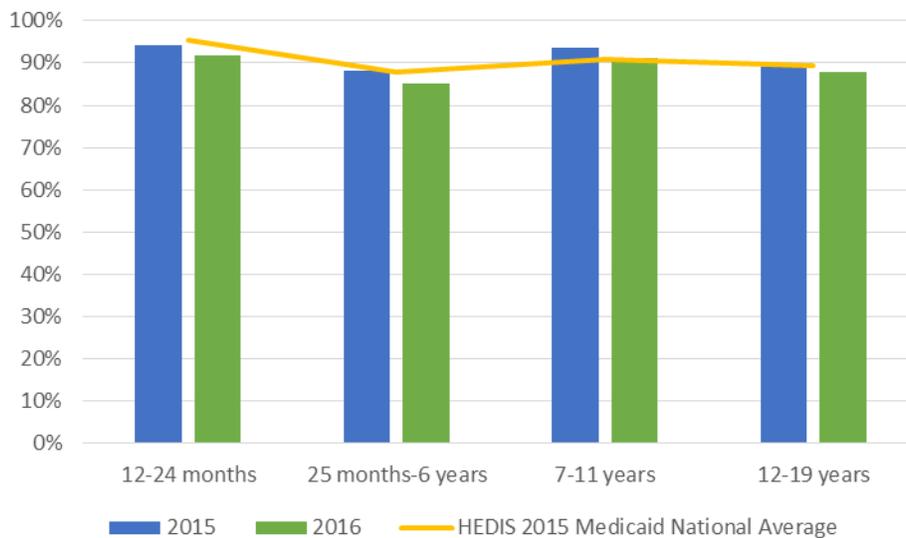
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Charts 3 and 4 show the Tennessee weighted rates for 2015 and 2016. These rates are compared with the HEDIS 2015 Medicaid National Average.

**Chart 3. HEDIS 2015 and 2016 Weighted Rates Comparisons: CHL**



**Chart 4. HEDIS 2015 and 2016 Weighted Rates Comparisons: CAP**



## MCO Validated Measures Trended 2014-2016

Tables 8 through 14 present MCO-specific rates from 2014 to 2016 for CHL and CAP. These results were compared to the HEDIS 2015 Medicaid National Average. Beginning in 2015, three new MCOs (AGE, AGW and BCM) contracted with HCFA to provide services. While their 2016 data are provided in Table 7, trending is not possible.

AGM demonstrated a decline in its overall percentages for three indicators for CHL: from 54.27 to 48.17 percent for 16-20 years; from 63.19 to 55.52 percent for 21-24 years; and from 58.09 to 51.65 for Total. AGM demonstrated a decline in its overall percentages for four indicators for CAP: from 97.45 to 92.84 percent for 12-24 months; from 90.61 to 85.50 percent for 25 months-6 years; from 93.88 to 90.08 percent for 7-11 years; and from 91.59 to 86.15 for 12-19 years.

Table 8. Trended HEDIS Validated Measures: AGM				
Measure	2014	2015	2016	HEDIS 2015 Medicaid National Average
<b>Chlamydia Screening in Women (CHL)</b>				
16-20 years	54.27%	49.29%	48.17%	51.27%
21-24 years	63.19%	56.97%	55.52%	60.16%
<b>Total</b>	<b>58.09%</b>	<b>52.97%</b>	<b>51.65%</b>	<b>54.63%</b>
<b>Children and Adolescents' Access to Primary Care Practitioners (CAP)</b>				
12-24 months	97.45%	93.82%	92.84%	95.50%
25 months-6 years	90.61%	87.62%	85.50%	87.78%
7-11 years	93.88%	93.06%	90.08%	90.95%
12-19 years	91.59%	89.66%	86.15%	89.32%

BCE demonstrated an increase in its overall percentages for one indicator for CHL (from 42.54 to 44.28 percent for 16-20 years), and it demonstrated a decrease in two indicators (from 56.18 to 50.31 percent for 21-24 years and 47.93 to 47.05 percent for Total). BCE demonstrated a decrease in its overall percentages for four indicators for CAP: from 98.36 to 96.02 percent for 12-24 months; 91.38 to 88.36 percent for 25 months-6 years; 94.75 to 93.24 for 7-11 years; and from 92.17 to 90.44 for 12-19 years. For 2016, the MCO exceeded the HEDIS 2015 Medicaid National Average for all four measures of CAP by 0.52 (12-24 months), 0.58 (25 months-6 years), 2.29 (7-11 years) and 1.12 (12-19 years) percentage points.

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Table 9. Trended HEDIS Validated Measures: BCE				
Measure	2014	2015	2016	HEDIS 2015 Medicaid National Average
<b>Chlamydia Screening in Women (CHL)</b>				
16-20 years	42.54%	45.76%	44.28%	51.27%
21-24 years	56.18%	51.09%	50.31%	60.16%
<b>Total</b>	<b>47.93%</b>	<b>48.18%</b>	<b>47.05%</b>	<b>54.63%</b>
<b>Children and Adolescents' Access to Primary Care Practitioners (CAP)</b>				
12-24 months	98.36%	95.68%	96.02%	95.50%
25 months-6 years	91.38%	89.90%	88.36%	87.78%
7-11 years	94.75%	94.29%	93.24%	90.95%
12-19 years	92.17%	91.29%	90.44%	89.32%

**BCW** demonstrated a decline in its overall percentages for all three indicators for CHL: from 58.92 to 49.35 percent for 16-20 years; from 69.14 to 57.60 percent for 21-24 years; and from 63.49 to 53.13 percent for Total. **BCW** also demonstrated a decline in its overall percentages for all four indicators for CAP: from 96.84 to 94.01 percent for 12-24 months; 89.14 to 84.61 percent for 25 months to 6 years; from 94.69 to 92.24 percent for 7-11 years; and from 91.26 to 89.07 percent for 12-19 years. For 2016, the MCO exceeded the HEDIS 2015 Medicaid National Average for the CAP measure 7-11 years by 1.29 percentage points.

Table 10. Trended HEDIS Validated Measures: BCW				
Measure	2014	2015	2016	HEDIS 2015 Medicaid National Average
<b>Chlamydia Screening in Women (CHL)</b>				
16-20 years	58.92%	54.08%	49.35%	51.27%
21-24 years	69.14%	61.84%	57.60%	60.16%
<b>Total</b>	<b>63.49%</b>	<b>57.73%</b>	<b>53.13%</b>	<b>54.63%</b>
<b>Children and Adolescents' Access to Primary Care Practitioners (CAP)</b>				
12-24 months	96.84%	95.13%	94.01%	95.50%
25 months-6 years	89.14%	87.69%	84.61%	87.78%
7-11 years	94.69%	94.32%	92.24%	90.95%
12-19 years	91.26%	90.74%	89.07%	89.32%

**TCS** demonstrated an increase in its overall percentages for one indicator for CHL (from 35.29 to 45.54 percent for 21-24 years). The MCO demonstrated a decline from 49.96 to 49.82 percent for 16-20 years and from 49.74 to 49.43 percent for Total. **TCS** also demonstrated a decline in its overall percentages for all four indicators for CAP: from 97.98 to 88.70 percent for 12-24 months; from 93.26 to 82.31 for 25 months-6 years; from 95.13 to 92.19 percent for 7-11 years; and from

90.48 to 88.12 for 12-19 years. For 2016, the MCO exceeded the HEDIS 2015 Medicaid National Average for the CAP measure 7-11 years by 1.24 percentage points.

Table 11. Trended HEDIS Validated Measures: TCS				
Measure	2014	2015	2016	HEDIS 2015 Medicaid National Average
<b>Chlamydia Screening in Women (CHL)</b>				
16-20 years	49.96%	50.61%	49.82%	51.27%
21-24 years	35.29%	46.48%	45.54%	60.16%
<b>Total</b>	<b>49.74%</b>	<b>50.50%</b>	<b>49.43%</b>	<b>54.63%</b>
<b>Children and Adolescents' Access to Primary Care Practitioners (CAP)</b>				
12-24 months	97.98%	95.10%	88.70%	95.50%
25 months-6 years	93.26%	91.29%	82.31%	87.78%
7-11 years	95.13%	94.85%	92.19%	90.95%
12-19 years	90.48%	89.57%	88.12%	89.32%

**UHCE** demonstrated a decline in its overall percentages for all three indicators for CHL: from 46.45 to 42.01 percent for 16-20 years; from 57.78 to 50.36 percent for 21-24 years; and from 50.78 to 45.70 for Total. **UHCE** also demonstrated a decline in its overall percentages for all four indicators for CAP: from 97.12 to 90.27 percent for 12-24 months; from 88.59 to 84.45 percent for 25 months-6 years; from 91.85 to 88.72 percent for 7-11 years; and from 89.08 to 85.67 for 12-19 years.

Table 12. Trended HEDIS Validated Measures: UHCE				
Measure	2014	2015	2016	HEDIS 2015 Medicaid National Average
<b>Chlamydia Screening in Women (CHL)</b>				
16-20 years	46.45%	41.80%	42.01%	51.27%
21-24 years	57.78%	49.97%	50.36%	60.16%
<b>Total</b>	<b>50.78%</b>	<b>45.27%</b>	<b>45.70%</b>	<b>54.63%</b>
<b>Children and Adolescents' Access to Primary Care Practitioners (CAP)</b>				
12-24 months	97.12%	92.77%	90.27%	95.50%
25 months-6 years	88.59%	86.11%	84.45%	87.78%
7-11 years	91.85%	91.60%	88.72%	90.95%
12-19 years	89.08%	88.56%	85.67%	89.32%

**UHCM** demonstrated a decline in its overall percentages for all three indicators for CHL: from 53.72 to 48.51 percent for 16-20 years; from 63.17 to 53.87 percent for 21-24 years; and from 57.77 to 50.94 percent for Total. **UHCM** also demonstrated a decline in its overall percentages for all four indicators for CAP: from 97.34 to 91.41 percent for 12-24 months; from 91.44 to 87.84 percent

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for 25 months-6 years; from 94.06 to 92.07 percent for 7-11 years; and from 91.96 to 89.37 for 12-19 years. In 2016, the MCO exceeded the HEDIS 2015 Medicaid National Average for three CAP measures by 0.06 (25 months-6 years), 1.12 (7-11 years) and 0.05 (12-19 years) percentage points.

Table 13. Trended HEDIS Validated Measures: UHCM				
Measure	2014	2015	2016	HEDIS 2015 Medicaid National Average
<b>Chlamydia Screening in Women (CHL)</b>				
16-20 years	53.72%	50.78%	48.51%	51.27%
21-24 years	63.17%	55.15%	53.87%	60.16%
<b>Total</b>	<b>57.77%</b>	<b>52.79%</b>	<b>50.94%</b>	<b>54.63%</b>
<b>Children and Adolescents' Access to Primary Care Practitioners (CAP)</b>				
12-24 months	97.34%	94.24%	91.41%	95.50%
25 months-6 years	91.44%	89.55%	87.84%	87.78%
7-11 years	94.06%	94.11%	92.07%	90.95%
12-19 years	91.96%	91.21%	89.37%	89.32%

**UHCW** demonstrated a decline in its overall percentages for all three indicators for CHL: from 55.02 to 47.11 percent for 16-20 years; from 63.99 to 56.33 percent for 21-24 years; and from 59.17 to 51.87 percent for Total. **UHCW** also demonstrated a decline in its overall percentages for all four indicators for CAP: from 96.23 to 88.15 percent for 12-24 months; from 89.27 to 83.74 percent for 25 months-6 years; from 93.68 to 89.35 percent for 7-11 years; and from 89.00 to 84.83 percent for 12-19 years.

Table 14. Trended HEDIS Validated Measures: UHCW				
Measure	2014	2015	2016	HEDIS 2015 Medicaid National Average
<b>Chlamydia Screening in Women (CHL)</b>				
16-20 years	55.02%	51.40%	47.11%	51.27%
21-24 years	63.99%	59.67%	56.33%	60.16%
<b>Total</b>	<b>59.17%</b>	<b>55.48%</b>	<b>51.87%</b>	<b>54.63%</b>
<b>Children and Adolescents' Access to Primary Care Practitioners (CAP)</b>				
12-24 months	96.23%	93.28%	88.15%	95.50%
25 months-6 years	89.27%	86.24%	83.74%	87.78%
7-11 years	93.68%	93.20%	89.35%	90.95%
12-19 years	89.00%	88.06%	84.83%	89.32%

## MCO Strengths and Opportunities for Improvement

### Strengths

All MCOs were compliant with the HEDIS Information Systems Standards and HEDIS Determination Standards, and continue to use NCQA-certified software vendors for HEDIS measure production.

- ◆ **AGE, AGM** and **AGW** were fully compliant with all IS standards.
- ◆ **BCE, BCM, BCW** and **TCS** were fully compliant with all IS standards. **BC**'s expansion to the Middle Grand Region was implemented without any issues as there were multiple readiness reviews conducted to ensure a smooth transition.
- ◆ **UHCE, UHCM** and **UHCW** were fully compliant with all IS standards. The MCOs were commended for their processes in IS 3.0 Practitioner Data—Data Capture, Transfer and Entry, and the processes are considered to be a best practice.

### Areas of Noncompliance (AONs) and Suggestions

Qsource identified the following opportunities for improvement:

- ◆ The MCOs should continue to investigate ways to automate the data transfer between credentialing/provider management and administrative software platforms.
- ◆ Also, the **MCO** should consider using notification dates to determine continuous enrollment.

## State Best Practices

TennCare requires MCOs to report a full set of audited HEDIS measures each year in accordance with required NCQA accreditation standards. In an effort to reduce the administrative burden PMV places on the MCOs, TennCare identifies two relevant HEDIS measures for validation by Qsource annually. The selected measures represent objectives in TennCare's Quality Strategy (e.g., child health, prevention and screening services) that seek to assure timely, high-quality healthcare for TennCare members. Upon completion of a new State Quality Strategy, TennCare evaluates the measures selected for validation, with respect to its goals and objectives, and adapts its focus on particular strategies. The state aggregates annual MCO results, trends performance and compares those results to national and local benchmarks by monitoring MCO performance and conducting ongoing evaluations of TennCare member satisfaction.

# Performance Improvement Project (PIP) Validation

## Assessment Background

To evaluate PIPs, Qsource assembled a validation team of experienced clinicians specializing in QI, a healthcare data analyst and a biostatistician with expertise in statistics and study design. For the 2016 PIP validation cycle, 20 PIP topics were spread across the 11 MCCs. This is shown in **Table 15**, along with the overall validation status of each MCC.

MCC	PIPs Met/Submitted	MCC	PIPs Met/Submitted
AGE	5/5	TCS	6/6
AGM	5/5	UHCE	3/4
AGW	5/5	UHCM	3/4
BCE	6/6	UHCW	3/4
BCM	5/5	DQ	0/2
BCW	6/6		

### Technical Methods of Data Collection

Each MCC is contractually required to submit its PIP studies annually to TennCare as requested. Submitted PIPs should include the necessary documentation for data collection, data analysis plans and an interpretation of all results. MCCs should also address threats to validity regarding data analysis and interpretation of study results.

Qsource developed a PIP Summary Form and a validation tool to standardize the process by which each MCC provides PIP information to TennCare and how that information is assessed. Using Qsource's PIP Summary Form, each MCC submitted multiple PIP studies and supplemental information in August 2016.

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

## PIP Validation

The elements within each activity were scored as Met, Not Met or Not Assessed. To ensure a valid and reliable review, 13 elements across eight activities were designated as “critical”— i.e., necessary to be Met in order for the MCC to produce an accurate and reliable PIP. Given the importance of the critical elements to this scoring methodology, any critical element that received a Not Met status resulted in an overall validation rating of Not Met and required future revisions of the PIP. More specific information on validation methodology is available in the individual topic-specific *2016 PIP Validation Technical Papers* for each MCC.

### Description of Data Obtained

**Table 16** summarizes the 10 CMS protocol activity requirements and the 13 critical elements addressed in the PIP Summary Form.

Table 16. CMS PIP Activities and Critical Elements	
PIP Activities	Critical Elements
<b>I. Choose the Study Topic(s)</b>	<ul style="list-style-type: none"> <li>◆ Has the potential to affect member health, functional status or satisfaction</li> </ul>
<b>II. Define the Study Question(s)</b>	<ul style="list-style-type: none"> <li>◆ States the problem to be studied in simple terms</li> <li>◆ Is answerable</li> </ul>
<b>III. Select the Study Indicators</b>	<ul style="list-style-type: none"> <li>◆ Are well-defined, objective and measurable</li> <li>◆ Allow for the study questions to be answered</li> <li>◆ Have available data that can be collected on each indicator</li> </ul>
<b>IV. Use a Representative and Generalizable Study Population</b>	<ul style="list-style-type: none"> <li>◆ Is accurately and completely defined</li> <li>◆ Captures all members to whom the study question applies</li> </ul>
<b>V. Use Sound Sampling Methods</b>	<ul style="list-style-type: none"> <li>◆ Ensure a representative sample of the eligible population</li> </ul>
<b>VI. Use Valid and Reliable Data Collection Procedures</b>	<ul style="list-style-type: none"> <li>◆ A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications</li> </ul>
<b>VII. Include Improvement Strategies</b>	<ul style="list-style-type: none"> <li>◆ Related to causes/barriers identified through data analysis and QI processes</li> </ul>
<b>VIII. Analyze Data and Interpret Study Results</b>	<ul style="list-style-type: none"> <li>◆ Are conducted according to the data analysis plan in the study design</li> <li>◆ Allow for generalization of results to the study population if a sample was selected</li> </ul>
<b>IX. Assess for Real Improvement</b>	<ul style="list-style-type: none"> <li>◆ No critical elements</li> </ul>
<b>X. Assess for Sustained Improvement</b>	<ul style="list-style-type: none"> <li>◆ No critical elements</li> </ul>

## PIP Interventions

**Table 17** presents a summary of those PIPs conducted for a minimum of three remeasurement years and includes each PIP's title, summary of performance, interventions, validation results, discussion points, study indicators, populations affected, and any decrease or increase in measurement results. This information is useful for determining whether to continue or retire a specific PIP. Italicized text was taken directly from MCC materials and has not been edited by Qsource.

<b>Table 17. Performance Summary for 2016 PIPs ≥ Three Years</b>	
<b>AGM: Prenatal and Postpartum</b>	
<b>Validation Status</b>	Met
<b>Study Population</b>	<i>Random sample as defined in HEDIS® 2016 Technical Specifications of the entire eligible Medicaid population for women who delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. The member must be enrolled 43 days prior to delivery through 56 days after delivery, with no allowable gap during the continuous enrollment period. Deliveries not resulting in a live birth are excluded. Members with special care needs were not excluded.</i>
<b>Interventions</b>	<ul style="list-style-type: none"> <li>◆ <i>“Taking care of Baby and Me Incentive Gift Cards” (TCOB) \$20.00 gift cards for completing prenatal and postpartum visits.</i> <ul style="list-style-type: none"> <li>- Prenatal Cards awarded = 325</li> <li>- Postpartum Cards awarded = 174</li> </ul> </li> <li>◆ <i>Prenatal education packets mailed to all identified pregnant members.</i> <ul style="list-style-type: none"> <li>- Number mailed = 6,653</li> </ul> </li> <li>◆ <i>Postpartum education packets mailed to all identified pregnant members.</i> <ul style="list-style-type: none"> <li>- Number mailed = 4,462</li> </ul> </li> <li>◆ <i>Community Based ALERE Maternity Services for High Risk OB Members</i> <ul style="list-style-type: none"> <li>- Referrals = 51</li> </ul> </li> <li>◆ <i>OB Screener – Member Outreach Calls to identify high risk pregnancy, previous cesarean deliveries and prior pregnancy and outcomes.</i> <ul style="list-style-type: none"> <li>- Members reached in 2015 = 934</li> </ul> </li> <li>◆ <i>“Maternal Postpartum Outreach Program (MPOP)</i> <ul style="list-style-type: none"> <li>- Members identified = 3,265</li> <li>- Members that were reached and kept postpartum appointment = 773</li> <li>- Members that were not able to be reached = 615</li> <li>- Members that had postpartum visits outside of the 21-56 day postpartum visit time frame = 91</li> <li>- Members that were reached but did not have visit = 586</li> </ul> </li> <li>◆ <i>OB outreach to the identified pregnant members during the completion of the OB Risk Screener who have not chosen an OB Provider or initiated prenatal care.</i> <ul style="list-style-type: none"> <li>- Total Attempted = 705</li> <li>- Total completed = 108</li> </ul> </li> </ul>
<b>Summary of Performance</b>	<i>In 2015, the Plan has continued in its member and provider outreach efforts through case management and care coordination and implemented ongoing interventions to improve staff assessment of the member's needs. In addition to the continuation of outreach reminder calls to members who are missing their</i>

## PIP Validation

Table 17. Performance Summary for 2016 PIPs ≥ Three Years

AGM: Prenatal and Postpartum	
	<i>postpartum visit care conducted monthly by Case Management and Member outreach staff. The Plan also continued the “Taking Care of Baby and Me” (TCOB) program, which provides gift certificates to members to incentivize members to obtain prenatal and postpartum physician visits. Additionally, the program provides education packets with useful tools to help members through and beyond their pregnancy. For high risk members, the Plan contracted with Alere Women’s and Children Health to provide home health services that help empower members to make choices that enable them to experience successful pregnancies. “My Advocate”, formerly known as “Warm Health”, delivers maternal health education by telephone, text message and by Smartphone app to pregnant and postpartum women.</i>
<b>EQRO Discussion</b>	The MCO described numerous interventions implemented in January 2013, January 2014 and January 2015, including specific data capture related to measures. The MCO Quality Management team participated in the maternity workgroup collaboration with TennCare and other MCOs; completed data and barrier analyses; and, along with the healthcare management system and medical advisory teams, identified improvement opportunities in the Middle region. These opportunities included addressing member and provider knowledge deficit barriers through prenatal/postpartum education via various outreach methods; enhancing pop-up reminders to staff for member contact for missed screenings; completing provider report care face-to-face education projects; proposing new provider incentives for billing; and unbundling pregnancy global billing. The MCO also described the causal/barrier analysis process and subsequent development of the PIP interventions in explicit detail both within the Summary Form and attachments.
BCE, BCW, TCS: Cultural Assessment Data Collection—Race and Ethnicity	
<b>Validation Status</b>	Met
<b>Study Population</b>	<i>All BlueCare-East, BlueCare-West and TennCareSelect members during the measurement period.</i>
<b>Interventions</b>	<ul style="list-style-type: none"> <li>◆ <i>Monitored results from data collection strategy focused on the inclusion of qualitative data analysis in regards to the validity of the collected enhanced and/or supplemental information on race and ethnicity data.</i></li> <li>◆ <i>Continued use of external qualitative data validation for reporting race and ethnicity reporting for various quality initiatives.</i></li> </ul>
<b>Summary of Performance</b>	<i>Due to the addition of a census packet to the already received Credit Bureau information provided via the external vendor Experian, BlueCare Tennessee modified its hierarchy as this enhancement shifted quantity and validity of collected information on race and ethnicity. Medical Informatics finalized hierarchal priority list placing priority on 1) Self-reported data (CCMS), 2) 834 eligibility file, 3) Experian Census Tracts, and 4) Experian Data (other).</i>
<b>EQRO Discussion</b>	The MCO provided a detailed description of the intervention work plan accomplishments and how improvements were made and barriers addressed. The final remeasurement period included monitoring of qualitative data analysis to address validity of data and the finalized priority list to address enhanced data reports.

## Comparative Findings

**AGE**, **AGM** and **AGW** each achieved 100-percent compliance and a Met validation status for all five submitted PIPs. **BCE**, **BCM** and **BCW** also achieved 100-percent compliance for each submitted PIP (**BCM** submitted five; **BCE** and **BCW** submitted six). **TCS** achieved 100-percent compliance and a Met validation status for all six of its PIPs. **UHCE**, **UHCM** and **UHCW** earned a Met validation status for three of their four PIPs. For both of its PIPs, **DQ** received total element scores of 64.1 percent and critical element scores of 80.0 percent, resulting in both receiving a Not Met validation status. For all MCCs, total elements scores ranged from 64.1 to 100 percent. The MCOs received 87.5-percent compliance for critical elements and 95.7-percent compliance for total elements for the Not Met PIP.

A summary of scores for both total and critical elements, as well as validation status, is presented in **Table 18**.

PIP Topic	Elements Met		Validation Status*
	Total	Critical	
<b>AGE</b>			
<i>Antidepressant Medication Management</i>	100%	100%	Met
<i>Prenatal and Postpartum Care</i>	100%	100%	Met
<i>Improving Member Satisfaction with Case Management Health-Related Information Received</i>	100%	100%	Met
<i>Increasing the Percentages of LOC Assessments Conducted with CHOICES Members</i>	100%	100%	Met
<i>Reducing Transportation (NEMT) Member Complaints</i>	100%	100%	Met
<b>AGM</b>			
<i>Antidepressant Medication Management</i>	100%	100%	Met
<i>Prenatal and Postpartum Care</i>	100%	100%	Met
<i>Improving Member Satisfaction with Case Management Health-Related Information Received</i>	100%	100%	Met
<i>Increasing the Percentages of LOC Assessments Conducted with CHOICES Members</i>	100%	100%	Met
<i>Reducing Transportation (NEMT) Member Complaints</i>	100%	100%	Met
<b>AGW</b>			
<i>Antidepressant Medication Management</i>	100%	100%	Met
<i>Prenatal and Postpartum Care</i>	100%	100%	Met
<i>Improving Member Satisfaction with Case Management Health-Related Information Received</i>	100%	100%	Met

## PIP Validation

<b>Table 18. Overall 2016 PIP Validation Scores</b>			
<b>PIP Topic</b>	<b>Elements Met</b>		<b>Validation Status*</b>
	<b>Total</b>	<b>Critical</b>	
<i>Increasing the Percentages of LOC Assessments Conducted with CHOICES Members</i>	100%	100%	Met
<i>Reducing Transportation (NEMT) Member Complaints</i>	100%	100%	Met
<b>BCE</b>			
<i>Maternal Health: Improving Prenatal and Postpartum Care Rates</i>	100%	100%	Met
<i>Improving the Rate of Antidepressant Medication Management Acute and Continuation Phase</i>	100%	100%	Met
<i>Transition from Acute Care Settings—Reducing Acute Care Readmissions</i>	100%	100%	Met
<i>Cultural Assessment Data Collection—Race and Ethnicity</i>	100%	100%	Met
<i>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)</i>	100%	100%	Met
<i>Improving Provider Satisfaction Survey Response Rates</i>	100%	100%	Met
<b>BCM</b>			
<i>Maternal Health: Improving Prenatal and Postpartum Care Rates</i>	100%	100%	Met
<i>Improving the Rate of Antidepressant Medication Management Acute and Continuation Phase</i>	100%	100%	Met
<i>Transition from Acute Care Settings—Reducing Acute Care Readmissions</i>	100%	100%	Met
<i>Improving Provider Satisfaction Survey Response Rates</i>	100%	100%	Met
<i>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)</i>	100%	100%	Met
<b>BCW</b>			
<i>Maternal Health: Improving Prenatal and Postpartum Care Rates</i>	100%	100%	Met
<i>Improving the Rate of Antidepressant Medication Management Acute and Continuation Phase</i>	100%	100%	Met
<i>Transition from Acute Care Settings—Reducing Acute Care Readmissions</i>	100%	100%	Met
<i>Cultural Assessment Data Collection—Race and Ethnicity</i>	100%	100%	Met
<i>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)</i>	100%	100%	Met
<i>Improving Provider Satisfaction Survey Response Rates</i>	100%	100%	Met
<b>TCS</b>			
<i>Maternal Health: Improving Prenatal and Postpartum Care Rates</i>	100%	100%	Met
<i>Cultural Assessment Data Collection—Race and Ethnicity</i>	100%	100%	Met
<i>Improving the Rate of Follow-Up Care for Children with Prescribed ADHD Medication</i>	100%	100%	Met

**Table 18. Overall 2016 PIP Validation Scores**

PIP Topic	Elements Met		Validation Status*
	Total	Critical	
<i>Improving Cervical Cancer Screening Rates in SelectCommunity</i>	100%	100%	Met
<i>Improving the Rate of Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life</i>	100%	100%	Met
<i>Improving Provider Satisfaction Survey Response Rates</i>	100%	100%	Met
<b>UHCE</b>			
<i>Electronic Visit Verification (EVV)</i>	95.2%	100%	Met
<i>Impact on EPSDT Screening Rates with Targeted Intervention on CAP 12-19 Year Old Age Group</i>	95.7%	87.5%	Not Met
<i>Increasing Health Risk Assessment (HRA) Annual Completion Rates</i>	100%	100%	Met
<i>Text4Health</i>	100%	100%	Met
<b>UHCM</b>			
<i>Electronic Visit Verification (EVV)</i>	95.2%	100%	Met
<i>Impact on EPSDT Screening Rates with Targeted Intervention on CAP 12-19 Year Old Age Group</i>	95.7%	87.5%	Not Met
<i>Increasing Health Risk Assessment (HRA) Annual Completion Rates</i>	100%	100%	Met
<i>Text4Health</i>	100%	100%	Met
<b>UHCW</b>			
<i>Electronic Visit Verification (EVV)</i>	95.2%	100%	Met
<i>Impact on EPSDT Screening Rates with Targeted Intervention on CAP 12-19 Year Old Age Group</i>	95.7%	87.5%	Not Met
<i>Increasing Health Risk Assessment (HRA) Annual Completion Rates</i>	100%	100%	Met
<i>Text4Health</i>	100%	100%	Met
<b>DQ</b>			
<i>Education Focused PIP – Adolescents Age 15-18</i>	64.1%	80.0%	Not Met
<i>Prevention Focused PIP – Fluoride Adolescents Age 12-20</i>	64.1%	80.0%	Not Met

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

## MCC Strengths and Opportunities for Improvement

### Strengths

Strengths indicate that the MCC demonstrated particular proficiency on a given activity and can be identified regardless of validation status. The lack of an identified strength should not be interpreted as a shortcoming on the part of an MCC.

## PIP Validation

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### AGE, AGM and AGW

- ◆ *Reducing Transportation (NEMT) Member Complaints*: commended for submitting thorough documentation for complaint database management that included complaint entry and assignment instructions, flowcharts, job descriptions, and pre-transportation validation checks.

### AGM

- ◆ *Antidepressant Medication Management and Increasing the Percentages of LOC Assessments Conducted with CHOICES Members*: commended for providing supporting documentation for statistical tests and results with all necessary data.
- ◆ *Improving Member Satisfaction with Case Management Health-Related Information Received*: commended for conducting a thorough analysis that addressed survey completeness and respondent characteristics for each measurement period, and for providing supporting DataStar documentation of z tests.
- ◆ *Improving Access to Prenatal and Postpartum Care*: commended for describing the causal/barrier analysis process and subsequent development of the PIP interventions with explicit detail both within the Summary Form and attachments.

### BCE, BCM and BCW

- ◆ *Improving the Rate of Antidepressant Medication Management Acute and Continuation Phase*: commended for selecting a topic that showed strength in its potential to significantly impact the health of its members 18 years of age and older through its in-depth analysis of depression.
- ◆ *Transition from Acute Care Settings—Reducing Acute Care Readmissions*: commended for conducting a complete and thorough review, analysis of industry readmission data and best practices, and internal research for development of their PIP study topic.

### BCE and BCW

- ◆ *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)*: commended for providing a thorough analysis of IET measure data to identify study area opportunities. The MCO drilled down through four years of data to identify two targeted subgroups of the population: emergency room patients and those admitted through an outpatient setting.
- ◆ *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)*: commended for establishing a dedicated work group used an effective Plan-Do-Study-Act (PDSA) strategy that enabled continual monitoring of PIP interventions through process change and root-cause/impact analysis, and support ongoing improvement efforts and follow-up opportunities relative to the study goals.

### BCM

- ◆ *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)*: commended for its dissection of the IET measure data and identification of other study area opportunities. New in January 2015, the MCO did a thorough internal analysis of

current IET data to identify the two major components of the denominator: emergency room patients and those admitted via the outpatient setting.

#### BCE, BCM, BCW and TCS

- ◆ *Cultural Assessment Data Collection—Race and Ethnicity*: commended for including the background for topic selection and provided supporting final analysis documentation of its data-collection strategy with corresponding final results compared to baseline.
- ◆ *Maternal Health: Improving Prenatal and Postpartum Care Rates*: commended for conducting a complete and thorough review of the topic through extensive literature review, research and data analysis. **TCS** was commended for deriving the PIP study topic from extensive literature review, data research and analysis.

#### TCS

- ◆ *Follow-Up Care for Children Prescribed ADHD Medication*: commended for selecting a topic that showed a strength in its potential to significantly impact the health of its members ages 6-12 through its in-depth data collection and analysis. Also, the MCO engaged in data mining by conducting statistical analyses to test specific effects of each of the two interventions compared to a control group (no intervention). Although the z-tests did not result in statistically significant differences for either intervention, the results of this analysis can inform continued improvement efforts. The MCO also identified barriers that may explain the interventions' lack of impact.
- ◆ *Improving the Rate of Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*: commended for demonstrating a thorough understanding of the study topic by citing research, current evidence and statistics.

#### DQ

- ◆ *Education-Focused PIP—Adolescents Age 15-18*: commended for using additional methods to focus intervention efforts. A survey was conducted to determine barriers to dental care from sample of adolescents from the target counties.

### **Suggestions**

Suggestions can be identified when documentation for an evaluation element includes the basic components to meet requirements, but enhanced documentation would demonstrate a stronger understanding of CMS protocols.

#### AGE, AGM and AGW

- ◆ *Antidepressant Medication Management*: additional data were requested from the MCO regarding clarification of data and rates for each Grand Region; therefore, the MCOs could make sure the PIP is submitted in its entirety. According to the data provided in the PIP Summary Form in Activity VIII, the MCO provided the benchmark rather than its actual goal, and in Activity III the Baseline goal section included the baseline rate. The MCO could ensure to provide rates accurately for baseline goals, baseline rates and benchmarks. Also, the MCO could ensure that only information relative to the specific

## PIP Validation

study is submitted. The supporting documentation included numerous pages of HEDIS data unrelated to this study.

- ◆ *Improving Member Satisfaction with Case Management Health-Related Information Received:* the rate of member satisfaction under the goal and/or Remeasurement 1 section of Activity III because it is more applicable there. The MCOs were contacted to provide additional information pertaining to member satisfaction rates for Baseline; therefore, the MCOs could submit the PIP study in its entirety during initial submission.
- ◆ *Prenatal and Postpartum Care:* the MCOs could ensure that attachments referenced within the Summary Form are labeled within the attachment document, and that only information relevant to the PIP study is submitted.
- ◆ *Increasing the Percentages of LOC Assessments Conducted with CHOICES Members:* the MCOs could restate the study indicator in the study indicator field in the Summary Form instead of leaving the form field blank. The MCOs could also ensure only information relevant to the specific PIP study and/or activity is attached and/or referenced.
- ◆ *Reducing Transportation (NEMT) Member Complaints:* the MCOs could rephrase the study question to clearly state the provider intervention, which was education. The study question could be rephrased as “Will targeted member and provider education reduce transportation complaints per 1000 scheduled NEMT member trips?” Also, the MCOs could clarify and report the baseline rate, the baseline goal and the benchmark because the terms were used interchangeably throughout the Summary Form. Also, the Summary Form included four study indicators, but there was one study indicator per region and one statewide. The MCOs could make sure the Summary Form includes the correct notation of the study indicators (one per region).

## AGM

- ◆ *Antidepressant Medication Management:* could provide a brief discussion of the member, provider and system barriers identified or a copy of the barrier analysis document if one was created. Also, although it stated that statistical analysis techniques were used to determine p-values, the MCO could include the specific statistical test used, level of significance and p-values.
- ◆ *Improving Member Satisfaction with Case Management Health-Related Information Received:* could check the DataStar instructions to ensure the baseline is accurately entered into the program.
- ◆ *Prenatal and Postpartum Care*
  - Included measurement periods for Baseline and Remeasurement 1 and 2, but not for Remeasurement 3. The MCO could ensure it provides all study timeframes in Activity III.
  - Could report that no factors were identified that influenced the comparability of results from year to year in Activity VIII, and could describe changes in performance for each measurement year and provide an interpretation of results for Study

- Indicator 2. Additionally, the MCO could report the 2015, Remeasurement Year 3 results in the summary of the study's progression of statistical percentages obtained from the Baseline Measurement.
- The MCO could also mention that although there has been a steady decline, the decline was only statistically significant for Study Indicator 1 (prenatal visits) between Baseline and Remeasurement 1 and between Remeasurement 1 and Remeasurement 2, but not between Remeasurement 2 and Remeasurement 3.
  - The MCO could also mention that no decreases were statistically significant between any consecutive measurement periods for Study Indicator 2 (postpartum visits).
  - The MCO could proof the information reported because inconsistencies were reported in the statistical results. For Activity VIIIa, the z-test score and p-value reported stated, "The increase of the rate from 2014 to 2015 is a significant difference at the 95th percentile with a z-test score of 2.429294 and a p-value of 0.0151." The information reported under Activity VIIIb stated, "The increase of the rate from 2014 to 2015 is not a significant difference at the 95th percentile with a z-test score of 0.926343 and a p value of 0.3543." Both statements referred to Attachment V. The DataStar results shown in the attachment were consistent with the information reported under Activity VIIIb. In addition, under Activity VIIIa, the MCO referenced Remeasurement Year 1 and stated, "This is below the industry benchmark by 9.51 percentage points"; however, under Activity VIIIb, the MCO stated, "This rate is below the industry goal of 95% by 9.52 percentage points."
  - The MCO could report that the baseline to remeasurement results were not statistically significant. The MCO could also include a description that the change that occurred was positive, although not statistically significant.

#### BCE, BCM and BCW

- ◆ *Improving Provider Satisfaction Survey Response Rates:* could submit regional baseline goal and rates in the initial PIP study submission. The MCOs could also provide more thorough documentation on the data collection and analysis related to the PIP study selection process. The MCOs was requested to submit additional information and, in the future, could complete the PIP in its entirety to facilitate validation. The MCOs could submit more thorough documentation and complete the Activity V section with a description of the sampling methods used in initial PIP study submission. The MCOs could complete the Activity VI section, describe data collection procedures, and include all applicable attachments and more thorough documentation in the initial PIP submission.
- ◆ *Transition from Acute Care Settings—Reducing Acute Care Readmissions:* could provide a specified numerical value/baseline result under baseline goal in their PIP Summary Form as the basis for the study to assist in the evaluation for improvements in future measurement years. The MCOs could also document and specify within Activity VI of the PIP Summary Form when a single rate is applicable for all three Grand Regions or provide individual rates to facilitate PIP validation.

**PIP Validation**

- ◆ *Maternal Health: Improving Prenatal and Postpartum Care Rates*: could document and specify within Activity VI of the PIP Summary Form when a single rate is applicable for all three Grand Regions or provide individual rates to facilitate PIP validation.

**BCE and BCW**

- ◆ *Transition from Acute Care Settings—Reducing Acute Care Readmissions*: could report statistical information/results by Grand Region in Activity VIII. Additionally, the MCOs could report the z-test result in addition to the reported p-value.

**BCW**

- ◆ *Improving the Rate of Antidepressant Medication Management Acute and Continuation Phase*: could ensure all data in its submitted PIP Summary Form are correctly stated.

**BCE, BCW and TCS**

- ◆ *Cultural Assessment Data Collection—Race and Ethnicity*: could include total membership numbers for each year of the study. The MCOs could include a description of the test used for statistical differences reported between remeasurement years and report the p-values as well as percentage changes between each measurement year. Additionally, the MCOs could name the statistical test used and the resulting test statistic (e.g., z-value or chi-square with the p-value).

**TCS**

- ◆ *Follow-Up Care for Children Prescribed ADHD Medication*: could report the statistical technique that was used for the analysis (e.g., z-test) and the value obtained.
- ◆ *Improving the Rate of Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*: could provide further descriptions and specifications for the study population, as stated in Activity I. Also, the MCO could include a statement that no one who meets the criteria is excluded from the study. For clarity, the MCO could mark only one section for Data Source, either Hybrid or Administrative data.

**UHCE, UHCM and UHCW**

- ◆ *Electronic Visit Verification (EVV)*: could make sure the study is presented in its entirety in the PIP Summary Form to avoid requests for additional information, such as regional baseline rates in this case. Additionally, the MCO could explicitly state that no sampling was used in the study in Activity V instead of leaving it blank in the Summary Form.
- ◆ *Impact on EPSDT Screening Rates with Targeted Intervention on CAP 12-19 Year Old Age Group*: could make sure the study is presented in its entirety in the PIP Summary Form to avoid requests for additional information, such as regional baseline rates in this case. Additionally, the MCOs could explicitly state no sampling was used in the study in Activity V instead of leaving it blank in the Summary Form.
- ◆ *Increasing Health Risk Assessment Annual Completion Rates for the East, Middle and West TN Regions*: could include whether the administrative rate is applicable statewide or regional. To facilitate PIP validation, the MCOs could include information in their initial PIP regarding regionally specific rates to further support the PIP significance, enhance

the overall PIP focus as it related to regional variations and improve regional outcomes. Additionally, the MCOs could explicitly state that no sampling was used in the study in Activity V instead of leaving it blank in the Summary Form.

- ◆ *Text4Health*: could include the baseline rate and the baseline goal in the original PIP submission to facilitate the PIP validation. Also, the MCO could include a more detailed description of the study population, including a specification of the population that meets the criteria. Additionally, the MCOs could explicitly state that no sampling was used in the study in Activity V instead of leaving it blank in the Summary Form.

#### DQ

- ◆ *Education-Focused PIP—Adolescents Age 15-18*: provided the basis upon which the indicators were developed and placed the information under the Study Indicator 2 section. The explanation of the indicator development could be better placed in the section below Benchmark Goal, which is identified in the Summary Form as the area to discuss the guidelines used and the basis for each study indicator. The DBM could also omit the mid-year remeasurement since it is not considered Remeasurement 2 and is not comparable to Baseline and Remeasurement 1.
- ◆ *Prevention-Focused PIP—Fluoride Adolescents Age 12-20*: could omit the mid-year measurements and focus future data collection on the full year for comparability with Baseline and benchmarks. Also, since Activity IX reports Remeasurement 3 as a full year, this year was technically comparable to Baseline. The DBM could consider dropping the mid-year assessments and computing all required statistics to determine if a statistically significant change occurred.

#### **AONs**

AONs arise from evaluation elements that receive a Not Met score, indicating that those elements are not in full compliance with CMS protocols.

#### UHCE, UHCM and UHCW

- ◆ *Electronic Visit Verification (EVV)*: should select the study topic after collection and analysis of local data to define the problem.
- ◆ *Impact on EPSDT Screening Rates with Targeted Intervention on CAP 12-19 Year Old Age Group*: the study question should be clear, simple and answerable. It should be stated in a way that supports the MCOs' ability to determine whether the intervention has a measureable result/improvement for a clearly defined population.

#### DQ

- ◆ *Education-Focused PIP—Adolescents Age 15-18*:
  - The DBM should provide a brief analysis of local data for each of the targeted counties to better define the problem, its prevalence and the importance of potential consequences associated with lack of this treatment in the selected populations.

## PIP Validation

- The DBM should provide an administrative data collection algorithm/flowcharts that show activities involved in the production of the study indicators. The DBM should also provide an estimated degree of administrative completeness.
  - The DBM should have initiated improvement interventions in 2015.
  - The DBM should report statistical tests, p-values and a statistical analysis plan to determine if significant changes in the percentages occurred between Baseline and Remeasurement 1. The DBM should report factors that may threaten validity or factors that affect comparability of results. Statistical tests should be performed and statistical differences between Baseline and Remeasurement 1 should be reported. Also, the DBM should identify and report factors that may affect the comparability of Baseline Measurement to Remeasurement 1.
  - Although the DBM reported that the Remeasurement 1 percentage increased compared to Baseline, it should include a statement about how the intervention was successful. In addition, it should report statistical tests or p-values to indicate whether the increase was statistically significant. The DBM should provide information to indicate how the results were related to the intervention. The DBM should report statistical tests, results, significance and p-values.
- ◆ *Prevention-Focused PIP—Fluoride Adolescents Age 12-20:*
- The DBM should provide an algorithm showing the steps in the production of its quality indicators. Also, the DBM should provide a degree of administrative completeness of the automated data used for the PIP study indicator.
  - The DBM should have initiated interventions after the Mid-Year Report in 2015.
  - The DBM should describe the data analysis process and report statistical tests or p-values. The DBM incorrectly reported Baseline (12 months) and three mid-year data points and concluded that statistical testing was not applicable. Since this was a Remeasurement 1 year, the DBM should report only the annual full remeasurement percentages, as referenced in Activity IX. This would allow for comparable measurements to be statistically tested. The interpretation of findings in Activity VIII should be based on consistent timeframes rather than mid-year comparisons. The DBM defined Remeasurement 1 as a mid-year measurement (10/1/2013-3/31/2014) that occurred as a subset of the full-year timeframe for Baseline (10/1/2013-9/30/2014). Also in Activity VIII, the DBM should present clear information. Three mid-year percentages were reported and labeled as Remeasurements 1, 2 and 3, but this was a Remeasurement 1 (year 2) PIP. In addition, this was inconsistent with the information reported in Activity IX. Statistical testing and statistical differences between Baseline and Remeasurement 1 should be identified and reported.
  - The DBM should report consistent timeframes for remeasurements in Activity IX. Mid-year remeasurements were reported for Remeasurement 1, Remeasurement 2 and Remeasurement 4. The DBM reported that Remeasurement 3 was a full-year measurement subsequent to the Baseline measurement. Technically, this should have been Remeasurement 1 as it was the same time period as Baseline. For Element 2 of Activity IX, the DBM should include documentation to explain the changes of

the percentages for each of the four remeasurements reported. For Element 3, the DBM should provide information to indicate the results were related to an intervention. For Element 4, the DBM should report statistical tests, statistical significance and p-values.

Additional information about strengths, suggestions and AONs is available in each MCC's 2016 *PIP Validation Technical Papers*.

## State Best Practices

TennCare's contracts with its MCOs require each MCO to conduct two clinical and three non-clinical PIPs relevant to the member population. A contract with the DBM requires submission of two PIP study topics, one clinical and one non-clinical. PIP topics include a variety of areas intended to encourage better practices, promote growth and identify areas for improvement in member healthcare. TennCare required that all PIPs from each MCC be evaluated by the EQRO.

# Annual Network Adequacy and Benefit Delivery Review (ANA)

## Assessment Background

For the ANA reviews, directed by the Tennessee Department of Commerce and Insurance and TennCare, Qsource evaluated each MCC to determine if it had a provider network adequate to ensure the effective and efficient delivery of healthcare to members, pursuant to *TCA §56-32-131*. The ANA reviews were conducted from February through March of 2016.

### Technical Methods of Data Collection

The 2016 ANA evaluation period was January 1 to December 31, 2015, for which the surveyors focused on the following areas:

- ◆ Analyses of the distribution, availability and assignment of providers to TennCare members
- ◆ Appointment availability and contracting P&Ps
- ◆ MCC provider manuals and member handbooks
- ◆ Sample of provider contracts
- ◆ MCC staff interviews, as needed, regarding the availability and accessibility of providers to the MCC's members
- ◆ Credentialing/recredentialing P&Ps and a sample of provider credentialing/recredentialing files (all credentialing/recredentialing findings and results were submitted to Qsource to incorporate into its AQS reports).

### Description of Data Obtained

The data used in the quantitative analyses were derived from provider files supplied by the MCCs and downloaded from TennCare. Once extracted from their respective source files, provider and member data were prepared using a software application called DataCleaner from GeoAccess, Inc. Provider and member address information was first validated, then cleaned and standardized to U.S. Postal Service specifications. Next, data were geocoded using these updated, standardized addresses. The files generated from this process were analyzed to assess network adequacy for all MCCs. Further details can be found in each MCC's *2016 Annual Network Adequacy Report*.

## Comparative Findings

The majority of the MCCs received 97.8-percent or greater compliance ratings for both overall Network Adequacy and overall Benefit Delivery for the 2016 ANA, as shown in [Table 11](#). Compliance ratings for each MCC are also provided for 2014 and 2015, although exact comparisons

**ANA**

cannot be made due to minor contract updates. The MCCs' overall ANA compliance ratings for Network Adequacy improved or were maintained from 2015 to 2016, with lowest percentages ranging from 99.4 to 100 percent. With ratings ranging from 98.3 to 100 percent, MCC compliance for Benefit Delivery remained consistent overall with the 2015 ANA. Four MCOs lowered Benefit Delivery scores since 2015: **BCE** from >99.9 to 99.3 percent, **BCW** from >99.9 to 99.3 percent, **TCS** from >99.9 to 99.0 percent and **UHCE** from >99.9 to 98.3 percent.

For the 2016 ANA, the MCCs were determined to be compliant for Overall Network Adequacy, which includes provider-to-member ratios and accessibility to providers, facilities and services, with eight MCCs scoring >99.9 percent or higher. Six MCOs achieved >99.9-percent compliance for the 2016 Benefit Delivery scores. The DBM's 2016 Benefit Delivery score was 100 percent, an improvement over its 2015 score of 97.8 percent.

MCC	2014		2015		2016	
	Network Adequacy	Benefit Delivery	Network Adequacy	Benefit Delivery	Network Adequacy	Benefit Delivery
<b>AGE*</b>	NA	NA	NA	NA	99.8%	>99.9%
<b>AGM</b>	98.8%	99.3%	99.4%	>99.9%	100%	>99.9%
<b>AGW*</b>	NA	NA	NA	NA	99.5%	>99.9%
<b>BCE</b>	>99.9%	>99.9%	>99.9%	>99.9%	>99.9%	99.3%
<b>BCM*</b>	NA	NA	NA	NA	99.9%	99.3%
<b>BCW</b>	>99.9%	>99.9%	>99.9%	>99.9%	100%	99.3%
<b>TCS</b>	>99.9%	>99.9%	>99.9%	>99.9%	>99.9%	99.0%
<b>UHCE</b>	99.9%	>99.9%	>99.9%	>99.9%	>99.9%	98.3%
<b>UHCM</b>	>99.9%	>99.9%	>99.9%	>99.9%	>99.9%	>99.9%
<b>UHCW</b>	>99.9%	>99.9%	>99.9%	>99.9%	>99.9%	>99.9%
<b>DQ</b>	>99.9%	96.3%	100%	97.8%	100%	100%

\*MCOs become operational on 1/1/2015, hence the first reporting year was 2016.

**MCO Network Adequacy (Region-Specific)**

For the 2016 evaluation, all three regions displayed high compliance for overall Network Adequacy, with no MCO earning less than a 99.5-percent rating. MCOs in the East and West Grand Regions maintained their scores of >99.9% percent (**BCE**, **UHCE** and **UHCW**) or improved to 100 percent (**BCW**). In the Middle Grand Region, **AGM** improved its score for the second year, achieving 100-percent compliance (compared to 99.4 percent in 2015); **UHCM** maintained its score of >99.9 percent.

Due to the statewide expansion of services in 2015, tracking cannot be given for three MCOs. However, all three received high compliance ratings of 99.8 percent (**AGE**), 99.5 percent (**AGW**) and 99.9 percent (**BCM**).

Both **BCE** and **UHCE** maintained overall Network Adequacy scores at >99.9 percent from 2015 to 2016. The lowest score for the East region was 94.3 percent (**AGE**) for Distance Analysis—Substance Abuse—Outpatient Treatment Services.

**UHCM** maintained its overall Network Adequacy score of >99.9 percent from 2015 to 2016 and **AGM**'s score improved 0.6 percentage points, from 99.4 to 100 percent. The lowest score for the Middle region was 94.9 percent (**BCM**) for CHOICES Providers—Inpatient Respite Care.

**UHCW** maintained its overall Network Adequacy score of >99.9 percent, and **BCW** improved its score from >99.9 to 100 percent from 2015 to 2016. In the West Grand Region, the lowest score was 65.9 percent (**AGW**) for CHOICES Providers—Adult Day Care Providers.

### **TennCareSelect Network Adequacy (Statewide)**

**TCS**'s statewide overall Network Adequacy rating for 2016 remained at >99.9 percent. Its Overall Compliance was at least 100 percent for all measures except Outpatient (Non-MD) (>99.9 percent) and Substance Abuse—Outpatient Treatment Services (99.9 percent).

### **DBM Network Adequacy (Statewide)**

**DQ**, the DBM, achieved 100-percent compliance in overall Network Adequacy in 2016, maintaining its 2015 score.

### **MCC Benefit Delivery**

For 2016, all MCCs received high compliance ratings for overall Benefit Delivery, with the lowest MCO score being 98.3 percent. Three MCOs also maintained individual overall ratings from 2015 to 2016. **DQ**, in its third year as the DBM, received a 100-percent compliance rating, improving from its 2015 score of 97.8 percent. The lowest score for Benefit Delivery measures was **UHCE**'s 95.0 percent for both MCO Provider Contracts—Quantity and Quality.

In their first year operating in their respective regions, **AGE** (>99.9 percent), **AGW** (>99.9 percent) and **BCM** (99.3 percent) all achieved high levels of compliance.

Credentialing and recredentialing file review results from the 2016 ANA were reported in the MCC individual AQS technical papers and summary report and are thus detailed in the [AQS section](#) of this report.

## MCC Strengths and Opportunities for Improvement

### Strengths and Best Practices

Qsource identified several best practices in the 2016 review cycle. The MCCs continued to revise policies and update provider manuals and member handbooks to ensure accuracy in dissemination of materials that directly affect members and providers. MCOs operating in the East Grand Region showed dedication to maintaining and improving scores in several Network Adequacy measures.

With the statewide expansion in 2015, **AG** began serving Medicaid members in all three regions of Tennessee. The expansion of the provider network needed to serve the East and West Grand regions resulted in 5,310 initial credentialing applications from providers in 2015. However, **AG** still achieved 96.5-percent compliance in processing initial credentialing files during the 2016 ANA review. **AG** is also to be commended for achieving 100-percent performance on the CHOICES initially credentialed and recredentialed file reviews.

**UHC** compiled the information required to be in the provider contracts and created a separate document, the TennCare Regulatory Appendix. The Regulatory Appendix is considered part of the provider contracts and contains the requirements included in the ANA contract review. Having one document that contains the State regulatory requirements facilitates the ANA review and assists the providers in locating any Tennessee-specific regulations that govern their practice in the State.

**BC** and **TCS** conduct quarterly patient experience surveys to monitor member satisfaction with office wait times and the overall patient experience with the TennCare Program. During the onsite review, HSAG examined a report containing survey results for 2015. Both MCOs analyzed paid claims and selected TennCare members who recently visited medical and BH providers. The report displayed separate responses for the two types of providers. Surveys were sent to members, and the response rates were noted in the reports. Members were requested to respond to questions concerning wait times for scheduling appointments, office wait times and their experience and satisfaction with office visits. They presented the survey responses for the last five quarters so that recent quarter responses could be compared to the corresponding quarter responses from the prior calendar year. **BC** and **TCS** are to be commended for their ongoing monitoring of members' experience of care.

The **DQ** provider engagement staff developed a protocol for visiting the ANA network providers in 2015. Based on the ranking of claims, the top 10 percent of providers were visited every quarter, the middle 50 percent every six months and the bottom 40 percent once during the year. While

onsite, the provider engagement staff conducted training sessions by answering any provider or staff member questions, furnishing copies of the provider newsletters and reviewing the information that could be accessed via the provider portal. The face-to-face visits ensured that **DQ** was continuously engaged with the network providers, and the network providers received current information concerning **DQ**'s benefits, policies and procedures.

## Recommendations

MCOs should ensure that all providers in the network have executed contracts and have a copy of the executed contract on file. Other recommendations include:

### East Grand Region

- ◆ **AGE** should address the shortage of OB/GYNs serving members residing in southeast Polk County, the shortage of urologists serving northeast Johnson County, and the shortage of general optometry service providers in Claiborne, Cocke, Green, Johnson and Polk counties. More providers of outpatient (non-MD) services in north central Claiborne county and southeast Polk County should be sought. **AGE** should contract with more providers of Substance Abuse—Inpatient Facility Services within 90 miles of members residing in Carter, Johnson, Sullivan, Unicoi and Washington counties, and providers of Substance Abuse—Outpatient Treatment Services in Bradley, Cocke, Franklin, Hamblen, Granger, Grundy, Jefferson, Marion, McMinn, Monroe, Polk and Sevier counties. **BCE** should address the shortage of providers of Substance Abuse—Outpatient Treatment services in Polk County. **UHCE** should improve the availability rates of providers of Outpatient (Non-MD) Services, Substance Abuse—Outpatient Treatment Services and General Optometry Services in Polk County.

### Middle Grand Region

- ◆ **AGM** should address the shortages of OB/GYNs, general optometry providers and providers of Substance Abuse—Outpatient Treatment Services. **BCM** should address the shortage of Outpatient (Non-MD Services) providers in Pickett County and contract with additional providers of Inpatient Respite Care in Cannon and Van Buren counties. **BCM** should also seek more providers of Substance Abuse—Outpatient Treatment Services in Houston, Humphreys, Perry and Stewart counties. **UHCM** should focus their efforts to increasing access to the types of providers listed above, for the Middle Grand Region.

### West Grand Region

- ◆ **UHCW** should focus their efforts on increasing access to OB/GYNs in the West Grand Region.

### Statewide

- ◆ **TCS**, serving all three Grand Regions, must ensure that the handbooks, manuals and educational materials include information which informs members and providers that mammography screening benefits are available at a minimum of once for ages 35-40, every 2 years or more frequently on physician recommendation for ages 40-50, and

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**ANA**

annually for ages 50 and older. This was also identified for **BC**. **TCS** should also be commended for its ongoing monitoring of the members' experience of care.

- ◆ **DQ** scored 100 percent on all elements included in the ANA review, therefore, no recommendations are included.

## State Best Practices

In addition to the annual comprehensive network adequacy surveys, TennCare closely monitors MCC performance throughout the year. The MCCs are required to submit monthly provider files and select data elements. These provider data are validated quarterly by Qsource and presented in the PDV reports. TennCare also annually evaluates MCC contracts and makes necessary amendments. These ongoing monitoring activities further ensure the availability of timely and accessible services for its members.

# Annual Quality Survey (AQS)

## Assessment Background

Qsource conducted the AQS reviews pursuant to the following nationally recognized guidelines (sources indicated in parentheses): (1) *2012 Standards and Guidelines for the Accreditation of MCOs* (NCQA); (2) *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs), Final Protocol; Version 2.0, February 2012* (CMS); and (3) additional state and federal regulations. The survey team consisted of clinicians with expertise in QI and a health analyst with expertise in data analyses and validation.

### Technical Method of Data Collection

For each MCC, the AQS included a pre-assessment documentation review, an onsite visit and post-onsite analysis. Qsource developed evidence-based oversight tools in consultation with HCFA and by referencing the *Statewide Contract with Amendment 2—July 1, 2015* and *An Agreement for the Administration of TennCare Select Between the State of Tennessee, d.b.a. TennCare, and Volunteer State Health Plan, Inc., Blended Document with Amendments 1 through 37—July 1, 2015*. Qsource provided the AQS onsite tools to each MCC prior to pre-assessment, giving the MCCs opportunities to ask questions before the onsite visit. Once onsite, the review team interacted with MCC staff to determine the degree of compliance with contractual requirements, to explore any issues not fully addressed in the documentation reviewed and to increase overall understanding of the MCC's performance. The 2016 onsite surveys took place February through April of 2016.

From March to May 2016, HSAG provided Qsource with ANA analyses of credentialing and recredentialing QP standards and file reviews. The *2016 AQS Technical Papers* include credentialing and recredentialing results from the 2016 ANA, as does this section of this *2016 EQRO Technical Report*.

Credentialing and recredentialing file reviews for both quantity and quality were performed for each qualifying MCC on independent practitioners and CHOICES providers, where applicable. Qsource conducted PA file reviews to assess member UM Denials and Appeals. Denial file review was restricted to members ages 20 years and younger to assess MCC compliance with the federal EPSDT program. Appeal files were reviewed for compliance with the *Grier Revised Consent Decree*. Three additional file reviews were completed for MCOs only: EPSDT Information System Tracking, CHOICES Annual LOC Assessment and CHOICES Transition Between MCOs.

## Description of Data Obtained

Throughout the documentation review and onsite assessment processes, Qsource reviewers used the survey tools to collect information and document findings regarding the MCC's compliance with contractual and regulatory standards through a review of P&Ps, committee minutes, quality studies, reports, medical record/file and other related MCC documentation. Qsource analyzed every element in the survey tools using weighted point values to determine the MCC's performance on each standard.

The following is a list of the QP Standards and PAs for the MCOs and the DBM.

### ◆ MCO QP Standards

- Network: Contracting, Availability, Access and Documentation
- QI Activities
- Clinical Criteria for Utilization Management (UM) Decisions
- Member Rights and Responsibilities
- EPSDT
- *Grier Revised Consent Decree*
- Non-Discrimination Compliance
- Credentialing/Recredentialing P&Ps

### ◆ MCO PAs

- UM Denials
- Appeals (*Grier*)
- EPSDT Information System Tracking
- CHOICES Annual Level of Care Assessment
- CHOICES Transition Between MCOs
- Credentialing File Review
- Recredentialing File Review
- CHOICES Credentialing File Review
- CHOICES Recredentialing File Review

### ◆ DBM QP Standards

- Written QMP Description
- Systematic Process of Quality Assessment and Improvement
- Accountability to the Governing Body

- Active Quality Monitoring Committee
  - Quality Monitoring Supervision
  - Adequate Resources
  - Provider Participation in the QMP
  - Delegation of QMP Activities
  - Member Rights and Responsibilities
  - Standards for Facilities
  - Dental Records Standards
  - Utilization Review
  - Coordination of QM Activity w/Other Management Activity
  - EPSDT
  - *Grier Revised Consent Decree*
  - Non-Discrimination Compliance
  - Credentialing P&Ps
- ◆ DBM PAs
- UM Denials (ages 20 and younger)
  - Appeals (*Grier*)
  - Complaints
  - Credentialing File Review

## Comparative Findings

### Overall AQS Compliance

Although survey tool changes were made from the 2015 to the 2016 AQS, some trending is possible. The MCOs maintained 100-percent overall compliance for six QP standards assessed for the 2014, 2015 and 2016 AQS reviews: QI Activities, Clinical Criteria for Utilization Management (UM) Decisions, Member Rights and Responsibilities, EPSDT, *Grier Revised Consent Decree* and Non-Discrimination Compliance.

From 2015 to 2016, the MCOs' PA performance improved overall. Of the nine PAs assessed in both review years, the MCOs' overall scores improved for three: UM Denials from 96.0 to 97.7 percent (**UHCM**), CHOICES Transitions Between MCOs from 90.0 to 97.1 percent (**BCW**), for Credentialing File Review (Quality) from 94.1 to 97.9 percent (**UHCM**) and 94.9 to 100 percent (**UHCW**), CHOICES Credentialing File Review (Quality) from 80.0 (**AGM**) and 97.4 (**BCE**) to 100

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**AQS**

percent, and CHOICES Recredentialing File Review (Quality) from 85.2 to 88.2 percent (**UHCM**). The MCOs also maintained their 100-percent compliance for Appeals, EPSDT, CHOICES Annual Level of Care Assessment, Credentialing (Quantity), Recredentialing (Quantity), CHOICES Credentialing (Quality) and CHOICES Recredentialing (Quality).

**DQ** achieved 100-percent compliance for 15 of its 18 QP standards for the 2016 AQS. The DBM improved its score in Written QMP Description, Systematic Process of Quality, Accountability to the Governing Body, Non-Discrimination Compliance and Credentialing P&P Review to 100 percent. The DBM maintained its 100-percent compliance in all five PAs in its second full year of service as TennCare's DBM.

**MCO QP Standard Compliance**

For the 2016 AQS, all MCOs achieved 100-percent compliance for six of eight QP standards, demonstrating strong compliance with contractual, federal and state requirements. During the first year of statewide operation, the MCOs in new regions showed excellent promise by achieving 100-percent compliance in all but one standard (**AG** received 0.0 percent for Network: Contracting, Availability, Access and Documentation).

**DBM QP Standard Compliance**

Because accreditation is not mandated for the DBM, the evaluated QP standards differed from those of the MCOs. **DQ** achieved 100-percent compliance on 15 of 18 QP standards. The remaining QP standard scores were 75.0 percent on Active Quality Monitoring Committee, 95.9 percent on Member Rights and Responsibilities and 96.0 percent on EPSDT.

**MCC PA Compliance**

While credentialing, appeal, and UM Denial file reviews were conducted for all MCCs during the 2016 AQS, nine other PA assessments were conducted for the MCOs only: EPSDT Information Tracking System, CHOICES Annual LOC Assessment, CHOICES Transition Between MCOs, Recredentialing File Review (Quantity), Recredentialing File Review (Quality), CHOICES Credentialing File Review (Quantity), CHOICES Credentialing File Review (Quality), CHOICES Recredentialing File Review (Quantity) and CHOICES Recredentialing File Review (Quality). Because recredentialing only occurs after an MCO has been operational for at least three years, recredentialing file reviews were not conducted for **AGE**, **AGW** or **BCM** during the 2016 AQS.

All MCCs achieved 100 percent compliance in Appeals file reviews.

Operating for the first time in their respective regions, **AGE**, **AGW** and **BCM** demonstrated strong dedication to quality care, with **AGE** and **AGW** achieving 100-percent compliance in seven

PAs and **BCM** achieving 100-percent compliance in eight PAs. During the credentialing process, **AG** should process completed applications within 30 days and, for recredentialing files, should review adverse events. For UM Denials, **BCE**, **BCW** and **UHCM** should ensure that timely member notifications about the decision are sent. For CHOICES Transition Between MCOs, **BCE** should request and review transfer of care data on all Group 1 members transferred from another MCO to its membership, and **BCW** should review the transition of care data it requests for new members. For Credentialing, **UHCM** should process completed applications within 30 days, and for Recredentialing, all regions of **UHC** should review adverse events and **UHCM** should complete recredentialing within 36 months. When reviewing CHOICES recredentialing applications, **UHCM** should verify Medicare/Medicaid participation, and all regions of **UHC** should complete recredentialing annually or every three years.

## MCC Strengths and Opportunities for Improvement

### Suggestions

All MCOs received a suggestion for Member Rights and Responsibilities. The MCOs could include more specific information in their Member Handbooks on appropriate prescription drug usage and avoiding prescription drug abuse; this kind of information was included in several Member Newsletters, but was not explicit in the Member Handbook. Furthermore, although the Member Handbook included information about continuing active treatment plans during pregnancy and about switching from the current MCO to another MCO, it could explicitly inform members that switching from another MCO to this MCO invalidates any previous prior authorizations.

**DQ** received two suggestions total. For Standards for Facilities Element #1, the Site Review Tool Sheet should correctly spell *Health Insurance Portability and Accountability Act* (HIPAA) and also could explicitly state that inventory is maintained for expired medication. For EPSDT Element #15, the DBM could develop a report to show the number of cases for services not covered by the DBM that it coordinates with the MCOs.

### AONs and Strengths

AQS AONs were identified in two QP standards and five PAs. Among QP standards, two AONs were noted for Network: Contracting, Availability, Access and Documentation. One AON was noted for Credentialing/Recredentialing P&Ps.

In PAs, AONs were noted for UM Denials, Credentialing File Review (Quality), Recredentialing File Review (Quality), CHOICES Transition Between MCOs and CHOICES Recredentialing File Review (Quality).

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**AQS**

For the DBM, AONs were noted for Active Quality Monitoring Committee, Member Rights and Responsibilities, and EPSDT.

**Improvements Since the Last AQS**

Qsource identified the following improvements on past AONs:

**AG**

**AG** conducted training with staff to ensure the appropriate turnaround times were met when credentialing providers. **AG** provided the updated credentialing process and conducted refresher training to staff to ensure that the signatures on attestations were no older than 180 days at the time of the credentialing decision. **AG** provided a copy of the process and the spreadsheet used to validate the TennCare numbers. **AG** also conducted training with the CHOICES staff to ensure that the Medicaid provider number was verified with TennCare prior to approving the CHOICES credentialing and recredentialing files.

**BC**

**BC**'s credentialing staff completed a monthly review to ensure that every file in the credentialing process included a verification of the TennCare Medicaid number. **BCE** also monitored the CHOICES credentialing files prior to credentialing to ensure that the Medicaid numbers were verified for every provider who was initially credentialed. The verification information also was included in each of the provider files. The Manager of Statewide CHOICES Operations discussed and provided a copy of the Executive Summary Report that described the course of action **BCW** had followed during 2015 to correct its AON. During file review there was evidence that all transition of care data was requested as required.

**UHC**

**UHC** revised operating procedures and retrained staff to ensure that delegated vendor information was loaded into its systems within 30 calendar days of receipt of notification. **UHCE** trained staff, reminded subcontractors performing delegated recredentialing, and performed monitoring activities to ensure that attestation signatures were not older than 180 days at the time of recredentialing. **UHCE** staff members also confirmed that they conducted the annual audit to ensure compliance with the 180-day requirement. **UHCE** enhanced its credentialing processes and retrained staff to ensure that CHOICES files contained verification of the provider's participation in Medicare/Medicaid prior to approval. Interviews with staff also confirmed that **UHCE** audited CHOICES credentialing files weekly to ensure compliance with verification of participation in Medicare/Medicaid.

**UHCE** enhanced its recredentialing processes and retrained staff to ensure that CHOICES files were recredentialed annually or every three years. During the onsite review, HSAG reviewed

reports used to monitor recredentialing dates for CHOICES providers, and interviews with staff confirmed that **UHCE** audited files weekly to ensure timeliness of completion of CHOICES recredentialing files. Staff members also confirmed that they held weekly meetings with the provider advocates to discuss the CHOICES recredentialing timelines.

An Excel excerpt from Prior Authorization Team Training for Turn Around Times was provided which included re-education and the National Letter Team notification by day 13. It would be recommended that **UHCM** provides the actual training material in addition to the excerpts. **UHCM** retrained staff and performed monitoring activities to ensure than five years' work history was included on all credentialing applications and that attestation signatures were not older than 180 days at the time of credentialing. **UHCM** also enhanced its credentialing reports and retrained staff to ensure that credentialing files met the 30-day processing requirement. **UHCM** enhanced its credentialing process and retrained staff to ensure that CHOICES files contained verification of the provider's participation in Medicare/Medicaid prior to approval. Interviews with staff confirmed that **UHCM** audited files weekly to ensure compliance with verification of participation in Medicare/Medicaid. **UHCM** enhanced its recredentialing processes and retrained staff to ensure that CHOICES files were recredentialed annually or every three years. During the onsite review, HSAG reviewed reports used to monitor recredentialing dates for CHOICES providers and confirmed that **UHCM** audited files weekly to ensure compliance with timeliness of recredentialing. Staff Members also confirmed that they held weekly meetings with the provider advocates to discuss the CHOICES recredentialing timelines.

**UHCW** enhanced its credentialing processes and retrained staff to ensure that credentialing files met the 30-day processing requirement. **UHCW** also created reports to more effectively monitor the 30-day requirement. **UHCW** enhanced its recredentialing processes and retrained staff to ensure that CHOICES files were credentialed annually or every three years. During the onsite review, HSAG reviewed reports used to monitor recredentialing dates for CHOICES providers and confirmed that **UHCW** audited files weekly to ensure compliance with timeliness of recredentialing. Staff members also confirmed that they held weekly meetings with the provider advocates to discuss the CHOICES recredentialing timeliness.

## DQ

The QMP information and number to call to obtain a copy has been added to the Member Handbook, fourth quarter Provider Newsletter and fourth quarter DentaQuest Digest proving guideline dissemination. **DQ** updated P&Ps #300.012 and #300.013 to include the methodology for modifying a CAP when actions did not lead to improved provider performance when placed on a CAP. The Manager of Contract Compliance stated all committee meeting minutes are placed

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## AQS

on a shared drive within 24 hours of the meeting completion. All Executive Committee (EC) members have access to this shared drive to view the minutes. The QOC met every month and DQ provided the QOC meeting minutes from each month. Formal approval of the P&P #1200.029: Non-Discrimination Compliance Program was documented by email from the Director of the Office of Civil Rights Compliance. The policy number changed after the approval process, but this numbering change was documented in the email. Review of this policy was conducted during DQ's September QOC Meeting and was evidenced in meeting minutes. DQ compiled daily reports containing the names of providers who were credentialed and recredentialed. The DQ staff used the daily reports to verify that reports sent to the Credentialing Committee contained every provider approved to be included in the DQ network. After ensuring that the Credentialing Committee reports were accurate, DQ moved to quarterly monitoring to ensure that all credentialed and recredentialed providers were listed on the report sent to the Credentialing Committee. A review of the reports and process validated that DQ performed the monitoring activities and presented complete and accurate reports of providers to the Credentialing Committee.

## State Best Practices

TennCare and Qsource collaborate annually to develop the AQS assessment tools. Tools are modified as necessary to reflect any state, federal or MCC-contract changes and are aligned with the State Quality Strategy to achieve its goals and objectives. TennCare and Qsource have implemented an effective corrective action process in which MCCs are required to submit a CAP for any deficient element for compliance evaluation by TennCare and Qsource. During each AQS, CAPs from the previous year's survey are assessed to determine the extent to which implementation was effective. This comprehensive process further assists the MCCs in QI.

# Conclusions and Recommendations

## MCC Strengths and Weaknesses

Overall, TennCare’s MCCs are delivering timely, accessible, high-quality care to members and demonstrating a commitment to their well-being. Qsource’s 2016 EQR activity results show that the MCCs are exhibiting primarily high rates of compliance with their contract requirements and with federal and state mandates. TennCare supports these efforts with its own initiatives, such as requiring NCQA accreditation and offering MCCs collaboration opportunities and incentives for QIs.

TennCare has established an effective and collaborative relationship with its MCC contractors to ensure quality services are delivered and available to TennCare members.

### PMV

Although comparisons to previous years cannot be performed, the audit results showed MCO dedication to providing complete, accurate information. The measures audited for each MCO were reportable and each MCO was in full compliance with all standards. For the individual MCOs, the following strengths were identified:

- ◆ **BC** expanded into the State’s Middle Grand Region. **BC**’s expansion to the Middle Grand Region was implemented without any issues as there were multiple readiness reviews conducted to ensure a smooth transition.
- ◆ **UHCE**, **UHCM** and **UHCW** were commended for their processes in IS 3.0 Practitioner Data—Data Capture, Transfer and Entry and the processes are considered to be a best practice.

### PIPs

Fifty-two PIPs (with 20 unique topics) were selected for validation for 2016. MCOs achieved a Met validation status for all but five PIPs. Forty-seven PIPs earned 100-percent compliance on all critical elements, and 44 earned 100-percent compliance on all total elements. The MCCs demonstrated the following:

- ◆ **AG** submitted thorough documentation for complaint database management that included complaint entry and assignment instructions, flowcharts, job descriptions and pre-transportation validation checks.
- ◆ **AGM** provided supporting documentation for statistical tests and results with all necessary data. They were also commended for conducting a thorough analysis that addressed survey completeness and respondent characteristics for each measurement period and for providing supporting DataStar documentation of z tests. **AGM** also described the casual/barrier analysis process and subsequent development of the PIP interventions with explicit detail both within the Summary form and attachments.

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**Conclusions and Recommendations**

- ◆ **BC** selected a topic that showed strength in its potential to significantly impact the health of its members 18 years of age and older through its in-depth analysis of depression. **BC** also conducted a complete thorough review of the topic through extensive literature review, research and data analysis.
- ◆ **BCE** and **BCW** provided a thorough analysis of IET measure data to identify study area opportunities. The MCO drilled down through four years of data to identify two targeted subgroups of the population: emergency room patients and those admitted through an outpatient setting. **BCE** and **BCW** also created a dedicated work group used an effective Plan-Do-Study-Act (PDSA) strategy that enabled continual monitoring of PIP interventions through process change and root-cause/impact analysis, and support ongoing improvement efforts and follow-up opportunities relative to the study goals.
- ◆ **BCM** showed strength through its dissection of the IET measure data and identification of other study area opportunities. New in January 2015, the MCO did a thorough internal analysis of current IET data to identify the two major components of the denominator: emergency room patients and those admitted via outpatient setting.
- ◆ **BC** conducted a complete thorough review of the topic through extensive literature review, research and data analysis, and **TCS** derived the PIP study topic from extensive literature review, data research and analysis.
- ◆ **BC** and **TCS** included the background for topic selection. The MCO also provided supporting final analysis documentation of its data-collection strategy with corresponding final results compared to baseline.
- ◆ **TCS** selected a topic that showed a strength in its potential to significantly impact the health of its members ages 6-12 through its in-depth data collection and analysis. Also, the MCO engaged in data mining by conducting statistical analyses to test specific effects of each of the two interventions compared to a control group (no intervention). Although the z-tests did not result in statistically significant differences for either intervention, the results of this analysis can inform continued improvement efforts. The MCO also identified barriers that may explain the interventions' lack of impact. Additionally, **TCS** demonstrated a thorough understanding of the study topic by citing research, current evidence and statistics.
- ◆ **TCS** used extensive literature review, data research and analysis for its study topic selection.
- ◆ **DQ** reported using additional methods to focus intervention efforts. A survey was conducted to determine barriers to dental care from sample of adolescents from the target counties.

## ANA

For the 2016 ANA, the MCCs demonstrated the following:

- ◆ **AG** expanded coverage into all three regions of Tennessee beginning in CY2015. **AG** received 5,310 initial credentialing applications from providers in 2015, but still achieved 96.5-percent compliance in processing initial credentialing files.
- ◆ **BC** and **TCS** conduct quarterly patient experience surveys to monitor member satisfaction with office wait times and the overall patient experience with the TennCare Program. **BC** and **TCS** presented the survey responses for the last five quarters so that recent quarter responses could be compared to the corresponding quarter responses from the prior calendar year and should both be commended for the ongoing monitoring of the members' experience of care.
- ◆ **UHC** compiled the information required to be in the provider contracts and created a separate document, the TennCare Regulatory Appendix. **UHC** should be commended for having one document that contains the State regulatory requirements facilitating the ANA review and assisting the providers in locating any Tennessee-specific regulations that govern their practice in the State.

## AQS

The MCOs maintained 100 percent overall compliance for six QP standards assessed for the 2014, 2015 and 2016 AQS reviews: QI Activities, Clinical Criteria for UM Decisions, Member Rights and Responsibilities, EPSDT, *Grier Revised Consent Decree* and Non-Discrimination Compliance.

## Recommendations

### PMV

While no deficiencies were noted, MCOs should continue to investigate ways to automate the data transfer between credentialing/provider management and administrative software platforms, and should also consider using notification dates to determine continuous enrollment.

### PIPs

Most MCC suggestions concerned including clear and relevant information in the appropriate sections of the PIP Summary Form to avoid requests for missing information after the initial PIP submission. MCCs should also include more explicit statements in their submissions, including more specific descriptions of the study population, whether sampling methods were used, and whether any factors influenced the comparability of results or the validity of findings. Finally, MCCs should be sure to use and describe consistent and comparable measurement periods.

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## Conclusions and Recommendations

### AQS

To continue fostering improvement, MCOs should focus on the QP standards and PAs related to credentialing and recredentialing files and P&Ps. Although several scores were higher in these categories this year, some MCOs should pay special attention to credentialing application processing times, provider recredentialing timelines and reviewing adverse events in recredentialing files. Other opportunities for improvement for MCOs include improving the timeliness of member notifications sent after provider or specialist terminations as well as UM Denial decisions. Finally, MCOs should be sure to both request and review transfer of care data on all CHOICES members transferred from another MCO. Additionally, the following recommendations were noted for the MCOs:

- ◆ **AG** should ensure timely member notifications are sent after a specialist or a specialty group terminates participation and when a PCP terminates participation with the MCO. **AG** should process completed applications with 30 days and review adverse events.
- ◆ **BC** should ensure that timely member notifications are sent. **BC** also should request and review transfer of care data on all Group 1 CHOICES Transition Between MCOs members transferred from another MCO to its membership and new members.
- ◆ **UHC** must ensure that all letters sent to providers whose privileges are suspended or terminated contain evidence of notification of the providers' appeal rights and processes. Timely notifications should be sent to the members and completed applications processed within 30 days. **UHC** should review adverse events and complete recredentialing within 36 months. **UHC** should also verify Medicare/Medicaid participation and complete recredentialing annually or every three years.

The DBM should focus its improvement efforts on explicitly stating required information in its member handbooks and P&Ps. This information includes various statements about member financial responsibilities, prior authorizations and expiration of TennCare eligibility. The DBM should also aim to improve its quality monitoring committee processes, making sure to hold meetings more frequently and to include TennCare providers in committee membership.

### ANA

For the East Grand Region, **AGE** should address the shortages of OB/GYNs, urologists and other providers of healthcare services. **BCE** should address the shortages of Outpatient providers for both Substance Abuse and Non-MD Services. **UHCE** should improve the availability rates of providers of Outpatient (Non-MD) Services, Substance Abuse—Outpatient Treatment Services and General Optometry.

For the Middle Grand Region, **AGM** should address the shortage of OB/GYNs and contract with more providers for general optometry and Substance Abuse—Outpatient Treatment Services. **BCM** should address the shortage of Outpatient (Non-MD Services) and contract additional

Inpatient Respite Care providers. **UHCM** should work to increase access to OB/GYNs, Outpatient (Non-MD), Substance Abuse providers, and Hospitals.

For the West Grand Region, **AGW** should address the shortages of OB/GYNs, Outpatient (Non-MD Services), Substance Abuse, general optometry and Adult Day Care providers. **UHCW** should increase access to OB/GYNs in the region. (No recommendations were provided for **BCW**.)

Operating statewide, **TCS** should increase access to providers of Outpatient (Non-MD Services) and Substance Abuse—Outpatient Treatment Services.

## APPENDIX A | MCC Findings

In accordance with CMS guidelines for EQRO technical reporting, this appendix presents MCC-specific results for the 2016 **PIP Validation**, [ANA](#) and [AQS](#) activities.

### PIP Validation

TennCare required that all PIPs submitted by MCCs be validated for CY2015. Individual elements were assessed as **Met**, **Not Met** or **Not Assessed (NA)**. Elements were designated **NA** if related data had not been collected for the PIP study at the time of the review. A **Met** validation status indicates confidence/high confidence that the PIP was valid, while a **Not Met** status indicates that PIP results were not credible.

For each applicable activity, [Tables A-1](#) through [A-11](#) summarize overall PIP validation scores, including the number of total evaluation elements, the number of critical elements, the percentage of elements that were **Met**, as well as the overall validation status. The actual number of activities validated for each MCO varied depending on the progress of the PIP study.

Table A-1. 2016 PIP Validation Scores by Review Activity: AGE

Review Activities	Total (T) and Critical (C) Elements Met/Assessed										
	Antidepressant Medication Management		Improving Member Satisfaction with Case Management Health-Related Information Received		Increasing the Percentages of LOC Assessments Conducted with CHOICES Members		Improving Access to Prenatal and Postpartum Care		Reducing Transportation (NEMT) Member Complaints		
	T	C	T	C	T	C	T	C	T	C	
I. Choose the Study Topic(s)	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	
II. Define the Study Question(s)	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	
III. Select the Study Indicator(s)	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	
IV. Use a Representative and Generalizable Study Population	3/3	2/2	3/3	2/2	2/2	2/2	2/2	2/2	2/2	2/2	
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	
VI. Use Valid and Reliable Data Collection Procedures	6/6	0/0	9/9	1/1	11/11	1/1	11/11	1/1	6/6	0/0	
VII. Include Improvement Strategies	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	
VIII. Analyze and Interpret Study Results	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	
IX. Assess for Real Improvement	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	
X. Assess for Sustained Improvement	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	
<b>Overall Score</b>	<b>23/23</b>	<b>8/8</b>	<b>26/26</b>	<b>9/9</b>	<b>27/27</b>	<b>9/9</b>	<b>27/27</b>	<b>9/9</b>	<b>22/22</b>	<b>8/8</b>	
<b>Percentage of Elements Met</b>	<b>Total</b>	100%		100%		100%		100%		100%	
	<b>Critical</b>	100%		100%		100%		100%		100%	
<b>Validation Status</b>	<b>Met</b>		<b>Met</b>		<b>Met</b>		<b>Met</b>		<b>Met</b>		

Table A-2. 2016 PIP Validation Scores by Review Activity: AGM

Review Activities	Total (T) and Critical (C) Elements Met/Assessed										
	Antidepressant Medication Management		Improving Member Satisfaction with Case Management Health-Related Information Received		Increasing the Percentages of LOC Assessments Conducted with CHOICES Members		Improving Access to Prenatal and Postpartum Care		Reducing Transportation (NEMT) Member Complaints		
	T	C	T	C	T	C	T	C	T	C	
I. Choose the Study Topic(s)	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	
II. Define the Study Question(s)	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	
III. Select the Study Indicator(s)	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	
IV. Use a Representative and Generalizable Study Population	3/3	2/2	3/3	2/2	2/2	2/2	2/2	2/2	2/2	2/2	
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	
VI. Use Valid and Reliable Data Collection Procedures	6/6	0/0	9/9	1/1	11/11	1/1	11/11	1/1	6/6	0/0	
VII. Include Improvement Strategies	2/2	1/1	2/2	1/1	1/1	1/1	3/3	1/1	0/0	0/0	
VIII. Analyze and Interpret Study Results	8/8	1/1	8/8	1/1	8/8	1/1	9/9	2/2	0/0	0/0	
IX. Assess for Real Improvement	4/4	0/0	4/4	0/0	4/4	0/0	4/4	0/0	0/0	0/0	
X. Assess for Sustained Improvement	0/0	0/0	1/1	0/0	0/0	0/0	1/1	0/0	0/0	0/0	
<b>Overall Score</b>	<b>37/37</b>	<b>10/10</b>	<b>41/41</b>	<b>11/11</b>	<b>40/40</b>	<b>11/11</b>	<b>44/44</b>	<b>12/12</b>	<b>22/22</b>	<b>8/8</b>	
<b>Percentage of Elements Met</b>	<b>Total</b>	100%		100%		100%		100%		100%	
	<b>Critical</b>	100%		100%		100%		100%		100%	
<b>Validation Status</b>	<b>Met</b>		<b>Met</b>		<b>Met</b>		<b>Met</b>		<b>Met</b>		

Table A-3. 2016 PIP Validation Scores by Review Activity: AGW

Review Activities	Total (T) and Critical (C) Elements Met/Assessed										
	Antidepressant Medication Management		Improving Member Satisfaction with Case Management Health-Related Information Received		Increasing the Percentages of LOC Assessments Conducted with CHOICES Members		Improving Access to Prenatal and Postpartum Care		Reducing Transportation (NEMT) Member Complaints		
	T	C	T	C	T	C	T	C	T	C	
I. Choose the Study Topic(s)	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	
II. Define the Study Question(s)	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	
III. Select the Study Indicator(s)	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	
IV. Use a Representative and Generalizable Study Population	3/3	2/2	3/3	2/2	2/2	2/2	2/2	2/2	2/2	2/2	
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	
VI. Use Valid and Reliable Data Collection Procedures	6/6	0/0	9/9	1/1	11/11	1/1	11/11	1/1	6/6	0/0	
VII. Include Improvement Strategies	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	
VIII. Analyze and Interpret Study Results	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	
IX. Assess for Real Improvement	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	
X. Assess for Sustained Improvement	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	
<b>Overall Score</b>	<b>23/23</b>	<b>8/8</b>	<b>26/26</b>	<b>9/9</b>	<b>27/27</b>	<b>9/9</b>	<b>27/27</b>	<b>9/9</b>	<b>22/22</b>	<b>8/8</b>	
<b>Percentage of Elements Met</b>	<b>Total</b>	100%		100%		100%		100%		100%	
	<b>Critical</b>	100%		100%		100%		100%		100%	
<b>Validation Status</b>	<b>Met</b>		<b>Met</b>		<b>Met</b>		<b>Met</b>		<b>Met</b>		

Table A-4. 2016 PIP Validation Scores by Review Activity: BCE

Review Activities	Total (T) and Critical (C) Elements Met/Assessed												
	Improving the Rate of Antidepressant Medication Management Acute and Continuation Phase		Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)		Transition from Acute Care Settings—Reducing Acute Care Readmissions		Cultural Assessment Data Collection—Race and Ethnicity		Maternal Health: Improving Prenatal and Postpartum Care Rates		Improving Provider Satisfaction Survey Response Rates		
	T	C	T	C	T	C	T	C	T	C	T	C	
I. Choose the Study Topic(s)	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	5/5	1/1	
II. Define the Study Question(s)	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	
III. Select the Study Indicator(s)	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	
IV. Use a Representative and Generalizable Study Population	3/3	2/2	3/3	2/2	2/2	2/2	2/2	2/2	3/3	2/2	1/1	1/1	
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	6/6	1/1	
VI. Use Valid and Reliable Data Collection Procedures	6/6	0/0	6/6	0/0	6/6	0/0	6/6	0/0	6/6	0/0	9/9	1/1	
VII. Include Improvement Strategies	0/0	0/0	0/0	0/0	2/2	1/1	4/4	1/1	0/0	0/0	0/0	0/0	
VIII. Analyze and Interpret Study Results	0/0	0/0	0/0	0/0	8/8	1/1	8/8	1/1	0/0	0/0	0/0	0/0	
IX. Assess for Real Improvement	0/0	0/0	0/0	0/0	4/4	0/0	4/4	0/0	0/0	0/0	0/0	0/0	
X. Assess for Sustained Improvement	0/0	0/0	0/0	0/0	0/0	0/0	1/1	0/0	0/0	0/0	0/0	0/0	
<b>Overall Score</b>	<b>23/23</b>	<b>8/8</b>	<b>23/23</b>	<b>8/8</b>	<b>36/36</b>	<b>10/10</b>	<b>39/39</b>	<b>10/10</b>	<b>23/23</b>	<b>8/8</b>	<b>29/29</b>	<b>9/9</b>	
<b>Percentage of Elements Met</b>	Total	100%		100%		100%		100%		100%		100%	
	Critical	100%		100%		100%		100%		100%		100%	
<b>Validation Status</b>	<b>Met</b>		<b>Met</b>		<b>Met</b>		<b>Met</b>		<b>Met</b>		<b>Met</b>		

Table A-5. 2016 PIP Validation Scores by Review Activity: BCM

Review Activities	Total (T) and Critical (C) Elements Met/Assessed										
	Improving the Rate of Antidepressant Medication Management Acute and Continuation Phase		Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)		Transition from Acute Care Settings—Reducing Acute Care Readmissions		Maternal Health: Improving Prenatal and Postpartum Care Rates		Improving Provider Satisfaction Survey Response Rates		
	T	C	T	C	T	C	T	C	T	C	
I. Choose the Study Topic(s)	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	5/5	1/1	
II. Define the Study Question(s)	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	
III. Select the Study Indicator(s)	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	
IV. Use a Representative and Generalizable Study Population	3/3	2/2	3/3	2/2	2/2	2/2	3/3	2/2	1/1	1/1	
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	6/6	1/1	
VI. Use Valid and Reliable Data Collection Procedures	6/6	0/0	6/6	0/0	6/6	0/0	6/6	0/0	9/9	1/1	
VII. Include Improvement Strategies	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	
VIII. Analyze and Interpret Study Results	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	
IX. Assess for Real Improvement	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	
X. Assess for Sustained Improvement	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	
<b>Overall Score</b>	<b>23/23</b>	<b>8/8</b>	<b>23/23</b>	<b>8/8</b>	<b>22/22</b>	<b>8/8</b>	<b>23/23</b>	<b>8/8</b>	<b>29/29</b>	<b>9/9</b>	
<b>Percentage of Elements Met</b>	<b>Total</b>	100%		100%		100%		100%		100%	
	<b>Critical</b>	100%		100%		100%		100%		100%	
<b>Validation Status</b>	<b>Met</b>		<b>Met</b>		<b>Met</b>		<b>Met</b>		<b>Met</b>		

Table A-6. 2016 PIP Validation Scores by Review Activity: BCW

Review Activities	Total (T) and Critical (C) Elements Met/Assessed												
	Improving the Rate of Antidepressant Medication Management Acute and Continuation Phase		Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)		Transition from Acute Care Settings—Reducing Acute Care Readmissions		Cultural Assessment Data Collection—Race and Ethnicity		Maternal Health: Improving Prenatal and Postpartum Care Rates		Improving Provider Satisfaction Survey Response Rates		
	T	C	T	C	T	C	T	C	T	C	T	C	
I. Choose the Study Topic(s)	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1	5/5	1/1	
II. Define the Study Question(s)	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	
III. Select the Study Indicator(s)	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	
IV. Use a Representative and Generalizable Study Population	3/3	2/2	3/3	2/2	2/2	2/2	2/2	2/2	3/3	2/2	1/1	1/1	
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	6/6	1/1	
VI. Use Valid and Reliable Data Collection Procedures	6/6	0/0	6/6	0/0	6/6	0/0	6/6	0/0	6/6	0/0	9/9	1/1	
VII. Include Improvement Strategies	0/0	0/0	0/0	0/0	2/2	1/1	4/4	1/1	0/0	0/0	0/0	0/0	
VIII. Analyze and Interpret Study Results	0/0	0/0	0/0	0/0	8/8	1/1	8/8	1/1	0/0	0/0	0/0	0/0	
IX. Assess for Real Improvement	0/0	0/0	0/0	0/0	4/4	0/0	4/4	0/0	0/0	0/0	0/0	0/0	
X. Assess for Sustained Improvement	0/0	0/0	0/0	0/0	0/0	0/0	1/1	0/0	0/0	0/0	0/0	0/0	
<b>Overall Score</b>	<b>23/23</b>	<b>8/8</b>	<b>23/23</b>	<b>8/8</b>	<b>36/36</b>	<b>10/10</b>	<b>39/39</b>	<b>10/10</b>	<b>23/23</b>	<b>8/8</b>	<b>29/29</b>	<b>9/9</b>	
<b>Percentage of Elements Met</b>	<b>Total</b>	100%		100%		100%		100%		100%		100%	
	<b>Critical</b>	100%		100%		100%		100%		100%		100%	
<b>Validation Status</b>	<b>Met</b>		<b>Met</b>		<b>Met</b>		<b>Met</b>		<b>Met</b>		<b>Met</b>		

Table A-7. 2016 PIP Validation Scores by Review Activity: TCS

Review Activities	Total (T) and Critical (C) Elements Met/Assessed												
	Cultural Assessment Data Collection—Race and Ethnicity		Maternal Health: Improving Prenatal and Postpartum Care Rates		Improving Provider Satisfaction Survey Response Rates		Follow-up Care for Children Prescribed ADHD Medication		Improving Cervical Cancer Screening Rates in SelectCommunity		Improving the Rate of Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life		
	T	C	T	C	T	C	T	C	T	C	T	C	
I. Choose the Study Topic(s)	6/6	1/1	6/6	1/1	5/5	1/1	6/6	1/1	6/6	1/1	6/6	1/1	
II. Define the Study Question(s)	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	
III. Select the Study Indicator(s)	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	
IV. Use a Representative and Generalizable Study Population	2/2	2/2	3/3	2/2	1/1	1/1	2/2	2/2	3/3	2/2	3/3	2/2	
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	6/6	1/1	0/0	0/0	0/0	0/0	0/0	0/0	
VI. Use Valid and Reliable Data Collection Procedures	6/6	0/0	6/6	0/0	9/9	1/1	6/6	0/0	6/6	0/0	6/6	0/0	
VII. Include Improvement Strategies	4/4	1/1	0/0	0/0	0/0	0/0	3/3	1/1	0/0	0/0	0/0	0/0	
VIII. Analyze and Interpret Study Results	8/8	1/1	0/0	0/0	0/0	0/0	8/8	1/1	0/0	0/0	0/0	0/0	
IX. Assess for Real Improvement	4/4	0/0	0/0	0/0	0/0	0/0	4/4	0/0	0/0	0/0	0/0	0/0	
X. Assess for Sustained Improvement	1/1	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	
<b>Overall Score</b>	<b>39/39</b>	<b>10/10</b>	<b>23/23</b>	<b>8/8</b>	<b>29/29</b>	<b>9/9</b>	<b>37/37</b>	<b>10/10</b>	<b>23/23</b>	<b>8/8</b>	<b>23/23</b>	<b>8/8</b>	
<b>Percentage of Elements Met</b>	<b>Total</b>	100%		100%		100%		100%		100%		100%	
	<b>Critical</b>	100%		100%		100%		100%		100%		100%	
<b>Validation Status</b>	<b>Met</b>		<b>Met</b>		<b>Met</b>		<b>Met</b>		<b>Met</b>		<b>Met</b>		

Table A-8. 2016 PIP Validation Scores by Review Activity: UHCE

Review Activities	Total (T) and Critical (C) Elements Met/Assessed							
	Electronic Visit Verification (EVV)		Impact on EPSDT Screening Rates with Targeted Intervention on CAP 12-19 Year Old Age Group		Increasing Health Risk Assessment Annual Completion Rates for the East, Middle and West TN Regions		Text4Health	
	T	C	T	C	T	C	T	C
I. Choose the Study Topic(s)	5/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1
II. Define the Study Question(s)	2/2	2/2	1/2	1/2	2/2	2/2	2/2	2/2
III. Select the Study Indicator(s)	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3
IV. Use a Representative and Generalizable Study Population	2/2	2/2	3/3	2/2	3/3	2/2	3/3	2/2
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
VI. Use Valid and Reliable Data Collection Procedures	5/5	0/0	6/6	0/0	6/6	0/0	6/6	0/0
VII. Include Improvement Strategies	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
VIII. Analyze and Interpret Study Results	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
IX. Assess for Real Improvement	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
X. Assess for Sustained Improvement	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
<b>Overall Score</b>	<b>20/21</b>	<b>8/8</b>	<b>22/23</b>	<b>7/8</b>	<b>23/23</b>	<b>8/8</b>	<b>23/23</b>	<b>8/8</b>
<b>Percentage of Elements Met</b>	<b>Total</b>	95.2%		95.7%		100%		100%
	<b>Critical</b>	100%		87.5%		100%		100%
<b>Validation Status</b>	<b>Met</b>		<b>Not Met</b>		<b>Met</b>		<b>Met</b>	

Table A-9. 2016 PIP Validation Scores by Review Activity: UHCM

Review Activities	Total (T) and Critical (C) Elements Met/Assessed							
	Electronic Visit Verification (EVV)		Impact on EPSDT Screening Rates with Targeted Intervention on CAP 12-19 Year Old Age Group		Increasing Health Risk Assessment Annual Completion Rates for the East, Middle and West TN Regions		Text4Health	
	T	C	T	C	T	C	T	C
I. Choose the Study Topic(s)	5/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1
II. Define the Study Question(s)	2/2	2/2	1/2	1/2	2/2	2/2	2/2	2/2
III. Select the Study Indicator(s)	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3
IV. Use a Representative and Generalizable Study Population	2/2	2/2	3/3	2/2	3/3	2/2	3/3	2/2
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
VI. Use Valid and Reliable Data Collection Procedures	5/5	0/0	6/6	0/0	6/6	0/0	6/6	0/0
VII. Include Improvement Strategies	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
VIII. Analyze and Interpret Study Results	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
IX. Assess for Real Improvement	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
X. Assess for Sustained Improvement	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
<b>Overall Score</b>	<b>20/21</b>	<b>8/8</b>	<b>22/23</b>	<b>7/8</b>	<b>23/23</b>	<b>8/8</b>	<b>23/23</b>	<b>8/8</b>
<b>Percentage of Elements Met</b>	<b>Total</b>	95.2%	95.7%		100%		100%	
	<b>Critical</b>	100%	87.5%		100%		100%	
<b>Validation Status</b>	<b>Met</b>		<b>Not Met</b>		<b>Met</b>		<b>Met</b>	

Table A-10. 2016 PIP Validation Scores by Review Activity: UHCW

Review Activities	Total (T) and Critical (C) Elements Met/Assessed							
	Electronic Visit Verification (EVV)		Impact on EPSDT Screening Rates with Targeted Intervention on CAP 12-19 Year Old Age Group		Increasing Health Risk Assessment Annual Completion Rates for the East, Middle and West TN Regions		Text4Health	
	T	C	T	C	T	C	T	C
I. Choose the Study Topic(s)	5/6	1/1	6/6	1/1	6/6	1/1	6/6	1/1
II. Define the Study Question(s)	2/2	2/2	1/2	1/2	2/2	2/2	2/2	2/2
III. Select the Study Indicator(s)	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3
IV. Use a Representative and Generalizable Study Population	2/2	2/2	3/3	2/2	3/3	2/2	3/3	2/2
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
VI. Use Valid and Reliable Data Collection Procedures	5/5	0/0	6/6	0/0	6/6	0/0	6/6	0/0
VII. Include Improvement Strategies	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
VIII. Analyze and Interpret Study Results	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
IX. Assess for Real Improvement	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
X. Assess for Sustained Improvement	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
<b>Overall Score</b>	<b>20/21</b>	<b>8/8</b>	<b>22/23</b>	<b>7/8</b>	<b>23/23</b>	<b>8/8</b>	<b>23/23</b>	<b>8/8</b>
<b>Percentage of Elements Met</b>	<b>Total</b>	95.2%	95.7%		100%		100%	
	<b>Critical</b>	100%	87.5%		100%		100%	
<b>Validation Status</b>	<b>Met</b>		<b>Not Met</b>		<b>Met</b>		<b>Met</b>	

Table A-11. 2016 PIP Validation Scores by Review Activity: DQ

Review Activities	Total (T) and Critical (C) Elements Met/Assessed			
	Education-Focused PIP— Adolescents Age 15-18		Prevention-Focused PIP— Fluoride Adolescents Age 12-20	
	T	C	T	C
I. Choose the Study Topic(s)	5/6	1/1	6/6	1/1
II. Define the Study Question(s)	2/2	2/2	2/2	2/2
III. Select the Study Indicator(s)	6/6	3/3	6/6	3/3
IV. Use a Representative and Generalizable Study Population	3/3	2/2	3/3	2/2
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0
VI. Use Valid and Reliable Data Collection Procedures	4/6	0/0	4/6	0/0
VII. Include Improvement Strategies	0/4	0/1	0/4	0/1
VIII. Analyze and Interpret Study Results	4/8	0/1	4/8	0/1
IX. Assess for Real Improvement	1/4	0/0	0/4	0/0
X. Assess for Sustained Improvement	0/0	0/0	0/0	0/0
<b>Overall Score</b>	<b>25/39</b>	<b>8/10</b>	<b>25/39</b>	<b>8/10</b>
<b>Percentage of Elements Met</b>	<b>Total</b>	64.1%	64.1%	
	<b>Critical</b>	80.0%	80.0%	
<b>Validation Status</b>	<b>Not Met</b>		<b>Not Met</b>	

## ANA

The following evaluation activities were performed for all MCCs:

- ◆ Provider Ratio Analysis
- ◆ Time/Distance Analysis
- ◆ Covered Benefits
- ◆ Appointment Availability
- ◆ Qualified Provider Analysis\*

\* Results for the Qualified Provider Analysis, which was conducted during the ANA review, were reported in the AQS technical papers and reports.

### Network Adequacy

The information in **Tables A-12** and [A-13](#) for all MCCs was obtained from analyses performed on provider and member data.

Table A-12. 2016 ANA Network Adequacy Results: MCOs											
Measure	Standard (max)	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
Primary Care Provider (PCP) Ratio	2,500:1 or 1,250:1*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Urban PCP Time/Distance	30 minutes or 20 miles	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Rural PCP Time/Distance	30 minutes or 30 miles	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TennCare Kids Provider Ratio	2,500:1 or 1,250:1*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TennCare Kids Provider Time/Distance	30 minutes	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OB/GYN Provider Ratio	2,500:1 or 1,250:1*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

**Table A-12. 2016 ANA Network Adequacy Results: MCOs**

Measure	Standard (max)	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
OB/GYN Provider Time/Distance	30 minutes	99.8%	99.2%	99.9%	100%	100%	100%	100%	100%	99.7%	99.9%
General Optometry Time/Distance	30 minutes	99.5%	99.5%	99.3%	100%	100%	100%	100%	>99.9%	100%	100%
Hospital Time/Distance	30 minutes	100%	>99.9%	100%	100%	100%	100%	100%	100%	98.1%	>99.9%
<b>Member-to-Provider Ratios for SCPs</b>											
Allergy and Immunology	100,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Cardiology	20,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Dermatology	40,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Endocrinology	25,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Gastroenterology	30,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
General Surgery	15,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Nephrology	50,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Neurology	35,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Neurosurgery	45,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Oncology/Hematology	80,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Ophthalmology	20,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Orthopedics/ Orthopedic Surgery	15,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Otolaryngology	30,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Psychiatry (Adult)	25,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Psychiatry (Child and Adolescent)	150,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Urology	30,000:1	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table A-12. 2016 ANA Network Adequacy Results: MCOs

Measure	Standard (max)	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
<b>Physical Health-Specific Specialties Time/Distance Analysis</b>											
Allergy and Immunology	1 within 60/90 miles**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Cardiology	1 within 60/90 miles**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Dermatology	1 within 60/90 miles**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Endocrinology	1 within 60/90 miles**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Gastroenterology	1 within 60/90 miles**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
General Surgery	1 within 60/90 miles**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Nephrology	1 within 60/90 miles**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Neurology	1 within 60/90 miles**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Neurosurgery	1 within 60/90 miles**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Oncology/Hematology	1 within 60/90 miles**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Ophthalmology	1 within 60/90 miles**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Orthopedics/Orthopedic Surgery	1 within 60/90 miles**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Otolaryngology	1 within 60/90 miles**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

**Table A-12. 2016 ANA Network Adequacy Results: MCOs**

Measure	Standard (max)	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
Psychiatry (Adult)	1 within 60/90 miles**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Psychiatry (Child and Adolescent)	1 within 60/90 miles**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Urology	1 within 60/90 miles**	99.9%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Behavioral Health-Specific Specialties Time/Distance Analysis											
Psychiatric Inpatient	90 miles†	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Outpatient (Non-MD Services)	30 miles‡	99.5%	100%	>99.9%	100%	>99.9%	100%	>99.9%	>99.9%	>99.9%	100%
Intensive Outpatient (may include Day Treatment [Adult], Intensive Day Treatment [Child and Adolescent], or Partial Hospitalization)	90 miles†	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Substance Abuse—Inpatient Facility Services	90 miles†	96.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Substance Abuse—24-Hour Residential Treatment Services	1 Provider Within Grand Region◆	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Substance Abuse—Outpatient Treatment Services	30 miles‡	94.3%	97.9%	99.3%	>99.9%	99.7%	100%	99.9%	>99.9%	>99.9%	100%
24-Hour Psychiatric Residential Treatment (Adult)	1 Provider Within Grand Region◆	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table A-12. 2016 ANA Network Adequacy Results: MCOs

Measure	Standard (max)	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
24-Hour Psychiatric Residential Treatment (Child)	1 within 60/90 miles♦♦	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
<b>Audit Results for Special Programs</b>											
Essential Hospital Services	All in 5 services	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Centers of Excellence (COEs): People With HIV/AIDs	At least two COEs	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
COEs: People With BH Needs	All COEs	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Disease Management for Obesity	At least one disease management program	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Children In or At Risk of State Custody	Tertiary Care Academic Medicine Center							100%			
<b>Results for CHOICES** Providers</b>											
Adult Day Care Providers	20 miles in urban, 30 miles in suburban, 60 miles in rural	100%	100%	65.9%	100%	100%	100%	NA	100%	100%	100%
Assisted Care Living Facility	1 in region	100%	100%	100%	100%	100%	100%	NA	100%	100%	100%
Assistive Technology	2 providers per county	100%	100%	100%	100%	100%	100%	NA	100%	100%	100%
Attendant Care	2 providers per county	100%	100%	100%	100%	100%	100%	NA	100%	100%	100%

**Table A-12. 2016 ANA Network Adequacy Results: MCOs**

Measure	Standard (max)	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
Home-Delivered Meals	2 providers per county	100%	100%	100%	100%	100%	100%	NA	100%	100%	100%
In-Home Respite Care	2 providers per county	100%	100%	100%	100%	100%	100%	NA	100%	100%	100%
Inpatient Respite Care	2 providers per county	100%	100%	100%	100%	94.9%	100%	NA	100%	100%	100%
Minor Home Modifications	2 providers per county	100%	100%	100%	100%	100%	100%	NA	100%	100%	100%
Nursing Facility Services	All in region	100%	100%	100%	100%	100%	100%	NA	100%	100%	100%
Personal Care Visits	2 providers per county	100%	100%	100%	100%	100%	100%	NA	100%	100%	100%
PERS	2 providers per county	100%	100%	100%	100%	100%	100%	NA	100%	100%	100%
Pest Control	2 providers per county	100%	100%	100%	100%	100%	100%	NA	100%	100%	100%
<b>Overall Network Adequacy Results</b>		<b>99.8%</b>	<b>100%</b>	<b>99.5%</b>	<b>&gt;99.9%</b>	<b>99.9%</b>	<b>100%</b>	<b>&gt;99.9%</b>	<b>&gt;99.9%</b>	<b>&gt;99.9%</b>	<b>&gt;99.9%</b>

Note: Boxes that are grayed out were NA.

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

## DBM

**Table A-13. 2016 ANA Network Adequacy Results: DBM**

Measure	Standard (max)	DentaQuest
General Dental Provider Ratio (Members < Age 21 years)	2,500:1	100%
Dental Provider Time/Distance (Members < Age 21 years)	30 minutes	100%
<b>Overall Network Adequacy Results</b>		<b>100%</b>

## Benefit Delivery

The information in **Table A-14** for all MCCs was obtained from reviews of the six areas used to determine the effectiveness of the MCC's delivery of covered benefits.

<b>Table A-14. 2016 ANA Benefit Delivery Results: MCCs</b>										
<b>AGE</b>	<b>AGM</b>	<b>AGW</b>	<b>BCE</b>	<b>BCM</b>	<b>BCW</b>	<b>TCS</b>	<b>UHCE</b>	<b>UHCM</b>	<b>UHCW</b>	<b>DQ</b>
<b>Covered Benefits</b>										
<b>Member Handbook</b>										
100%	100%	100%	97.9%	97.9%	97.9%	97.1%	100%	100%	100%	100%
<b>Provider Manual</b>										
100%	100%	100%	97.9%	97.9%	97.9%	97.1%	100%	100%	100%	100%
<b>Appointment Availability</b>										
<b>Policies and Procedures</b>										
100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
<b>Complaints</b>										
99.9%	99.9%	99.9%	>99.9%	>99.9%	>99.9%	>99.9%	>99.9%	>99.9%	>99.9%	100%
<b>Provider Contracts</b>										
<b>Quantity</b>										
100%	100%	100%	100%	100%	100%	100%	95.0%	100%	100%	100%
<b>Quality</b>										
100%	100%	100%	100%	100%	100%	100%	95.0%	100%	100%	100%
<b>Overall Benefit Delivery Results</b>										
>99.9%	>99.9%	>99.9%	99.3%	99.3%	99.3%	99.0%	98.3%	>99.9%	>99.9%	100%

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

## AQS

### QP Standards

Tables A-15 and A-16 display each MCC's compliance with federal statutes, its relative contract, applicable court-ordered provisions and additional quality standards established by the state. Individual results are presented for each QP standard.

**Table A-15. 2016 AQS QP Standard Results: MCOs**

Standard	AG	BC	TCS	UHC
Network: Contracting, Availability, Access and Documentation	0.0%	100%	100%	100%
QI Activities	100%	100%	100%	100%
Clinical Criteria for UM Decisions	100%	100%	100%	100%
Member Rights and Responsibilities	100%	100%	100%	100%
EPSDT	100%	100%	100%	100%
<i>Grier Revised Consent Decree</i>	100%	100%	100%	100%
Non-Discrimination Compliance	100%	100%	100%	100%
Credentialing and Recredentialing P&Ps	100%	100%	100%	96.6%

**Table A-16. 2016 AQS QP Standard Results: DBM**

Standard	Score	Standard	Score
Written QMP Description	100%	Standards for Facilities	100%
Systematic Process of Quality Assessment and Improvement	100%	Dental Records Standards	100%
Accountability to the Governing Body	100%	Utilization Review	100%
Active Quality Monitoring Committee	75.0%	QMP Documentation	100%
Quality Monitoring Supervision	100%	Coordination of QM Activity	100%
Adequate Resources	100%	EPSDT	96.0%
Provider Participation in the QMP	100%	<i>Grier Revised Consent Decree</i>	100%

Table A-16. 2016 AQS QP Standard Results: DBM

Standard	Score	Standard	Score
Delegation of QMP Activities	100%	Non-Discrimination Compliance	100%
Member Rights and Responsibilities	95.9%	Credentialing P&P Review	100%

## PA File Reviews

The results in **Tables A-17** and **A-18** present each MCC's compliance with each review activity. Again, individual results are presented for each PA, and overall results are presented where possible.

Table A-17. 2016 AQS PA File Review Results: MCOs

AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
<b>Clinical Criteria for UM Decisions: Denial File Review (ages 20 and younger only)</b>									
100%	100%	100%	97.6%	100%	97.6%	100%	100%	97.7%	100%
<b>Grier Revised Consent Decree: Appeal File Review</b>									
100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
<b>EPSDT: Information System Tracking Review</b>									
100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
<b>CHOICES Annual LOC Assessment</b>									
	100%		100%		100%		100%	100%	100%
<b>CHOICES Transitions Between MCOs</b>									
100%	100%	100%	73.7%	100%	97.1%		100%	100%	100%
<b>Credentialing File Review (Quantity)</b>									
100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
<b>Credentialing File Review (Quality)</b>									
96.5%	98.6%	94.4%	100%	100%	100%	100%	100%	97.9%	100%
<b>Recredentialing File Review (Quantity)</b>									
	100%		100%		100%	100%	100%	100%	100%

Table A-17. 2016 AQS PA File Review Results: MCOs									
AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
<b>Recredentialing File Review (Quality)</b>									
	83.3%		100%		100%	100%	86.6%	83.7%	90.0%
<b>CHOICES Credentialing File Review (Quantity)</b>									
100%	100%	100%	100%	100%	100%				
<b>CHOICES Credentialing File Review (Quality)</b>									
100%	100%	100%	100%	100%	100%				
<b>CHOICES Recredentialing File Review (Quantity)</b>									
	100%		100%		100%		100%	100%	100%
<b>CHOICES Recredentialing File Review (Quality)</b>									
	100%		100%		100%		73.3%	88.2%	70.5%

Note: Boxes that are grayed out were NA.

Table A-18. 2016 AQS PA File Review Results: DBM		
PAs	Score	
UM Denials (ages 20 and younger)	100%	
Appeals ( <i>Grier</i> )	100%	
Complaints	100%	
Credentialing File Review	Quantity	100%
	Quality	100%
Recredentialing File Review	Quantity	*
	Quality	*

\*Because the **DO** contract had not reached three full years of operation at the time of review, recredentialing files were not evaluated. HSAG did conduct a review of recredentialing P&Ps to ensure that the DBM maintained a credentialing and recredentialing program that was consistent with the requirements specified in the contract.

## APPENDIX B | 2016 Sample Assessment Tools

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

- ◆ [PMV](#)
- ◆ [PIP Validation](#)
- ◆ [ANA](#)
- ◆ [AQS\\*](#)

The complete, individual MCC tools used for these listed reviews are contained within the individual MCC reports previously submitted to TennCare.

Qsource's subcontractor, HSAG, helped to conduct certain EQR activities. As such, independent tools were developed by both Qsource and HSAG in conjunction with each organization's unique style guidelines.

*\* The results related to credentialing and recredentialing detailed in this year's AQS technical papers and reports were obtained through the Credentialing and Recredentialing File Review Tools, which are located in the ANA section of Appendix B of this report.*

## PMV

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

NCQA's Information Systems Standards		
Standard	Audit Findings	Impact on Reporting
<b>IS 1.0 Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry</b>		
<p><b>IS 1.1</b> Industry standard codes (e.g., ICD-9-CM, ICD-10-CM, CD-10-PCS, CPT, DRG, HCPCS) are used and all characters are captured.</p> <p><b>IS 1.2</b> Principal codes are identified and secondary codes are captured.</p> <p><b>IS 1.3</b> Nonstandard coding schemes are fully documented and mapped back to industry standard codes.</p> <p><b>IS 1.4</b> Standard submission forms are used and capture all fields relevant to measure reporting. All proprietary forms capture equivalent data. Electronic transmission procedures conform to industry standards.</p> <p><b>IS 1.5</b> Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files for measure reporting.</p> <p><b>IS 1.6</b> The organization continually assesses data completeness and takes steps to improve performance.</p> <p><b>IS 1.7</b> The organization regularly monitors vendor performance against expected performance standards.</p>		
<b>IS 2.0 Enrollment Data—Data Capture, Transfer and Entry</b>		
<p><b>IS 2.1</b> The organization has procedures for submitting measure-relevant information for data entry. Electronic transmissions of membership data have necessary procedures to ensure accuracy.</p> <p><b>IS 2.2</b> Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files.</p> <p><b>IS 2.3</b> The organization continually assesses data completeness and takes steps to improve performance.</p> <p><b>IS 2.4</b> The organization regularly monitors vendor performance against expected performance standards.</p>		

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

NCQA's Information Systems Standards		
Standard	Audit Findings	Impact on Reporting
<p><b>IS 5.3</b> Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.</p> <p><b>IS 5.4</b> The organization continually assesses data completeness and takes steps to improve performance.</p> <p><b>IS 5.5</b> The organization regularly monitors vendor performance against expected performance standards.</p>		
<b>IS 6.0 Member Call Center Data—Capture, Transfer and Entry</b>		
<p><b>IS 6.1</b> Member call center data are reliably and accurately captured.</p>		
<b>IS 7.0 Data Integration—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity</b>		
<p><b>IS 7.1</b> Nonstandard coding schemes are fully documented and mapped to industry standard codes.</p> <p><b>IS 7.2</b> Data transfers to HEDIS repository from transaction files are accurate.</p> <p><b>IS 7.3</b> File consolidations, extracts and derivations are accurate.</p> <p><b>IS 7.4</b> Repository structure and formatting are suitable for measures and enable required programming efforts.</p> <p><b>IS 7.5</b> Report production is managed effectively and operators perform appropriately.</p> <p><b>IS 7.6</b> Measure reporting software is managed properly with regard to development, methodology, documentation, version control and testing.</p> <p><b>IS 7.7</b> The organization regularly monitors vendor performance against expected performance standards.</p>		

## PIP Validation

The TennCare 2016 PIP Validation Tool was used to assess applicable MCC PIPs in accordance with CMS protocol.

2016 PIP Validation Tool—<MCC>						
<PIP Topic>						
Activity I: Choose the Study Topic(s)						
Topics selected for the study should reflect the Medicaid-enrolled population in terms of demographic characteristics, prevalence of disease and the potential consequences (risks) of disease. Topics could also address the need for a specific service. The goal of the project should be to improve processes and outcomes of healthcare. The topic may be specified by the State Medicaid Agency or based on input from Medicaid members.						
Element #	C*	Study topic(s):	Met	Not Met	NA**	
1	<input type="checkbox"/>	Reflects high-volume or high-risk conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2	<input type="checkbox"/>	Is selected following collection and analysis of data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3	<input type="checkbox"/>	Addresses a broad spectrum of care and services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4	<input type="checkbox"/>	Includes all eligible populations that meet the study criteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5	<input type="checkbox"/>	Does not exclude members with special healthcare needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6	<input checked="" type="checkbox"/>	Has the potential to affect member health, functional status or satisfaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Activity I Results:</b>			<b>Total</b>	<b>Met</b>	<b>Not Met</b>	<b>NA</b>
<b>All Elements</b>			6			
<b>Critical Elements</b>			1			
<b>Comment:</b>						
<b>Strength:</b>						
<b>AON:</b>						
<b>Suggestion:</b>						

\*\* NA = Not Assessed

\* C = Critical Element

**2016 PIP Validation Tool—<MCC>  
<PIP Topic>**

**Activity II: Define the Study Question(s)**

Stating the study question(s) helps to maintain the focus of the PIP and sets the framework for data collection, analysis and interpretation.

Element #	C*	The study question(s):	Met	Not Met	NA**	
1	<input checked="" type="checkbox"/>	States the problem to be studied in simple terms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2	<input checked="" type="checkbox"/>	Is answerable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Activity II Results:</b>			<b>Total</b>	<b>Met</b>	<b>Not Met</b>	<b>NA</b>
<b>All Elements</b>			2			
<b>Critical Elements</b>			2			

**Comment:**

**Strength:**

**AON:**

**Suggestion:**

**2016 PIP Validation Tool—<MCC>  
<PIP Topic>**

**Activity III: Select the Study Indicators**

A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event (e.g., an older adult has not received an influenza vaccination in the last 12 months) or a status (e.g., a member's blood pressure is or is not below a specified level) that is to be measured. The selected indicators should track performance or improvement over time. The indicators should be objective, clearly and unambiguously defined and be based on current clinical knowledge or health services research.

Element #	C*	Study indicators:	Met	Not Met	NA**
1	<input checked="" type="checkbox"/>	Are well-defined, objective and measurable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	<input type="checkbox"/>	Are based on current, evidence-based practice guidelines, pertinent peer-reviewed literature or consensus of expert panels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	<input checked="" type="checkbox"/>	Allow for the study questions to be answered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	<input type="checkbox"/>	Measure changes (outcomes) in health or functional status, member satisfaction or valid process alternatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	<input checked="" type="checkbox"/>	Have available data that can be collected on each indicator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	<input type="checkbox"/>	Are nationally recognized measures, such as HEDIS Technical Specifications, when appropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	<input type="checkbox"/>	Include the basis on which the indicators were adopted, if internally developed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Activity III Results:	Total	Met	Not Met	NA
All Elements	7			
Critical Elements	3			

**Comment:**

**Strength:**

**AON:**

**Suggestion:**

2016 PIP Validation Tool—<MCC>

<PIP Topic>

**Activity IV: Use a Representative and Generalizable Study Population**

The selected topic should represent the entire eligible Medicaid-enrolled population, with systemwide measurement and improvement efforts to which the study indicators apply.

Element #	C*	The representative and generalizable study population:	Met	Not Met	NA**	
1	<input checked="" type="checkbox"/>	Is accurately and completely defined	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2	<input type="checkbox"/>	Includes requirements for the length of a member's enrollment in the MCO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3	<input checked="" type="checkbox"/>	Captures all members to whom the study question applies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Activity IV Results:</b>			<b>Total</b>	<b>Met</b>	<b>Not Met</b>	<b>NA</b>
<b>All Elements</b>			3			
<b>Critical Elements</b>			2			

**Comment:**

**Strength:**

**AON:**

**Suggestion:**

**2016 PIP Validation Tool—<MCC>  
<PIP Topic>**

**Activity V: Use Sound Sampling Methods**

(This activity is only scored if sampling is used.) If sampling is used to select members of the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. The true prevalence or incidence rate for the event in the population may not be known the first time a topic is studied.

Element #	C*	Sampling methods:	Met	Not Met	NA**
1	<input type="checkbox"/>	Consider and specify the true or estimated frequency of occurrence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	<input type="checkbox"/>	Identify the sample size	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	<input type="checkbox"/>	Specify the confidence level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	<input type="checkbox"/>	Specify the acceptable margin of error	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	<input checked="" type="checkbox"/>	Ensure a representative sample of the eligible population	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	<input type="checkbox"/>	Are in accordance with generally accepted principles of research design and statistical analysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Activity V Results:	Total	Met	Not Met	NA
<b>All Elements</b>	6			
<b>Critical Elements</b>	1			

**Comment:**

**Strength:**

**AON:**

**Suggestion:**

2016 PIP Validation Tool—<MCC>

<PIP Topic>

Activity VI: Use Valid and Reliable Data Collection Procedures

Data collection must ensure that the data collected on the study indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement.

Element #	C*	Data collection procedures include:	Met	Not Met	NA**
1	<input type="checkbox"/>	The identification of data elements to be collected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	<input type="checkbox"/>	The identification of specified sources of data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	<input type="checkbox"/>	A defined and systematic process for collecting baseline and remeasurement data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	<input type="checkbox"/>	A timeline for the collection of baseline and remeasurement data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	<input type="checkbox"/>	Qualified staff and personnel to abstract manual data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	<input checked="" type="checkbox"/>	A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	<input type="checkbox"/>	A manual data collection tool that supports inter-rater reliability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	<input type="checkbox"/>	Clear and concise written instructions for completing the manual data collection tool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	<input type="checkbox"/>	An overview of the study in written instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	<input type="checkbox"/>	Administrative data collection algorithms/flow charts that show activities in the production of indicators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	<input type="checkbox"/>	An estimated degree of administrative completeness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Activity VI Results:	Total	Met	Not Met	NA
All Elements	11			
Critical Elements	1			

Comment:

Strength:

AON:

Suggestion:

2016 PIP Validation Tool—<MCC>

<PIP Topic>

**Activity VII: Include Improvement Strategies**

Real, sustained improvements in care result from a continuous cycle of measuring and analyzing performance, as well as developing and implementing systemwide improvements in care. Interventions are designed to change behavior at an institutional, practitioner or member level.

Element #	C*	Improvement strategies are:	Met	Not Met	NA**
1	<input checked="" type="checkbox"/>	Related to causes/barriers identified through data analysis and quality improvement processes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	<input type="checkbox"/>	System changes that are likely to induce permanent change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	<input type="checkbox"/>	Revised if the original interventions were not successful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	<input type="checkbox"/>	Standardized and monitored if interventions were successful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Activity VII Results:	Total	Met	Not Met	NA
All Elements	4			
Critical Elements	1			

Comment:

Strength:

AON:

Suggestion:

2016 PIP Validation Tool—<MCC>

<PIP Topic>

Activity VIII: Analyze and Interpret Study Results

Review the data analysis process for the selected clinical or non-clinical study indicators. Review appropriateness of and adherence to the statistical analysis techniques used.

Element #	C*	Study results:	Met	Not Met	NA**	
1	<input checked="" type="checkbox"/>	Are conducted according to the data analysis plan in the study design	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2	<input checked="" type="checkbox"/>	Allow for the generalization of results to the study population if a sample was selected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3	<input type="checkbox"/>	Identify factors that threaten internal or external validity of findings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4	<input type="checkbox"/>	Include an interpretation of findings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5	<input type="checkbox"/>	Are presented in a way that provides accurate, clear and easily understood information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6	<input type="checkbox"/>	Identify the initial measurement and remeasurement of study indicators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7	<input type="checkbox"/>	Identify statistical differences between the initial measurement and the remeasurement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8	<input type="checkbox"/>	Identify factors that affect the ability to compare the initial measurement with the remeasurement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9	<input type="checkbox"/>	Include an interpretation of the extent to which the study was successful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Activity VIII Results:</b>			<b>Total</b>	<b>Met</b>	<b>Not Met</b>	<b>NA</b>
<b>All Elements</b>			9			
<b>Critical Elements</b>			2			
<b>Comment:</b>						
<b>Strength:</b>						
<b>AON:</b>						
<b>Suggestion:</b>						

**2016 PIP Validation Tool—<MCC>  
<PIP Topic>**

**Activity IX: Assess for Real Improvement**

Through repeated measurement of the quality indicators selected for the project, meaningful change in performance relative to the performance observed during baseline measurement must be demonstrated. Assess for any random, year-to-year variations, population changes or sampling errors that may have occurred during the measurement process.

Element #	C*	Assessments for real improvement strategies indicate that:	Met	Not Met	NA**
1	<input type="checkbox"/>	The remeasurement methodology is the same as the baseline methodology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	<input type="checkbox"/>	There are documented improvements in processes or outcomes of care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	<input type="checkbox"/>	The improvements appear to be the result of planned intervention(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	<input type="checkbox"/>	There is statistical evidence that observed improvement is true improvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Activity IX Results:	Total	Met	Not Met	NA
<b>All Elements</b>	4			
<b>Critical Elements</b>	0			

**Comment:**

**Strength:**

**AON:**

**Suggestion:**

**2016 PIP Validation Tool—<MCC>  
<PIP Topic>**

**Activity X: Assess for Sustained Improvement**

Describe any demonstrated improvement through repeated measurements over comparable time periods. Discuss any random, year-to-year variation, population changes or sampling errors that may have occurred during the remeasurement process.

Element #	C*	Sustained improvement strategies indicate that:	Met	Not Met	NA**	
1	<input type="checkbox"/>	Repeated measurements over comparable time periods demonstrate sustained improvement or that a decline in improvement is not statistically significant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Activity X Results:</b>			<b>Total</b>	<b>Met</b>	<b>Not Met</b>	<b>NA</b>
<b>All Elements</b>			1			
<b>Critical Elements</b>			0			
<b>Comment:</b>						
<b>Strength:</b>						
<b>AON:</b>						
<b>Suggestion:</b>						

2016 PIP Validation Tool—<MCC> <PIP Topic>				
Overall Results for PIP Study				
Overall Results:	Total	Met	Not Met	NA**
All Elements	XX	XX	XX	XX
Critical Elements	XX	XX	XX	XX

## ANA

The ANA tool templates are grouped by MCC and include all tools designed for MCOs and the DBM. The following were used to assess **Network Adequacy** and **Benefit Delivery** for TennCare’s MCOs and DBM as part of the 2016 ANA:

- ◆ ANA Questionnaires\* ([MCO](#) and [DBM](#))
- ◆ Evaluation Tools ([MCO](#) and [DBM](#))
- ◆ File Review Tools
  - Contract File Review Tools ([MCO](#) and [DBM](#))
  - Credentialing File Review Tools\*\* ([MCO](#) and [DBM](#))
  - [Recredentialing File Review Tools](#)\*\* (not used for **DQ**)
  - [CHOICES Credentialing File Review Tools](#)\*\* (not used for **BCW**, **TCS** or **DQ**)
  - [CHOICES Recredentialing File Review Tools](#)\*\* (not used for **TCS** or **DQ**)

\* Qsource has not edited or altered the ANA questionnaires.

\*\* These tools’ results were reported in the 2016 AQS Technical Papers and the 2016 AQS Summary Report.

**ANA Questionnaire: MCOs***«MCO\_Name»*

Please enter information requested.

General Information

Name of Managed Care Organization \_\_\_\_\_

Parent Organization \_\_\_\_\_

Mailing Address**Primary Street Mailing Address, Telephone Number and Fax Number:**

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

ZIP \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Website \_\_\_\_\_

**Address for Onsite Survey (if different from above):**

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

ZIP \_\_\_\_\_

Contact Information**Chief Executive  
Officer**

Prefix \_\_\_\_\_ First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Title \_\_\_\_\_  
 Address \_\_\_\_\_ Suite \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

**Contact for Survey**

Prefix \_\_\_\_\_ First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Title \_\_\_\_\_  
 Address \_\_\_\_\_ Suite \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

**Medical Director**

Prefix \_\_\_\_\_ First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Title \_\_\_\_\_  
 Address \_\_\_\_\_ Suite \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

Number of TennCare members assigned to your plan as of November 30, 2015:

\_\_\_\_\_

East Region–Network Standards

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

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

Specialist Service	Number of Non-Dual Members
Allergy and Immunology	100,000
Cardiology	20,000
Dermatology	40,000
Endocrinology	25,000
Gastroenterology	30,000
General Surgery	15,000
Nephrology	50,000
Neurology	35,000
Neurosurgery	45,000
Oncology/Hematology	80,000
Ophthalmology	20,000
Orthopedic Surgery	15,000
Otolaryngology	30,000
Urology	30,000
Optometry	Distance of 30 Miles
Psychiatry (Adult)	25,000
Psychiatry (Child/Adolescent)	150,000

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

Essential Hospital Service	Hospital Name
Neonatal	
Perinatal	
Pediatric	
Trauma	
Burn	

List the name of the CHOICES HCBS providers with whom you are contracted to provide assisted care living facility services.

CHOICES HCBS	Facility Name
Assisted-care living facility services	

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

CHOICES HCBS	Facility Name
Center of Excellence: HIV/AIDS	
Center of Excellence: HIV/AIDS	

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

CHOICES HCBS	Facility Name
Centers of Excellence: Behavioral Health	

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

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

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For *TennCareSelect* only: State your contracted COEs for children in or at risk of State custody and the timeframe of the contract (e.g., January 1, 2015 through December 31, 2015).

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East Region—Covered Services:

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

Yes       No

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

Yes       No

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

Yes       No

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

Yes       No

Section 2.11.6.1 of the Contractor Risk Agreement and the TennCareSelect Agreement included the requirement that your MCO contracts with all current nursing facilities (as defined in T.C.A. 71-5-1412[b]) that meet all the Centers for Medicare & Medicaid Services (CMS) certification requirements. Does your MCO have contracts with all current nursing facilities willing to contract with your MCO in the state?

Yes       No

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

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Middle Region–Network Standards

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

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

Specialist Service	Number of Non-Dual Members
Allergy and Immunology	100,000
Cardiology	20,000
Dermatology	40,000
Endocrinology	25,000
Gastroenterology	30,000
General Surgery	15,000
Nephrology	50,000
Neurology	35,000
Neurosurgery	45,000
Oncology/Hematology	80,000
Ophthalmology	20,000
Orthopedic Surgery	15,000
Otolaryngology	30,000
Urology	30,000
Optometry	Distance of 30 Miles
Psychiatry (Adult)	25,000
Psychiatry (Child/Adolescent)	150,000

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

Essential Hospital Service	Hospital Name
Neonatal	
Perinatal	
Pediatric	
Trauma	
Burn	

List the name of the CHOICES HCBS providers with whom you are contracted to provide assisted care living facility services.

CHOICES HCBS	Facility Name
Assisted-care living facility services	

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

CHOICES HCBS	Facility Name
Center of Excellence: HIV/AIDS	
Center of Excellence: HIV/AIDS	

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

CHOICES HCBS	Facility Name
Centers of Excellence: Behavioral Health	

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

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

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For *TennCareSelect* only: State your contracted COEs for children in or at risk of State custody and the timeframe of the contract (e.g., January 1, 2015 through December 31, 2015).

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Middle Region—Covered Services:

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

Yes       No

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

Yes       No

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

Yes       No

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

Yes       No

Section 2.11.6.1 of the Contractor Risk Agreement and the TennCareSelect Agreement included the requirement that your MCO contracts with all current nursing facilities (as defined in T.C.A. 71-5-1412[b]) that meet all the Centers for Medicare & Medicaid Services (CMS) certification requirements. Does your MCO have contracts with all current nursing facilities willing to contract with your MCO in the state?

Yes       No

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

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West Region–Network Standards

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

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

Specialist Service	Number of Non-Dual Members
Allergy and Immunology	100,000
Cardiology	20,000
Dermatology	40,000
Endocrinology	25,000
Gastroenterology	30,000
General Surgery	15,000
Nephrology	50,000
Neurology	35,000
Neurosurgery	45,000
Oncology/Hematology	80,000
Ophthalmology	20,000
Orthopedic Surgery	15,000
Otolaryngology	30,000
Urology	30,000
Optometry	Distance of 30 Miles
Psychiatry (Adult)	25,000
Psychiatry (Child/Adolescent)	150,000

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

Essential Hospital Service	Hospital Name
Neonatal	
Perinatal	
Pediatric	
Trauma	
Burn	

List the name of the CHOICES HCBS providers with whom you are contracted to provide assisted care living facility services.

CHOICES HCBS	Facility Name
Assisted-care living facility services	

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

CHOICES HCBS	Facility Name
Center of Excellence: HIV/AIDS	
Center of Excellence: HIV/AIDS	

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

CHOICES HCBS	Facility Name
Centers of Excellence: Behavioral Health	

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

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

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For *TennCareSelect* only: State your contracted COEs for children in or at risk of State custody and the timeframe of the contract (e.g., January 1, 2015 through December 31, 2015).

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West Region—Covered Services:

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

Yes       No

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

Yes       No

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

Yes       No

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

Yes       No

Section 2.11.6.1 of the Contractor Risk Agreement and the TennCareSelect Agreement included the requirement that your MCO contracts with all current nursing facilities (as defined in T.C.A. 71-5-1412[b]) that meet all the Centers for Medicare & Medicaid Services (CMS) certification requirements. Does your MCO have contracts with all current nursing facilities willing to contract with your MCO in the state?

Yes       No

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

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**Attestation Statement**

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

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Signature of CEO or responsible individual

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Date

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Print name and title

Please mail or scan and upload the signed attestation statement by **January 11, 2016** to:

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

Thank you for your prompt response.

**MCO Evaluation Tool**

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO*	Element	
				Value	Score
<b>Credentialing/Recredentialing</b>					
1. Written Policies and Procedures for Credentialing: Contracted/ Employed Providers  Contractor Risk Agreement (CRA) A.2.11.9 TennCareSelect Agreement (TSA) 2.11.9 NCQA CR1P7FP7†	The MCO has written credentialing policies and procedures that include the MCO’s initial credentialing for all providers with whom the MCO contracts or employs and who fall within its scope of authority and action.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
2. Written Policies and Procedures for Recredentialing: Contracted/ Employed Providers  CRA A.2.11.9 TSA 2.11.9 NCQA CR4	The MCO has written recredentialing policies and procedures that include the MCO’s recredentialing of all providers with whom the MCO contracts or employs and who fall within its scope of authority and action.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					

\* This column was submitted by the MCO to HSAG for review. HSAG has not altered the content or made grammatical corrections. This column does not include any attachments provided with the MCO tool.

† This tool was developed using the current MCO contract and the NCQA 2015 Health Plan Accreditation Standards and Guidelines for Credentialing.

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO*	Element	
				Value	Score
<b>Credentialing/Recredentialing</b>					
3. Credentialing Committee NCQA CR2	There is written documentation that a credentialing committee or other peer review body that includes the medical director or designated physician is designated by the MCO to make recommendations regarding credentialing decisions.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
4. Credentialing Prior to Providing Services NCQA CR2	Written credentialing policies and procedures include the statement that practitioners are credentialed prior to providing care to TennCare MCO members.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
5. Recredentialing Timeline NCQA CR4	Written recredentialing policies and procedures include the statement that practitioners are recredentialed at least every 36 months.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
6. Provisional Credentialing NCQA CR1	The organization has policies and procedures concerning the use of provisional credentialing for practitioners	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA <sup>‡</sup>		1.0	0.0

<sup>‡</sup> Responses found to be not applicable (NA) do not receive a point value and are not counted against the MCO.

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO*	Element	
				Value	Score
<b>Credentialing/Recredentialing</b>					
	applying to the organization for the first time.				
<b>Findings:</b>					
<b>Recommendations:</b>					
7. Length of Provisional Credentialing NCQA CR1	If the organization uses provisional credentialing, a practitioner may not be in provisional status for more than 60 calendar days.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
8. Documents Required for Provisional Credentialing NCQA CR1	If the MCO uses provisional credentialing, the following documents are obtained prior to the MCO granting provisional credentialing privileges: a. Primary-source verification of a current, valid license to practice b. Primary-source verification of the past five years of malpractice claims or settlements from the malpractice carrier, the National Practitioner Data Bank (NPDB) c. Current, signed application with the attestation d. The MCO follows the same process for presenting provisionally credentialed files to the credentialing committee or medical director as it does for its regular credentialing process.	a. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA b. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA c. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA d. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA Each Variable = .25		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO*	Element	
				Value	Score
<b>Credentialing/Recredentialing</b>					
<b>Findings:</b>					
<b>Recommendations:</b>					
9. Site Visits Generated by a Complaint  NCQA CR5	The plan monitors member complaints concerning practitioner sites and conducts site visits at offices that have met a reasonable complaint threshold.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
10. Delegated Credentialing Policies and Procedures  NCQA CR9	If credentialing and recredentialing activities are delegated, the MCO has a written policy and procedure describing the delegated credentialing activities.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
11. Delegated Credentialing Accountability  NCQA CR9	If credentialing and recredentialing activities are delegated, the agreement specifies that reporting is at least semi-annual, and the information to be reported by the delegate about the delegated activities.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
12. Delegated Credentialing Reporting	If credentialing and recredentialing activities are delegated, there is evidence (through the review of MCO reports,	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO*	Element	
				Value	Score
<b>Credentialing/Recredentialing</b>					
CRA A.2.26.1.4 TSA 2.26.1.4	policies and procedures and minutes) that the effectiveness of the delegated entity's credentialing/recredentialing process is monitored on an annual basis.				
<b>Findings:</b>					
<b>Recommendations:</b>					
13. Nondelegated Credentialing Activities NCQA CR1	If the MCO does not delegate credentialing activities, the credentialing policies and procedures explicitly specify that the MCO does not delegate credentialing activities.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
14. Nondiscrimination in Credentialing and Recredentialing NCQA CR1	Credentialing policies and procedures concerning nondiscrimination explicitly specify that the organization does not base credentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) in which the practitioner specializes.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
15. Monitoring to Prevent Discrimination in Credentialing and Recredentialing	Credentialing policies and procedures concerning nondiscrimination explicitly specify the steps that the organization takes to annually monitor for and prevent	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO*	Element	
				Value	Score
<b>Credentialing/Recredentialing</b>					
NCQA CR1	discriminatory practices during the credentialing and recredentialing process.				
<b>Findings:</b>					
<b>Recommendations:</b>					
16. Restricting, Suspending or Terminating Privileges NCQA CR7	Through the review of policies, procedures or provider files, there is evidence of the MCO’s mechanism for restricting, suspending or terminating the privileges of practitioners whose conduct could adversely affect members’ health or welfare.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
17. Reporting Quality Deficiencies NCQA CR7	Through the review of policies, procedures or provider files, there is evidence that the MCO notifies appropriate State or other authorities when a practitioner’s privileges are suspended or terminated.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
18. Notification of Denial to TennCare CRA A.2.11.9.1.4 TSA 2.11.9.1.4 NCQA CR7	Policies state that when the MCO denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons, the MCO notifies TennCare.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO*	Element	
				Value	Score
<b>Credentialing/Recredentialing</b>					
<b>Findings:</b>					
<b>Recommendations:</b>					
19. Confidentiality NCQA CR1	The MCO’s credentialing policies and procedures clearly specify that the information obtained in the credentialing process is confidential.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
20. Provider Appeals Processes NCQA CR7	The MCO has written policies and procedures for providers to appeal determinations that suspend or terminate a provider’s privileges.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
21. Provider Notification NCQA CR7	When provider privileges are suspended or terminated, there is evidence of written notification to the provider that includes the reasons for the action (see letter to provider).	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
22. Provider Appeal Rights NCQA CR7	When provider privileges are suspended or terminated, there is evidence of written notification to the provider that includes the appeal rights and process (see letter to provider).	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO*	Element	
				Value	Score
<b>Credentialing/Recredentialing</b>					
<b>Findings:</b>					
<b>Recommendations:</b>					
23. Unlicensed BH Providers CRA A.2.11.9.3.2 TSA 2.11.9.3.2	When individuals providing behavioral health treatment services are not required to be licensed or certified, the MCO ensures, based on applicable State license rules and/or program standards, that the individuals are: a. Appropriately educated b. Trained c. Qualified d. Competent to perform their job responsibilities	a. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA b. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA c. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA d. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA Each Variable = .25		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
24. Credentialing Timeline CRA A.2.11.9.1.2 TSA 2.11.9.1.2	The MCO completely processes credentialing applications within 30 calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. Completely processed means that the MCO has approved and loaded approved applicants into the provider files in its claims processing system or denied the application.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO*	Element	
				Value	Score
<b>Credentialing/Recredentialing</b>					
<b>Recommendations:</b>					
25. Credentialing Timeline for Delegated Vendors  CRA A.2.11.91.3 TSA 2.11.91.3	The MCO ensures that all providers submitted to the MCO from the delegated credentialing agent are loaded to its provider files and into its claims processing system within 30 calendar days of receipt.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
26. Credentialing and Recredentialing CHOICES (Home and Community Based-Services) (HCBS) Providers  CRA A.2.11.9.4.1.1 TSA 2.11.9.4.1.1	The MCO developed policies and procedures to credential and recredential long-term care providers that included the frequency and ongoing monitoring activities for each HCBS provider type.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
27. Frequency of Recredentialing for Ongoing CHOICES HCBS Providers  CRA A.2.11.9.4.1.1.1 TSA 2.11.9.4.1.1.1	The MCO had policies and procedures to ensure that the MCO recredentials the ongoing CHOICES HCBS providers at least annually. (Ongoing HCBS include community-based residential alternatives, personal care, attendant care, homemaker services, home-delivered meals, Personal Emergency Response System [PERS] and/or adult day care.)	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO*	Element	
				Value	Score
<b>Credentialing/Recredentialing</b>					
<b>Findings:</b>					
<b>Recommendations:</b>					
28. Background Checks Conducted by CHOICES HCBS Providers  CRA A.2.11.9.4.1.2.4 TSA 2.11.9.4.1.2.4	The MCO had policies and procedures to ensure that during credentialing of CHOICES HCBS providers, the MCO verified that the CHOICES HCBS providers had policies and procedures that described the requirement to conduct criminal background checks for prospective employees to include: a. Tennessee Abuse Registry b. Tennessee Felony Offender Registry c. National and Tennessee Sexual Offender Registry d. List of Excluded Individuals/Entities (LEIE)	a. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA b. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA c. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA d. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA  Each Variable = .25		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
29. Initial and Ongoing Education Conducted by CHOICES HCBS Providers  CRA A.2.11.9.4.1.2.5 TSA 2.11.9.4.1.2.5	The MCO had policies and procedures to ensure that during credentialing of CHOICES HCBS providers, the MCO verified that CHOICES HCBS providers had a process in place to conduct and document initial and ongoing education for employees who provided services to CHOICES members to include: a. Person-centered supports for the elderly and disabled population	a. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA b. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA c. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO*	Element	
				Value	Score
<b>Credentialing/Recredentialing</b>					
	b. Abuse and neglect prevention, identification and reporting c. Critical incident reporting d. Documentation of service delivery e. Use of the Electronic Visit Verification (EVV) System f. Other training requirements specified by TennCare	d. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA e. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA f. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA Variables a - d = .167 Variables e & f = .166			
<b>Findings:</b>					
<b>Recommendations:</b>					
30. Provider Policies and Processes Concerning Critical Incident Reporting for CHOICES HCBS Providers  CRA A.2.11.9.4.1.2.6 TSA 2.11.9.4.1.2.6	The MCO had policies and procedures to confirm that during the credentialing of CHOICES HCBS providers, the MCO verified that the CHOICES HCBS providers had policies and procedures to ensure that the providers complied with: a. The MCO’s critical incident reporting and management process b. Appropriate use of the EVV system	a. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA b. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA Each Variable = .50		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
31. Recredentialing Verifications for	The MCO had policies and procedures in place to ensure that the recredentialing of HCBS providers included:	a. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO*	Element	
				Value	Score
<b>Credentialing/Recredentialing</b>					
CHOICES HCBS Providers CRA A.2.11.9.4.1.3 TSA 2.11.9.4.1.3	a. Verification of licensure/certification b. Verification Background checks c. Verification of training requirements d. Verification of critical incident reporting and management e. Verification of the use of the EVV	b. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA c. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA d. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA e. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA Each Variable=.20			
<b>Findings:</b>					
<b>Recommendations:</b>					
32. Site Visits for CHOICES HCBS Providers CRA A.2.11.9.4.1.4 TSA 2.11.9.4.1.4	The MCO had policies and procedures to ensure that the MCO conducted a site visit for CHOICES HCBS providers for both credentialing and recredentialing, unless the provider was located out of State. If the provider was located out of State, the site visit may be waived if documentation concerning the reason for not completing the site visit was included in the provider’s file.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO*	Element	
				Value	Score
<b>Credentialing/Recredentialing</b>					
33. Monthly Verification of CHOICES HCBS Providers CRA A.2.11.9.4.1.5 TSA 2.11.9.4.1.5	The MCO had policies and procedures to ensure that the MCO conducted monthly checks to ensure that the CHOICES HCBS providers had not been excluded from participation in Medicare, Medicaid or the State Children’s Health Insurance Program (SCHIP).	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
<b>Standard Score for Credentialing/Recredentialing</b>			<###>%	33.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO <sup>5</sup>	Element	
				Value	Score
<b>Standards for Availability and Accessibility</b>					
1. Informing Members of Emergency Medical Services CRA A.2.7.1.1 TSA 2.7.1.1 TCA 56-7-2356(a)(1)	There is evidence through a review of policies and procedures and the member handbook that members are informed that emergency medical services are available at any available emergency care facility 24 hours a day, 7 days a week (including services outside the usual service area).	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
2. Informing Providers of Emergency Medical Services CRA A.2.7.1.1 TSA 2.7.1.1 TCA 56-7-2356(a)(1)	There is evidence through a review of policies and procedures and the provider manual that providers are informed that emergency medical services are available at any available emergency care facility 24 hours a day, 7 days a week (including services outside the usual service area).	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					

<sup>5</sup> This column was submitted by the MCO to HSAG for review. HSAG has not altered the content or made grammatical corrections. This column does not include any attachments provided with the MCO tool.

2016 Annual Network Adequacy—Evaluation Tool MCO																																						
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO <sup>5</sup>	Element																																		
				Value	Score																																	
<b>Standards for Availability and Accessibility</b>																																						
3. Maximum Members per Provider  CRA Attachment IV TSA Attachment IV	The MCO has processes and procedures in place to ensure that ratios of non-dual-eligible members to providers remain below the following maximum limits:	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0																																	
	<table border="1"> <thead> <tr> <th>Specialty</th> <th>Number of Non-dual Members</th> </tr> </thead> <tbody> <tr><td>Allergy Immunology</td><td>100,000</td></tr> <tr><td>Cardiology</td><td>20,000</td></tr> <tr><td>Dermatology</td><td>40,000</td></tr> <tr><td>Endocrinology</td><td>25,000</td></tr> <tr><td>Gastroenterology</td><td>30,000</td></tr> <tr><td>General Surgery</td><td>15,000</td></tr> <tr><td>Nephrology</td><td>50,000</td></tr> <tr><td>Neurology</td><td>35,000</td></tr> <tr><td>Neurosurgery</td><td>45,000</td></tr> <tr><td>Oncology/Hematology</td><td>80,000</td></tr> <tr><td>Ophthalmology</td><td>20,000</td></tr> <tr><td>Orthopedic Surgery</td><td>15,000</td></tr> <tr><td>Otolaryngology</td><td>30,000</td></tr> <tr><td>Psychiatry (Adult)</td><td>25,000</td></tr> <tr><td>Psychiatry (Child and Adolescent)</td><td>150,000</td></tr> <tr><td>Urology</td><td>30,000</td></tr> </tbody> </table>	Specialty	Number of Non-dual Members	Allergy Immunology	100,000	Cardiology	20,000	Dermatology	40,000	Endocrinology	25,000	Gastroenterology	30,000	General Surgery	15,000	Nephrology	50,000	Neurology	35,000	Neurosurgery	45,000	Oncology/Hematology	80,000	Ophthalmology	20,000	Orthopedic Surgery	15,000	Otolaryngology	30,000	Psychiatry (Adult)	25,000	Psychiatry (Child and Adolescent)	150,000	Urology	30,000			
	Specialty	Number of Non-dual Members																																				
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<b>Findings:</b>																																						

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO <sup>5</sup>	Element	
				Value	Score
<b>Standards for Availability and Accessibility</b>					
<b>Recommendations:</b>					
4. Appointment/Wait Times for PCPs CRA Attachment III TSA Attachment III	Through a review of provider contracts and policies and procedures, there is evidence that the MCO requires that providers offer adequate access to covered services. At a minimum, access standards must specify that primary care wait times: a. Do not exceed 3 weeks for a regular appointment b. Do not exceed 48 hours for an urgent care appointment c. Do not exceed 45 minutes from time of arrival	a. <input type="checkbox"/> Met <input type="checkbox"/> Not Met b. <input type="checkbox"/> Met <input type="checkbox"/> Not Met c. <input type="checkbox"/> Met <input type="checkbox"/> Not Met Variables a & b = .33 Variable c = .34		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
5. Appointment/Wait Times for SCPs CRA Attachment III TSA Attachment III	Through a review of provider contracts and policies and procedures, there is evidence that the MCO requires that providers offer adequate access to covered services. At a minimum, access standards must specify that referral appointments to SCPs: a. Do not exceed 30 days for routine care b. Do not exceed 48 hours for urgent care	a. <input type="checkbox"/> Met <input type="checkbox"/> Not Met b. <input type="checkbox"/> Met <input type="checkbox"/> Not Met c. <input type="checkbox"/> Met <input type="checkbox"/> Not Met Variables a & b = .33 Variable c = .34		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO <sup>5</sup>	Element	
				Value	Score
<b>Standards for Availability and Accessibility</b>					
	c. Do not exceed a 45-minute maximum wait time from time of arrival				
<b>Findings:</b>					
<b>Recommendations:</b>					
6. Appointment/Wait Times for Optometry CRA Attachment III TSA Attachment III	Through a review of provider contracts and policies and procedures, there is evidence that the MCO requires that providers offer adequate access to covered services. At a minimum, access standards must specify that optometry wait times: a. Do not exceed 3 weeks for a regular appointment b. Do not exceed 48 hours for an urgent appointment c. Do not exceed 45 minutes	a. <input type="checkbox"/> Met <input type="checkbox"/> Not Met b. <input type="checkbox"/> Met <input type="checkbox"/> Not Met c. <input type="checkbox"/> Met <input type="checkbox"/> Not Met Variables a & b = .33 Variable c = .34		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
7. Timeliness Standards for Access to BH Services CRA Attachment V TSA Attachment V	The MCO has standards for timeliness of access to BH services. There is evidence (policies and procedures, a review of quality improvement activities, or a report) that the MCO continually monitors its compliance	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA <sup>6</sup>		1.0	0.0

<sup>6</sup> Responses found to be not applicable (NA) do not receive a point value and are not counted against the MCO.

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO <sup>5</sup>	Element	
				Value	Score
<b>Standards for Availability and Accessibility</b>					
	with these standards and takes corrective action as necessary.				
<b>Findings:</b>					
<b>Recommendations:</b>					
8. Standards for Timely Access to Psychiatric Inpatient Hospital Services CRA Attachment V TSA Attachment V	The BH standards include access standards for psychiatric inpatient hospital services within: a. 4 hours (emergency, involuntary) b. 24 hours (involuntary) c. 24 hours (voluntary)	a. <input type="checkbox"/> Met <input type="checkbox"/> Not Met b. <input type="checkbox"/> Met <input type="checkbox"/> Not Met c. <input type="checkbox"/> Met <input type="checkbox"/> Not Met Variables a & b = .33 Variable c = .34		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
9. Standards for Timely Access to 24-Hour Psychiatric Residential Treatment CRA Attachment V TSA Attachment V	The BH standards include access standards for 24-hour psychiatric residential treatment within 30 calendar days.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
10. Standards for Timely Access to Outpatient (Non-MD) and Intensive	The BH standards include access standards for outpatient mental health services, including non-MD	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO <sup>5</sup>	Element	
				Value	Score
<b>Standards for Availability and Accessibility</b>					
Outpatient Services CRA Attachment V TSA Attachment V	and intensive outpatient (may include day treatment [adult], intensive day treatment [children and adolescents] or partial hospitalization), within 10 business days, and within 48 hours if urgent.				
<b>Findings:</b>					
<b>Recommendations:</b>					
11. Standards for Timely Access to Inpatient Substance Abuse Services CRA Attachment V TSA Attachment V	The BH standards include access standards for inpatient substance abuse services: a. Within 2 calendar days b. Within 4 hours in an emergency for detoxification c. Within 24 hours for a nonemergency for detoxification	a. <input type="checkbox"/> Met <input type="checkbox"/> Not Met b. <input type="checkbox"/> Met <input type="checkbox"/> Not Met c. <input type="checkbox"/> Met <input type="checkbox"/> Not Met Variables a & b = .33 Variable c = .34		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
12. Access Standards for Timely Access to 24-Hour Residential Substance Abuse Services CRA Attachment V TSA Attachment V	The BH standards include access standards for 24-hour residential substance abuse services within 10 business days.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO <sup>5</sup>	Element	
				Value	Score
<b>Standards for Availability and Accessibility</b>					
<b>Recommendations:</b>					
13. Access Standards for Timely Access to Outpatient Substance Abuse Services  CRA Attachment V TSA Attachment V	The BH standards include access standards for outpatient substance abuse treatment: a. Within 10 business days b. Within 24 hours for detoxification	a. <input type="checkbox"/> Met <input type="checkbox"/> Not Met b. <input type="checkbox"/> Met <input type="checkbox"/> Not Met Each Variable=.50		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
14. Access Standards for Timely Access to Mental Health Case Management  CRA Attachment V TSA Attachment V	The BH standards include access standards for mental health case management within 7 calendar days.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
15. Access Standards for Timely Access to Psychosocial Rehabilitation  CRA Attachment V TSA Attachment V	The BH standards include access standards for psychosocial rehabilitation within 10 business days.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO <sup>5</sup>	Element	
				Value	Score
<b>Standards for Availability and Accessibility</b>					
16. Access Standards for Timely Access to Supported Employment  CRA Attachment V TSA Attachment V	The BH standards include access standards for supported employment within 10 business days.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
17. Access Standards for Timely Access to Peer Recovery Services or Family Support  CRA Attachment V TSA Attachment V	The BH standards include access standards for peer support within 10 business days.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
18. Access Standards for Timely Access to Illness Management and Recovery  CRA Attachment V TSA Attachment V	The BH standards include access standards for illness management and recovery within 10 business days.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO <sup>5</sup>	Element	
				Value	Score
<b>Standards for Availability and Accessibility</b>					
19. Standards for Timely Access to Mobile Crisis Services CRA Attachment V TSA Attachment V	The BH standards include access standards for BH crisis services (mobile), which includes face-to-face contact: a. Within 2 hours for emergency situations b. Within 4 hours for urgent situations	a. <input type="checkbox"/> Met <input type="checkbox"/> Not Met b. <input type="checkbox"/> Met <input type="checkbox"/> Not Met Each Variable=.50		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
20. Standards for Timely Access to Crisis Stabilization CRA Attachment V TSA Attachment V	The BH standards include access standards for crisis stabilization within 4 hours of the referral.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
21. Standards for Timely Access to Supported Housing CRA Attachment V TSA Attachment V	The BH standards include access standards for supported housing within 30 calendar days.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO <sup>5</sup>	Element	
				Value	Score
<b>Standards for Availability and Accessibility</b>					
22. Geographic Access Requirements CRA Attachments III & V TSA Attachments III & V	The MCO has standards for geographic access to care. There is evidence (through policies and procedures and a review of quality improvement activities or reports) that the MCO continually monitors its compliance with these standards and takes corrective action as necessary.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
23. Geographic Access Requirements for Psychiatric Inpatient Hospital Services CRA Attachment V TSA Attachment V	The BH standards include access standards for psychiatric inpatient hospital services:  Travel distance does not exceed 90 miles for at least 90 percent of members.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
24. Geographic Access Requirements for Adult, 24-Hour Psychiatric Residential Treatment CRA Attachment V TSA Attachment V	The BH standards include access standards for adult, 24-hour psychiatric residential treatment:  The MCO contracts with at least one provider of service in each grand region (three statewide) for adult members.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO <sup>5</sup>	Element	
				Value	Score
<b>Standards for Availability and Accessibility</b>					
<b>Recommendations:</b>					
25. Geographic Access Requirements for Child, 24-Hour Psychiatric Residential Treatment  CRA Attachment V TSA Attachment V	The BH standards include access standards for child, 24-hour psychiatric residential treatment:  Travel distance does not exceed 60 miles for at least 75 percent of child members and does not exceed 90 miles for at least 90 percent of child members.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
26. Geographic Access Requirements for Outpatient Non-MD Behavioral Health Services  CRA Attachment V TSA Attachment V	The BH standards include access standards for outpatient mental health services:  Travel distance for non-MD services does not exceed 30 miles for all members.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO <sup>5</sup>	Element	
				Value	Score
<b>Standards for Availability and Accessibility</b>					
27. Geographic Access Requirements for Intensive Outpatient Behavioral Health Services  CRA Attachment V TSA Attachment V	The BH standards include access standards for intensive outpatient (may include day treatment [adults], intensive day treatment [children and adolescents] or partial hospitalization):  Travel distance does not exceed 90 miles for at least 90 percent of members.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
28. Geographic Access Requirements for Inpatient Substance Abuse Services  CRA Attachment V TSA Attachment V	The BH standards include access standards for inpatient substance abuse services:  Travel distance does not exceed 90 miles for at least 90 percent of members.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
29. Geographic Access Requirements for 24-Hour Residential Substance Abuse Services—Adult Members  CRA Attachment V TSA Attachment V	The BH standards include access standards for 24-Hour Residential Treatment Services:  The MCO contracts with at least one provider of service in each grand region (three statewide) for adult members.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO <sup>5</sup>	Element	
				Value	Score
<b>Standards for Availability and Accessibility</b>					
<b>Findings:</b>					
<b>Recommendations:</b>					
30. Geographic Access Requirements for 24-Hour Residential Substance Abuse Services—Child Members  CRA Attachment V TSA Attachment V	The BH standards include access standards for 24-Hour Residential Treatment Services:  The MCO contracts with at least one provider of service in each grand region (three statewide) for child members.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
31. Geographic Access Requirements for Outpatient Treatment for Substance Abuse  CRA Attachment V TSA Attachment V	The BH standards include access standards for outpatient treatment:  Travel distance does not exceed 30 miles for all members.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
32. Monthly Provider Enrollment File  CRA A.2.30.8.1 TSA 2.30.8.1	The MCO submits a monthly Provider Enrollment File report.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO <sup>5</sup>	Element	
				Value	Score
<b>Standards for Availability and Accessibility</b>					
<b>Recommendations:</b>					
33. Quarterly Reporting Requirements CRA A.2.30.8.3 CRA A.2.30.8.6 TSA 2.30.8.3 TSA 2.30.8.6	The MCO submits the following required quarterly reports: a. PCP Assignment Report b. BH Appointment Timeliness Summary Report	a. <input type="checkbox"/> Met <input type="checkbox"/> Not Met b. <input type="checkbox"/> Met <input type="checkbox"/> Not Met Each Variable= .50		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
34. Annual Reporting Requirements CRA A.2.30.8.2 CRA A.2.30.8.4-5 CRA A.2.30.8.7-8 TSA 2.30.8.2 TSA 2.30.8.4-5 TSA 2.30.8.7-8	The MCO submits the following required annual reports: a. Provider Compliance With Access Requirements Reports b. Report of Essential Hospital Services by September 1 of each year c. CHOICES Qualified Workforce Strategies Report d. Federally Qualified Health Center (FQHC) Report by January 1 of each year e. Monitoring of Behavioral Health Appointment Timeliness	a. <input type="checkbox"/> Met <input type="checkbox"/> Not Met b. <input type="checkbox"/> Met <input type="checkbox"/> Not Met c. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA d. <input type="checkbox"/> Met <input type="checkbox"/> Not Met e. <input type="checkbox"/> Met <input type="checkbox"/> Not Met Each Variable= .20		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by MCO <sup>5</sup>	Element	
				Value	Score
<b>Standards for Availability and Accessibility</b>					
35. Appointments Scheduling CRA Attachment III TSA Attachment III	There is evidence through a review of policies, procedures, committee minutes or reports that the MCO has a system in place to evaluate providers' compliance with appointment scheduling times (e.g., cold calling).	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
36. Exchange of Information CRA Attachment III TSA Attachment III	There is evidence that the MCO has a system in place to document exchange of member information if a provider, other than the PCP, provides healthcare (e.g., a school-based clinic or health department clinic).	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
37. PCP Selection CRA A.2.11.2.6 TSA 2.11.2.7	The MCO has written policies and procedures establishing that members can change PCPs at least every 12 months or more frequently for good cause. A definition of good cause and the procedure to request a PCP change shall be included in the policy and procedure.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
<b>Standard Score for Availability and Accessibility</b>			<###>%	37.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>7</sup>	Documentation/Evidence as Provided by MCO <sup>8</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Member (Evidence of benefits located in the member handbook, explanation of benefits or another location described.)</b>					
1. Inpatient Hospital Services CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary  Under age 21: Includes rehabilitation hospital facility  Age 21 and older: Inpatient rehabilitation hospital facility services are not covered for adults unless determined to be a cost effective alternative.	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
2. Outpatient Hospital Services CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
3. Physician Inpatient Services CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0

<sup>7</sup> Check appropriate box for location of benefit. Only one checked box is necessary for a full score.

<sup>8</sup> This column was submitted by the MCO to HSAG for review. HSAG has not altered the content or made grammatical corrections. This column does not include any attachments provided with the MCO tool.

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>7</sup>	Documentation/Evidence as Provided by MCO <sup>8</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Member (Evidence of benefits located in the member handbook, explanation of benefits or another location described.)</b>					
<b>Findings:</b>					
<b>Recommendations:</b>					
4. Physician Outpatient Services/ Community Health Clinic Services/ Other Clinic Services  CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
5. Lab and X-Ray Services  CRA A.2.6.1.3 CRA A.2.6.1.4 TSA 2.6.1.3 TSA 2.6.1.4	As medically necessary	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
6. Maternity/ Postpartum Services  TCA 56-7-2350	As medically necessary	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>7</sup>	Documentation/Evidence as Provided by MCO <sup>8</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Member (Evidence of benefits located in the member handbook, explanation of benefits or another location described.)</b>					
<b>Recommendations:</b>					
7. Hospice Care CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary (must be provided by a Medicare-Certified Hospice Program)	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
8. Vision Services CRA A.2.6.1.3 TSA 2.6.1.3	Preventive, diagnostic and treatment services (including eyeglasses) for members younger than 21 years of age as medically necessary in accordance with TennCare Kids requirements. One pair of cataract glasses or lenses following cataract surgery is covered for adults. Medical eye care, meaning evaluation and management of abnormal conditions, diseases and disorders of the eye, is covered as medically necessary.	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
9. Home Healthcare CRA A.2.6.1.3 TSA 2.6.1.3	Covered as medically necessary for those younger or older than 21 years of age in accordance with the definition of home health care in the Tennessee rules	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>7</sup>	Documentation/Evidence as Provided by MCO <sup>8</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Member (Evidence of benefits located in the member handbook, explanation of benefits or another location described.)</b>					
<b>Recommendations:</b>					
10. Durable Medical Equipment CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
11. Medical Supplies CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
12. Emergency Air and Ground Ambulance Transportation CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
13. Nonemergency Transportation, Including Nonemergency	Nonemergency transportation services are provided in accordance with federal law and the Bureau of TennCare’s rules and policies and procedures. Nonemergency	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>7</sup>	Documentation/Evidence as Provided by MCO <sup>8</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Member (Evidence of benefits located in the member handbook, explanation of benefits or another location described.)</b>					
Ambulance Transportation CRA A.2.6.1.3 TSA 2.6.1.3	transportation services are provided to convey members to and from TennCare covered services.				
<b>Findings:</b>					
<b>Recommendations:</b>					
14. Renal Dialysis Services CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
15. TennCare Kids Services CRA A.2.6.1.3 TSA 2.6.1.3	Services for members younger than 21 years of age: a. As medically necessary, except that screenings do not have to be medically necessary b. Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal and state requirements	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
16. Preventive Care Services	The MCO provides preventive services which include, but are not limited to, initial and periodic evaluations, family	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>7</sup>	Documentation/Evidence as Provided by MCO <sup>8</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Member (Evidence of benefits located in the member handbook, explanation of benefits or another location described.)</b>					
CRA A.2.7.5.1 TSA 2.7.5.1	planning services, prenatal care, laboratory services and immunizations in accordance with TennCare rules and regulations.	<input type="checkbox"/> Other (Describe)			
<b>Findings:</b>					
<b>Recommendations:</b>					
17. Occupational Therapy CRA A.2.6.1.3 TSA 2.6.1.3	<b>Occupational Therapy:</b> a. Age 21 and older, as medically necessary, when provided by a licensed occupational therapist to restore, improve or stabilize impaired functions b. Younger than age 21, as medically necessary, in accordance with TennCare Kids requirements	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
18. Physical Therapy CRA A.2.6.1.3 TSA 2.6.1.3	<b>Physical Therapy:</b> a. Age 21 and older, as medically necessary, when provided by a licensed physical therapist to restore, improve or stabilize impaired functions b. Younger than age 21, as medically necessary, in accordance with TennCare Kids requirements	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>7</sup>	Documentation/Evidence as Provided by MCO <sup>8</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Member (Evidence of benefits located in the member handbook, explanation of benefits or another location described.)</b>					
<b>Recommendations:</b>					
19. Chiropractic Services CRA A.2.6.1.3 TSA 2.6.1.3	<b>Chiropractic Services:</b> a. Age 21 and older, covered when determined to be a cost-effective alternative by the MCO b. Younger than age 21, covered as medically necessary in accordance with TennCare Kids requirements	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
20. Private Duty Nursing CRA A.2.6.1.3 TSA 2.6.1.3	Private duty nursing is covered as medically necessary in accordance with the definition of private duty nursing in the Tennessee rules.	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
21. Speech Therapy CRA A.2.6.1.3 TSA 2.6.1.3	<b>Speech Therapy:</b> a. Age 21 and older, as medically necessary, when provided by a licensed speech therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder.	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>7</sup>	Documentation/Evidence as Provided by MCO <sup>8</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Member (Evidence of benefits located in the member handbook, explanation of benefits or another location described.)</b>					
	b. Younger than age 21, as medically necessary in accordance with TennCare Kids requirements				
<b>Findings:</b>					
<b>Recommendations:</b>					
22. Organ and Tissue Transplants and Donor Organ Procurement CRA A.2.6.1.3 TSA 2.6.1.3	<b>Organ and Tissue Transplants and Donor Organ Procurement:</b> a. Age 21 and older, all medically necessary and non-investigational/ experimental organ and tissue transplants, as covered by Medicare b. Younger than age 21, covered as medically necessary in accordance with TennCare requirements	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
23. Reconstructive Breast Surgery CRA A.2.6.1.3 TSA 2.6.1.3	Reconstructive Breast Surgery is covered in accordance with TCA 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as any surgical procedure on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a nondiseased breast will only be	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>7</sup>	Documentation/Evidence as Provided by MCO <sup>8</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Member (Evidence of benefits located in the member handbook, explanation of benefits or another location described.)</b>					
	covered if the surgical procedure performed on a nondiseased breast occurs within five years of the date the reconstructive breast surgery was performed on a diseased breast.				
<b>Findings:</b>					
<b>Recommendations:</b>					
24. Mammography Screening TCA 56-7-2502	The MCO provides mammography screenings a minimum of once for ages 35–40, every two years or more frequently on physician recommendation for ages 40–50 and annually for ages 50 and older.	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
25. Phenylketonuria (PKU) TCA 56-7-2505 <XXXX> MCO Provider Network Adequacy and Benefit Delivery Review Questionnaire	The MCO provides coverage for the treatment of PKU, including licensed professional medical services and special dietary formulas.	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
26. Diabetic Services TCA 56-7-2605 <XXXX> MCO Provider Network Adequacy and	The MCO provides coverage for diabetic equipment, supplies and outpatient self-management training and education, including medical	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>7</sup>	Documentation/Evidence as Provided by MCO <sup>8</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Member (Evidence of benefits located in the member handbook, explanation of benefits or another location described.)</b>					
Benefit Delivery Review Questionnaire	nutrition counseling, when medically necessary.				
<b>Findings:</b>					
<b>Recommendations:</b>					
27. Chlamydia Screens  TCA 56-7-2606 <XXXX> MCO Provider Network Adequacy and Benefit Delivery Review Questionnaire	The MCO provides for one annual chlamydia screening test in conjunction with an annual Pap smear for females who are not more than 29 years of age, if deemed medically necessary.	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
28. Psychiatric Inpatient Hospital Services (Including Physician Services)  CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
29. Outpatient Mental Health Services, Including	As medically necessary	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>7</sup>	Documentation/Evidence as Provided by MCO <sup>8</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Member (Evidence of benefits located in the member handbook, explanation of benefits or another location described.)</b>					
Physician Services CRA A.2.6.1.4 TSA 2.6.1.4					
<b>Findings:</b>					
<b>Recommendations:</b>					
30. Inpatient/ Residential and Outpatient Substance Abuse BenefitsP11FP11 F <sup>9</sup> CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary for those younger than 21 years of age. For those 21 years of age and older: limited to 10 days detoxification and \$30,000 in medically necessary lifetime benefits, unless otherwise described in the 2008 Mental Health Parity Act, as determined by TennCare.	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
31. 24-Hour Psychiatric Residential Treatment CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					

<sup>9</sup> When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services. Methadone clinic services are not covered for adults.

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>7</sup>	Documentation/Evidence as Provided by MCO <sup>8</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Member (Evidence of benefits located in the member handbook, explanation of benefits or another location described.)</b>					
<b>Recommendations:</b>					
32. BH Crisis Services CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
33. Mental Health Case Management CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
34. Psychiatric Rehabilitation Services CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
35. CHOICES: Nursing Facility Care CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary: For CHOICES members in Group 1; and on a short-term basis only (up to 90 days) for members in CHOICES Group 2 and Group 3	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>7</sup>	Documentation/Evidence as Provided by MCO <sup>8</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Member (Evidence of benefits located in the member handbook, explanation of benefits or another location described.)</b>					
		<input type="checkbox"/> NA <sup>10</sup>			
<b>Findings:</b>					
<b>Recommendations:</b>					
36. CHOICES: Community-Based Residential Alternatives  CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary for CHOICES members in Group 2	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe) <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
37. CHOICES: Personal Care Visits  CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to two visits per day at intervals of no less than 4 hours between visits) for CHOICES members in Group 2 and Group 3	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe) <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
38. CHOICES: Attendant Care  CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to 1,080 hours per calendar year; up to 1,400 hours per full calendar year only for persons who require covered assistance with household chores or	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe) <input type="checkbox"/> NA		1.0	0.0

<sup>10</sup> Responses found to be not applicable (NA) do not receive a point value and are not counted against the MCO.

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>7</sup>	Documentation/Evidence as Provided by MCO <sup>8</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Member (Evidence of benefits located in the member handbook, explanation of benefits or another location described.)</b>					
	errands in addition to hands-on assistance with self-care tasks) for CHOICES members in Group 2 and Group 3				
<b>Findings:</b>					
<b>Recommendations:</b>					
39. CHOICES: Home-Delivered Meals CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to one meal per day) for CHOICES members in Group 2 and Group 3	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe) <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
40. CHOICES: PERS CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary for CHOICES members in Group 2 and Group 3	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe) <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
41. CHOICES: Adult Day Care CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to 2,080 hours per calendar year) for CHOICES members in Group 2 and Group 3	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe) <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>7</sup>	Documentation/Evidence as Provided by MCO <sup>8</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Member (Evidence of benefits located in the member handbook, explanation of benefits or another location described.)</b>					
<b>Recommendations:</b>					
42. CHOICES: In-Home Respite Care CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to 216 hours per calendar year) for CHOICES members in Group 2 and Group 3	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe) <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
43. CHOICES: Inpatient Respite Care CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to nine days per calendar year) for CHOICES members in Group 2 and Group 3	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe) <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
44. CHOICES: Assistive Technology CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to \$900 per calendar year) for CHOICES members in Group 2 and Group 3	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe) <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
45. CHOICES: Minor Home Modifications CRA A.2.6.1.5.3	As medically necessary (up to \$6,000 per project, \$10,000 per calendar year and \$20,000 per lifetime) for	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>7</sup>	Documentation/Evidence as Provided by MCO <sup>8</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Member (Evidence of benefits located in the member handbook, explanation of benefits or another location described.)</b>					
TSA 2.6.1.5.3	CHOICES members in Group 2 and Group 3	<input type="checkbox"/> NA			
<b>Findings:</b>					
<b>Recommendations:</b>					
46. CHOICES: Pest Control CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to nine units per calendar year) for CHOICES members in Group 2 and Group 3	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
47. Regulator Approval CRA A.2.17.1.1 TSA 2.17.1.1	The MCO’s member handbook was approved by the TDCI. Date of Approval: <Month Day, Year> (Please be prepared to show proof of the approval during the onsite audit.)	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
<b>Accessibility Benefits Review—Member</b>			<###>%	47.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>11</sup>	Documentation/Evidence as Provided by MCO <sup>12</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Provider (Evidence of benefits located in the provider manual, contract or another location described.)</b>					
1. Inpatient Hospital Services CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary Under age 21: Includes rehabilitation hospital facility Age 21 and older: Inpatient rehabilitation hospital facility services are not covered for adults unless determined to be a cost effective alternative.	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
2. Outpatient Hospital Services CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
3. Physician Inpatient Services CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0

<sup>11</sup> Check appropriate box for location of benefit. Only one checked box is necessary for a full score.

<sup>12</sup> This column was submitted by the MCO to HSAG for review. HSAG has not altered the content or made grammatical corrections. This column does not include any attachments provided with the MCO tool.

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>11</sup>	Documentation/Evidence as Provided by MCO <sup>12</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Provider (Evidence of benefits located in the provider manual, contract or another location described.)</b>					
<b>Findings:</b>					
<b>Recommendations:</b>					
4. Physician Outpatient Services/ Community Health Clinic Services/ Other Clinic Services  CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
5. Lab and X-Ray Services  CRA A.2.6.1.3 CRA A.2.6.1.4 TSA 2.6.1.3 TSA 2.6.1.4	As medically necessary	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
6. Maternity/ Postpartum Services  TCA 56-7-2350	As medically necessary.	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>11</sup>	Documentation/Evidence as Provided by MCO <sup>12</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Provider (Evidence of benefits located in the provider manual, contract or another location described.)</b>					
<b>Recommendations:</b>					
7. Hospice Care (Must be Provided by a Medicare-Certified Hospice Program)  CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary (must be provided by a Medicare-Certified Hospice Program)	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
8. Vision Services  CRA A.2.6.1.3 TSA 2.6.1.3	Preventive, diagnostic and treatment services (including eyeglasses) for members younger than 21 years of age as medically necessary in accordance with TennCare Kids requirements. One pair of cataract glasses or lenses following cataract surgery is covered for adults. Medical eye care, meaning evaluation and management of abnormal conditions, diseases and disorders of the eye, is covered as medically necessary.	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
9. Home Healthcare  CRA A.2.6.1.3	Covered as medically necessary for those younger or older than 21 years of age in accordance with the	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>11</sup>	Documentation/Evidence as Provided by MCO <sup>12</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Provider (Evidence of benefits located in the provider manual, contract or another location described.)</b>					
TSA 2.6.1.3	definition of home healthcare in the Tennessee rules				
<b>Findings:</b>					
<b>Recommendations:</b>					
10. Durable Medical Equipment CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
11. Medical Supplies CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
12. Emergency Air and Ground Ambulance Transportation CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
13. Nonemergency Transportation, Including Nonemergency	Nonemergency transportation services are provided in accordance with federal law and the Bureau of	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>11</sup>	Documentation/Evidence as Provided by MCO <sup>12</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Provider (Evidence of benefits located in the provider manual, contract or another location described.)</b>					
Ambulance Transportation CRA A.2.6.1.3 TSA 2.6.1.3	TennCare’s rules and policies and procedures. Nonemergency transportation services are provided to convey members to and from TennCare covered services.				
<b>Findings:</b>					
<b>Recommendations:</b>					
14. Renal Dialysis Services CRA A.2.6.1.3 TSA 2.6.1.3	As medically necessary	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
15. TennCare Kids Services CRA A.2.6.1.3 TSA 2.6.1.3	Services for members younger than 21 years of age: a. As medically necessary, except that screenings do not have to be medically necessary b. Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal and State requirements	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>11</sup>	Documentation/Evidence as Provided by MCO <sup>12</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Provider (Evidence of benefits located in the provider manual, contract or another location described.)</b>					
16. Preventive Care Services CRA A.2.7.5 TSA 2.7.5	The MCO provides preventive services which include, but are not limited to, initial and periodic evaluations, family planning services, prenatal care, laboratory services and immunizations in accordance with TennCare rules and regulations.	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
17. Occupational Therapy CRA A.2.6.1.3 TSA 2.6.1.3	<b>Occupational Therapy:</b> a. Age 21 and older, as medically necessary, when provided by a licensed occupational therapist to restore, improve or stabilize impaired functions b. Younger than age 21, as medically necessary, in accordance with TennCare Kids requirements	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
18. Physical Therapy CRA A.2.6.1.3 TSA 2.6.1.3	<b>Physical Therapy:</b> a. Age 21 and older, as medically necessary, when provided by a licensed physical therapist to restore, improve or stabilize impaired functions b. Younger than age 21, as medically necessary, in accordance with TennCare Kids requirements	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>11</sup>	Documentation/Evidence as Provided by MCO <sup>12</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Provider (Evidence of benefits located in the provider manual, contract or another location described.)</b>					
<b>Findings:</b>					
<b>Recommendations:</b>					
19. Chiropractic Services CRA A.2.6.1.3 TSA 2.6.1.3	<b>Chiropractic Services:</b> a. Age 21 and older, covered when determined to be a cost-effective alternative by the MCO b. Younger than age 21, covered as medically necessary in accordance with TennCare Kids requirements	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
20. Private Duty Nursing CRA A.2.6.1.3 TSA 2.6.1.3	Private duty nursing is covered as medically necessary in accordance with the definition of private duty nursing in the Tennessee rules.	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
21. Speech Therapy CRA A.2.6.1.3 TSA 2.6.1.3	<b>Speech Therapy:</b> a. Age 21 and older, as medically necessary, when provided by a licensed speech therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder.	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>11</sup>	Documentation/Evidence as Provided by MCO <sup>12</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Provider (Evidence of benefits located in the provider manual, contract or another location described.)</b>					
	b. Younger than age 21, as medically necessary in accordance with TennCare Kids requirements				
<b>Findings:</b>					
<b>Recommendations:</b>					
22. Organ and Tissue Transplants and Donor Organ Procurement CRA A.2.6.1.3 TSA 2.6.1.3	<b>Organ and Tissue Transplants and Donor Organ Procurement:</b> a. Age 21 and older, all medically necessary and non-investigational/experimental organ and tissue transplants, as covered by Medicare b. Younger than age 21, covered as medically necessary in accordance with TennCare Kids requirements	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
23. Reconstructive Breast Surgery CRA A.2.6.1.3 TSA 2.6.1.3	Reconstructive Breast Surgery is covered in accordance with TCA 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as any surgical procedure on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast will only be covered if the surgical procedure	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>11</sup>	Documentation/Evidence as Provided by MCO <sup>12</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Provider (Evidence of benefits located in the provider manual, contract or another location described.)</b>					
	performed on a non-diseased breast occurs within five years of the date the reconstructive breast surgery was performed on a diseased breast.				
<b>Findings:</b>					
<b>Recommendations:</b>					
24. Mammography Screening TCA 56-7-2502	The MCO provides mammography screenings a minimum of once for ages 35–40, every two years or more frequently on physician recommendation for ages 40–50 and annually for ages 50 and older.	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
25. PKU TCA 56-7-2505 <XXXX> MCO Provider Network Adequacy and Benefit Delivery Review Questionnaire	The MCO provides coverage for the treatment of PKU, including licensed professional medical services and special dietary formulas.	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
26. Diabetic Services TCA 56-7-2605 <XXXX> MCO Provider Network Adequacy and Benefit Delivery Review Questionnaire	The MCO provides coverage for diabetic equipment, supplies and outpatient self-management training and education, including medical nutrition counseling, when medically necessary.	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>11</sup>	Documentation/Evidence as Provided by MCO <sup>12</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Provider (Evidence of benefits located in the provider manual, contract or another location described.)</b>					
<b>Findings:</b>					
<b>Recommendations:</b>					
27. Chlamydia Screens  TCA 56-7-2606 <XXXX> MCO Provider Network Adequacy and Benefit Delivery Review Questionnaire	The MCO provides for one annual chlamydia screening test in conjunction with an annual Pap smear for females who are not more than 29 years of age, if deemed medically necessary.	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
28. Psychiatric Inpatient Hospital Services (Including Physician Services)  CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
29. Outpatient Mental Health Services, Including Physician Services  CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>11</sup>	Documentation/Evidence as Provided by MCO <sup>12</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Provider (Evidence of benefits located in the provider manual, contract or another location described.)</b>					
<b>Findings:</b>					
<b>Recommendations:</b>					
30. Inpatient/ Residential and Outpatient Substance Abuse Benefits <sup>13</sup> CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary for those younger than 21 years of age. For those 21 years of age and older: Limited to 10 days detoxification and \$30,000 in medically necessary lifetime benefits, unless otherwise described in the 2008 Mental Health Parity Act, as determined by TennCare	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
31. 24-Hour Psychiatric Residential Treatment CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
32. BH Crisis Services CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0

<sup>13</sup> When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services. Methadone clinic services are not covered for adults.

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>11</sup>	Documentation/Evidence as Provided by MCO <sup>12</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Provider (Evidence of benefits located in the provider manual, contract or another location described.)</b>					
<b>Findings:</b>					
<b>Recommendations:</b>					
33. Mental Health Case Management CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
34. Psychiatric Rehabilitation Services CRA A.2.6.1.4 TSA 2.6.1.4	As medically necessary	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
35. CHOICES: Nursing Facility Care CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary: For CHOICES members in Group 1; and on a short-term basis only (up to 90 days) for members in CHOICES Group 2 and Group 3	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe) <input type="checkbox"/> NA <sup>14</sup>		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					

<sup>14</sup> Responses found to be NA do not receive a point value and are not counted against the MCO.

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>11</sup>	Documentation/Evidence as Provided by MCO <sup>12</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Provider (Evidence of benefits located in the provider manual, contract or another location described.)</b>					
36. CHOICES: Community-Based Residential Alternatives  CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary for CHOICES members in Group 2	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe) <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
37. CHOICES: Personal Care Visits  CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to two visits per day at intervals of no less than 4 hours between visits) for CHOICES members in Group 2 and Group 3	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe) <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
38. CHOICES: Attendant Care  CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to 1,080 hours per calendar year; up to 1,400 hours per full calendar year only for persons who require covered assistance with household chores or errands in addition to hands-on assistance with self-care tasks) for CHOICES members in Group 2 and Group 3	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe) <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>11</sup>	Documentation/Evidence as Provided by MCO <sup>12</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Provider (Evidence of benefits located in the provider manual, contract or another location described.)</b>					
39. CHOICES: Home-Delivered Meals CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to one meal per day) for CHOICES members in Group 2 and Group 3	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe) <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
40. CHOICES: PERS CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary for CHOICES members in Group 2 and Group 3	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe) <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
41. CHOICES: Adult Day Care CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to 2,080 hours per calendar year) for CHOICES members in Group 2 and Group 3	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe) <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
42. CHOICES: In-Home Respite Care CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to 216 hours per calendar year) for CHOICES members in Group 2 and Group 3	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe) <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>11</sup>	Documentation/Evidence as Provided by MCO <sup>12</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Provider (Evidence of benefits located in the provider manual, contract or another location described.)</b>					
<b>Recommendations:</b>					
43. CHOICES: Inpatient Respite Care CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to nine days per calendar year) for CHOICES members in Group 2 and Group 3	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe) <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
44. CHOICES: Assistive Technology CRA A.2.6.1.5.4 TSA 2.6.1.5.4	As medically necessary (up to \$900 per calendar year) for CHOICES members in Group 2 and Group 3	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe) <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
45. CHOICES: Minor Home Modifications CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to \$6,000 per project, \$10,000 per calendar year and \$20,000 per lifetime) for CHOICES members in Group 2 and Group 3	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe) <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
46. CHOICES: Pest Control CRA A.2.6.1.5.3 TSA 2.6.1.5.3	As medically necessary (up to nine units per calendar year) for CHOICES members in Group 2 and Group 3	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe) <input type="checkbox"/> NA		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool MCO					
Evaluation Elements	Criteria	Criteria Met <sup>11</sup>	Documentation/Evidence as Provided by MCO <sup>12</sup>	Element	
				Value	Score
<b>Accessibility Benefits Review—Provider (Evidence of benefits located in the provider manual, contract or another location described.)</b>					
<b>Findings:</b>					
<b>Recommendations:</b>					
47. Regulator Approval CRA A.2.18.6.11 TSA 2.18.6.13	The MCO’s provider manual was approved by the TDCI. Date of Approval: <Month Day, Year> (Please be prepared to show proof of the approval during the onsite audit.)	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
<b>Accessibility Benefits Review—Provider</b>			<###>%	47.0	0.0

**Contract File Review Tools: MCOs**

Primary Care Providers (PCPs)

<b>MCO Name:</b>	<Abbreviated MCO Name>
<b>Date of Review:</b>	<Date Range>
<b>Reviewer:</b>	<Surveyor Name, Credentials>

Provider #	1			2			3			4			5			6			7			8			9			10		
Provider ID #																														
Other Provider or Contract Information																														
Contract Available																														
Item in Signed Agreement <sup>15</sup>	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P
A. <sup>16</sup> Specify that the provider may not refuse to provide covered medically necessary or covered preventive services to a child under the age of twenty-one (21) or a TennCare Medicaid patient under this Contract/Agreement for non-medical reasons. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship.  CRA A.2.12.9.6 TSA 2.12.9.6																														

<sup>15</sup> Y = Yes, N = No, P = Partial

<sup>16</sup> A–O are derived from CRA 2-12 and deal specifically with the quality and adequacy of the provider network.

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Provider #	1	2	3	4	5	6	7	8	9	10														
Provider ID #																								
Other Provider or Contract Information																								
Contract Available																								
Item in Signed Agreement <sup>15</sup>	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P
B. Specify the functions and/or services to be provided by the provider and assure that the functions and/or services to be provided are within the scope of his/her professional/ technical practice. CRA A.2.12.9.7 TSA 2.12.9.7																								
C. Specify the amount, duration and scope of services to be provided by the provider and inform the provider of TennCare non-covered services as described in Section A.2.10 of this Contract and the TennCare rules and regulations. CRA A.2.12.9.8 TSA 2.12.9.8																								
D. Provide that emergency services be rendered without the requirement of prior authorization of any kind. CRA A.2.12.9.9 TSA 2.12.9.9																								
E. If the provider performs laboratory services, require the provider to meet all applicable requirements of the <i>Clinical Laboratory Improvement Amendments (CLIA) of 1988</i> . CRA A.2.12.9.12 TSA 2.12.9.12																								
F. Specify that the CONTRACTOR shall monitor the quality of services delivered under the provider agreement and initiate																								

APPENDIX B | 2016 Sample Assessment Tools—ANA

Provider #	1	2	3	4	5	6	7	8	9	10														
Provider ID #																								
Other Provider or Contract Information																								
Contract Available																								
Item in Signed Agreement <sup>15</sup>	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P
<p>corrective action where necessary to improve quality of care, in accordance with that level of medical, behavioral health, or long-term-care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TENNCARE.</p> <p>CRA A.2.12.9.22 TSA 2.12.9.22</p>																								
<p>G. Require that the provider comply with corrective action plans initiated by the CONTRACTOR.</p> <p>CRA A.2.12.9.23 TSA 2.12.9.23</p>																								
<p>H. Informs providers of the package of benefits that TennCare Kids offers and which requires providers to make treatment decisions based upon children’s individual medical and behavioral health needs. All provider agreements shall contain language that references the TennCare Kids requirements.</p> <p>CRA A.2.12.9.63 TSA 2.12.9.63</p>																								
<p>I. Include a provision which states that providers are not permitted to encourage or suggest, in any way, that TennCare children be placed into state custody in order to receive medical, behavioral, or</p>																								

APPENDIX B | 2016 Sample Assessment Tools—ANA

Provider #	1	2	3	4	5	6	7	8	9	10														
Provider ID #																								
Other Provider or Contract Information																								
Contract Available																								
Item in Signed Agreement <sup>15</sup>	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P
long-term-care services covered by TENNCARE. CRA A.2.12.9.64 TSA 2.12.9.64																								
J. Provide for the participation and cooperation in any internal and external quality management/quality improvement, monitoring, utilization review, peer review and/or appeal procedures established by the CONTRACTOR and/or TENNCARE. CRA A.2.12.9.20 TSA 2.12.9.20																								
K. Provide that TennCare, the U.S. Department of Health and Human Services Office of the Inspector General (OIG), Office of the Comptroller of the Treasury, OIG, Tennessee Bureau of Investigation Medical Fraud Control Unit, and the Department of Justice, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this Contract including, but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or																								

APPENDIX B | 2016 Sample Assessment Tools—ANA

Provider #	1	2	3	4	5	6	7	8	9	10														
Provider ID #																								
Other Provider or Contract Information																								
Contract Available																								
Item in Signed Agreement <sup>15</sup>	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P
criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. CRA A.2.12.9.18 TSA 2.12.9.18																								
L. Require safeguarding of information about enrollees according to applicable state and federal laws and regulations and as described in Sections A.2.27 and Section E.6 of the Contract between the CONTRACTOR and TennCare. CRA A.2.12.9.55 TSA 2.12.9.55																								
M. Specify that unreasonable delay in providing care to a pregnant member seeking prenatal care shall be considered a material breach of the provider's agreement with the CONTRACTOR and include the definition of unreasonable delay as described Section A.2.7.5.2.3 of the Contract between the CONTRACTOR and TennCare. CRA A.2.12.9.11 TSA 2.12.9.11																								

APPENDIX B | 2016 Sample Assessment Tools—ANA

Provider #	1	2	3	4	5	6	7	8	9	10														
Provider ID #																								
Other Provider or Contract Information																								
Contract Available																								
Item in Signed Agreement <sup>15</sup>	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P
N. Provide for monitoring, whether announced or unannounced, of services rendered to members.  CRA A.2.12.9.19 TSA 2.12.9.19																								
O. Specify that the provider have written procedures for the provision of language assistance services to members and/or the member’s representative. Language assistance services include interpretation and translation services and effective communication assistance in alternative formats for any member and/or the member’s representative who needs such services, including but not limited to, members with Limited English Proficiency and individuals with disabilities.  CRA A.2.12.9.66.2  Specify that the provider have written procedures for the provision of language interpretation and translation services for any enrollees who needs such services, including but not limited to, enrollees with Limited English Proficiency.  TSA 2.12.9.66.2																								
P. Require compliance with applicable access requirements, including but not limited to appointment and wait times as referenced																								





APPENDIX B | 2016 Sample Assessment Tools—ANA

Provider #	1			2			3			4			5			6			7			8			9			10								
Provider ID #																																				
Other Provider or Contract Information																																				
Contract Available																																				
Item in Signed Agreement <sup>15</sup>	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P
provider-preventable conditions as a condition of payment. At a minimum, this shall mean non-payment of provider-preventable conditions as well as appropriate reporting as required by the CONTRACTOR and TENNCARE. CRA A.2.12.9.56 TSA 2.12.9.56																																				
<b>Total Number of Points</b>																																				
<b>Maximum Number of Points</b>																																				
<b>Score</b>																																				

MCO Abbrev Contract File Review Totals for All Reviewed PCPs				
Provider	Points Awarded	Total Points	Maximum Points	Score
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Specialty Care Providers (SCPs)

<b>MCO Name:</b>	<Abbreviated MCO Name>
<b>Date of Review:</b>	<Date Range>
<b>Reviewer:</b>	<Surveyor Name, Credentials>

Provider #	1	2	3	4	5	6	7	8	9	10															
<b>Provider ID #</b>																									
<b>Other Provider or Contract Information</b>																									
<b>Contract Available</b>																									
<b>Item in Signed Agreement <sup>17</sup></b>	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	
A. <sup>18</sup> Specify that the provider may not refuse to provide covered medically necessary or covered preventive services to a child under the age of twenty-one (21) or a TennCare Medicaid patient under this Contract/Agreement for non-medical reasons. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship.  CRA A.2.12.9.6 TSA 2.12.9.6																									
B. Specify the functions and/or services to be provided by the provider and assure that the functions and/or services to be provided are within the scope of his/her professional/technical practice.  CRA A.2.12.9.7																									

<sup>17</sup> Y = Yes, N = No, P = Partial

<sup>18</sup> A–O are derived from CRA 2-12 and deal specifically with the quality and adequacy of the provider network.





APPENDIX B | 2016 Sample Assessment Tools—ANA

Provider #	1			2			3			4			5			6			7			8			9			10					
Provider ID #																																	
Other Provider or Contract Information																																	
Contract Available																																	
Item in Signed Agreement <sup>17</sup>	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P
TSA 2.12.9.20																																	
K. Provide that TennCare, the U.S. Department of Health and Human Services Office of the Inspector General (OIG), Office of the Comptroller of the Treasury, OIG, Tennessee Bureau of Investigation Medical Fraud Control Unit, and the Department of Justice, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this Contract including, but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. CRA A.2.12.9.18 TSA 2.12.9.18																																	
L. Require safeguarding of information about enrollees according to applicable state and federal laws and regulations																																	









MCO Abbrev Contract File Review Totals for All Reviewed SCPs				
Provider	Points Awarded	Total Points	Maximum Points	Score
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

### Credentialing and Recredentialing File Review Tools: MCOs

#### MCO Credentialing File Review Tool

<b>MCO Name:</b>	<Abbreviated MCO Name>
<b>Date of Review:</b>	<Date Range>
<b>Reviewer:</b>	<Surveyor Name, Credentials>

Provider ID Number					
#	#	#	#	#	#
#	#	#	#	#	#
#	#	#	#	#	#
#	#	#	#	#	#
#	#	#	#	#	#
#	#	#	#	#	#
#	#	#	#	#	#

Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA				
Current and valid license  <i>NCOA CR3; Element A</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							

Appendix B | 2016 Sample Assessment Tools—ANA

Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA				
<b>Work history: Five years—verbal explanation for gaps greater than six months; written explanation for gaps greater than one year</b>  <i>NCOA CR3; Element A</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
<b>Valid DEA/CDS certificate, if applicable</b>  <i>NCOA CR3; Element A</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
<b>Education/training: Highest level of education/training (including board certification, if applicable)</b>  <i>NCOA CR3; Element A</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							

APPENDIX B | 2016 Sample Assessment Tools—ANA

Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA				
<b>Current malpractice insurance coverage</b>  <i>NCOA CR3; Element C</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
<b>Professional liability/ claims history: 5 years of history from malpractice carrier or NPDB/HIPDB</b>  <i>NCOA CR3; Element A</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
<b>State sanctions/ restrictions</b>  <i>NCOA CR3; Element B</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							

Appendix B | 2016 Sample Assessment Tools—ANA

Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA				
<b>Medicare/Medicaid sanctions</b>  <i>NCOA CR3; Element B</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
<b>Signed attestation: The signature on the attestation must not be older than 180 calendar days at the time of the credentialing decision.</b>  <i>NCOA CR3; Element C</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
<b>Attestation statement: Correctness and completeness of the application</b>  <i>NCOA CR3; Element C</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							

APPENDIX B | 2016 Sample Assessment Tools—ANA

Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA				
<b>Attestation statement: Reason for the inability to perform the essential functions of the position, with or without accommodation</b>  <i>NCQA CR3; Element C</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
<b>Attestation statement: Lack of present illegal drug use</b>  <i>NCQA CR3; Element C</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
<b>Attestation statement: History of loss of license and felony conviction</b>  <i>NCQA CR3; Element C</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							

Appendix B | 2016 Sample Assessment Tools—ANA

Item Verified?	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA
<b>Attestation statement: History of loss or limitation of privileges or disciplinary action</b>  <i>NCOA CR3; Element C</i>	#1			#8			#15			#22			#29			#36		
	#2			#9			#16			#23			#30			#37		
	#3			#10			#17			#24			#31			#38		
	#4			#11			#18			#25			#32			#39		
	#5			#12			#19			#26			#33			#40		
	#6			#13			#20			#27			#34					
	#7			#14			#21			#28			#35					
<b>Processing of application completed within 30 days of receipt of complete application (For delegated entities, the provider's information must be loaded into the MCO's provider system within 30 days.)</b>  <i>CRA A.2.11.9.1.2</i>	#1			#8			#15			#22			#29			#36		
	#2			#9			#16			#23			#30			#37		
	#3			#10			#17			#24			#31			#38		
	#4			#11			#18			#25			#32			#39		
	#5			#12			#19			#26			#33			#40		
	#6			#13			#20			#27			#34					
	#7			#14			#21			#28			#35					
<b>FINAL SCORE</b>	<b>YES</b>			<b>NO</b>			<b>SCORE</b>						<b>PERCENTAGE</b>					
	<X>			<X>			<XX>/<XX>						<XX%>					

MCO Recredentialing File Review Tool

<b>MCO Name:</b>	<Abbreviated MCO Name>
<b>Date of Review:</b>	<Date Range>
<b>Reviewer:</b>	<Surveyor Name, Credentials>

Provider ID Number					
#	#	#	#	#	#
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#	#	#	#	#	#
#	#	#	#	#	#
#	#	#	#	#	#

Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA				
<b>Current and valid license</b>  <i>NCQA CR3; Element A</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							

Appendix B | 2016 Sample Assessment Tools—ANA

Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA				
<b>Work history: View work history since prior credentialing by MCO</b>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
<b>Valid DEA/CDS certificate, if applicable</b>  <i>NCQA CR3; Element A</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
<b>Board certification renewed since prior credentialing approval, if applicable</b>  <i>NCQA CR3; Element A</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							

APPENDIX B | 2016 Sample Assessment Tools—ANA

Item Verified?	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	
<b>Current malpractice insurance coverage</b>  <i>NCQA CR3; Element C</i>	#1			#8			#15			#22			#29			#36			
	#2			#9			#16			#23			#30			#37			
	#3			#10			#17			#24			#31			#38			
	#4			#11			#18			#25			#32			#39			
	#5			#12			#19			#26			#33			#40			
	#6			#13			#20			#27			#34						
	#7			#14			#21			#28			#35						
<b>Professional liability/claims history: NPDB-HIPDB</b>  <i>NCQA CR3; Element A</i>	#1			#8			#15			#22			#29			#36			
	#2			#9			#16			#23			#30			#37			
	#3			#10			#17			#24			#31			#38			
	#4			#11			#18			#25			#32			#39			
	#5			#12			#19			#26			#33			#40			
	#6			#13			#20			#27			#34						
	#7			#14			#21			#28			#35						
<b>State sanctions/restrictions</b>  <i>NCQA CR3; Element B</i>	#1			#8			#15			#22			#29			#36			
	#2			#9			#16			#23			#30			#37			
	#3			#10			#17			#24			#31			#38			
	#4			#11			#18			#25			#32			#39			
	#5			#12			#19			#26			#33			#40			
	#6			#13			#20			#27			#34						
	#7			#14			#21			#28			#35						

Appendix B | 2016 Sample Assessment Tools—ANA

Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA				
<b>Medicare/Medicaid sanctions</b>  <i>NCQA CR3; Element B</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
<b>Signed attestation: The signature on the attestation must not be older than 180 calendar days at the time of the credentialing decision.</b>  <i>NCQA CR3; Element CTCA Chapter 1200-8-33: 12.a.2</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
<b>Attestation statement: The correctness and completeness of the application</b>  <i>NCQA CR3; Element C</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							

APPENDIX B | 2016 Sample Assessment Tools—ANA

Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA				
<b>Attestation statement: The reason for the inability to perform the essential functions of the position with or without accommodation</b>  <i>NCQA CR3; Element C</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
<b>Attestation statement: The lack of present illegal drug use</b>  <i>NCQA CR3; Element C</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
<b>Attestation statement: History of loss of license and felony conviction</b>  <i>NCQA CR3; Element C</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							

Appendix B | 2016 Sample Assessment Tools—ANA

Item Verified?	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	
<b>Attestation statement: History of loss or limitation of privileges or disciplinary action</b>  <i>NCQA CR3; Element C</i>	#1			#8			#15			#22			#29			#36			
	#2			#9			#16			#23			#30			#37			
	#3			#10			#17			#24			#31			#38			
	#4			#11			#18			#25			#32			#39			
	#5			#12			#19			#26			#33			#40			
	#6			#13			#20			#27			#34						
	#7			#14			#21			#28			#35						
<b>Ongoing review of Adverse Events (e.g., quality issues, complaints, member surveys, utilization, sanctions, etc.)</b>  <i>NCQA CR6; Element A</i>	#1			#8			#15			#22			#29			#36			
	#2			#9			#16			#23			#30			#37			
	#3			#10			#17			#24			#31			#38			
	#4			#11			#18			#25			#32			#39			
	#5			#12			#19			#26			#33			#40			
	#6			#13			#20			#27			#34						
	#7			#14			#21			#28			#35						
<b>Recredentialing complete within 36 months</b>  <i>NCQA CR4; Element A</i>	#1			#8			#15			#22			#29			#36			
	#2			#9			#16			#23			#30			#37			
	#3			#10			#17			#24			#31			#38			
	#4			#11			#18			#25			#32			#39			
	#5			#12			#19			#26			#33			#40			
	#6			#13			#20			#27			#34						
	#7			#14			#21			#28			#35						
<b>FINAL SCORE</b>	<b>YES</b>			<b>NO</b>			<b>SCORE</b>						<b>PERCENTAGE</b>						
	<XX>			<XX>			<XX>/<XX>						<XX%>						

MCO CHOICES HCBS Credentialing File Review Tool

<b>MCO Name:</b>	<Abbreviated MCO Name>
<b>Date of Review:</b>	<Date Range>
<b>Reviewer:</b>	<Surveyor Name, Credentials>

Provider ID Number					
#	#	#	#	#	#
#	#	#	#	#	#
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#	#	#	#	#	#
#	#	#	#	#	#
#	#	#	#	#	#
#	#	#	#	#	#

Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA				
Valid license or certification  <i>CRA A.2.11.9.4.1.2.1</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							

Appendix B | 2016 Sample Assessment Tools—ANA

Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA				
<b>Medicare and Medicaid: The provider is not excluded from participation in the Medicare or Medicaid program.</b>  <i>CRA A.2.11.9.4.1.2.2</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
<b>The provider has a National Provider Identifier (NPI), if applicable.</b>  <i>CRA A.2.11.9.4.1.2.3</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
<b>The provider has obtained a Medicaid provider number from TennCare.</b>  <i>CRA A.2.11.9.4.1.2.3</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							

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Item Verified?	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA
<b>A site visit is conducted for all in-state providers. Requirement may be waived for out-of-state providers and the reason documented in the provider file.</b>  <i>CRA A.2.11.9.4.1.4</i>	#1			#8			#15			#22			#29			#36		
	#2			#9			#16			#23			#30			#37		
	#3			#10			#17			#24			#31			#38		
	#4			#11			#18			#25			#32			#39		
	#5			#12			#19			#26			#33			#40		
	#6			#13			#20			#27			#34					
	#7			#14			#21			#28			#35					
<b>FINAL SCORE</b>	<b>YES</b>			<b>NO</b>			<b>SCORE</b>						<b>PERCENTAGE</b>					
	<X>			<X>			<XX>/<XX>						<XX%>					

MCO CHOICES HCBS Recredentialing File Review Tool

<b>MCO Name:</b>	<Abbreviated MCO Name>
<b>Date of Review:</b>	<Date Range>
<b>Reviewer:</b>	<Surveyor Name, Credentials>

Provider ID Number					
#	#	#	#	#	#
#	#	#	#	#	#
#	#	#	#	#	#
#	#	#	#	#	#
#	#	#	#	#	#
#	#	#	#	#	#
#	#	#	#	#	#

Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA				
Valid license or certification  <i>CRA A.2.11.9.4.1.2.1</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							

APPENDIX B | 2016 Sample Assessment Tools—ANA

Item Verified?	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	
<b>Medicare and Medicaid: The provider is not excluded from participation in the Medicare or Medicaid program.</b>  <i>CRA A.2.11.9.4.1.2.2</i>	#1			#8			#15			#22			#29			#36			
	#2			#9			#16			#23			#30			#37			
	#3			#10			#17			#24			#31			#38			
	#4			#11			#18			#25			#32			#39			
	#5			#12			#19			#26			#33			#40			
	#6			#13			#20			#27			#34						
	#7			#14			#21			#28			#35						
<b>A site visit is conducted for all in-state providers. Requirements may be waived for out-of-state providers and the reason documented in the provider file.</b>  <i>CRA A.2.11.9.4.1.4</i>	#1			#8			#15			#22			#29			#36			
	#2			#9			#16			#23			#30			#37			
	#3			#10			#17			#24			#31			#38			
	#4			#11			#18			#25			#32			#39			
	#5			#12			#19			#26			#33			#40			
	#6			#13			#20			#27			#34						
	#7			#14			#21			#28			#35						
<b>Ongoing (i.e., provide service on a regular basis) HCBS providers are recertified at least annually.</b>  <i>CRA A.2.11.9.4.1.1.1</i>	#1			#8			#15			#22			#29			#36			
	#2			#9			#16			#23			#30			#37			
	#3			#10			#17			#24			#31			#38			
	#4			#11			#18			#25			#32			#39			
	#5			#12			#19			#26			#33			#40			
	#6			#13			#20			#27			#34						
	#7			#14			#21			#28			#35						
<b>FINAL SCORE</b>	<b>YES</b>			<b>NO</b>			<b>SCORE</b>						<b>PERCENTAGE</b>						
	<X>			<X>			<XX>/<XX>						<XX%>						

**ANA Questionnaire: DBM***«DBM\_Name»*

Please enter information requested.

General Information

Name of Dental Benefits Manager \_\_\_\_\_

Parent Organization \_\_\_\_\_

Mailing Address**Primary Street Mailing Address, Telephone Number and Fax Number:**

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

ZIP \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Website \_\_\_\_\_

**Address for Onsite Survey (if different from above):**

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

ZIP \_\_\_\_\_

Contact Information

**Chief Executive Officer**

Prefix \_\_\_\_ First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Title \_\_\_\_\_

Address \_\_\_\_\_ Suite \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

**Contact for Survey**

Prefix \_\_\_\_ First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Title \_\_\_\_\_

Address \_\_\_\_\_ Suite \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

**Medical Director**

Prefix \_\_\_\_ First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Title \_\_\_\_\_

Address \_\_\_\_\_ Suite \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

Number of TennCare members assigned to the DBM as of November 30, 2015:

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Number of participating dentists and other dental specialists for your TennCare population by specialty as of November 30, 2015.

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

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

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

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

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

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**Attestation Statement**

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

---

Signature of CEO or responsible individual

---

Date

---

Print name and title

Please mail or scan and upload the signed attestation statement by **January 11, 2016**, to:

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

Thank you for your prompt response.

**DBM Evaluation Tool**

2016 Annual Network Adequacy—Evaluation Tool DBM					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by DBM*	Element	
				Value	Score
<b>Credentialing/Rec credentialing</b>					
1. Initial Credentialing Policies and Procedures DBMC A.119.b.	The DBM has written initial credentialing policies and procedures.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
2. Recredentialing Policies and Procedures DBMC A.119.b.	The DBM has written rec credentialing policies and procedures.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
3. Oversight by Governing Body DBMC A.119.c.	Credentialing policies and procedures are reviewed and approved by the governing body or the group/individual formally delegated the credentialing process by the governing body.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					

\* This column was submitted by the DBM to HSAG for review. HSAG has not altered the content or made grammatical corrections. This column does not include any attachments provided with the DBM tool.

2016 Annual Network Adequacy—Evaluation Tool DBM					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by DBM*	Element	
				Value	Score
<b>Credentialing/Recredentialing</b>					
4. Credentialing Entity DBM A.17.b. DBMC A.119.d.	A credentialing committee or other peer review body (to include the dental director) has been designated by the DBM to make recommendations regarding credentialing decisions.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
5. Credentialing/ Timeline DBMC A.119.f. DBMC A.119.f.1.	The DBM ensures that there is a process and procedure for the periodic reverification of clinical credentials (recredentialing, reappointment or recertification) and that the procedure is implemented at least every three years.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
6. Predelegation Credentialing Activities DBMC A.72.a.	If credentialing and recredentialing activities are delegated, the DBM evaluates the prospective subcontractor's ability to perform the activities to be delegated.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA†		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					

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

2016 Annual Network Adequacy—Evaluation Tool DBM					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by DBM*	Element	
				Value	Score
<b>Credentialing/Recredentialing</b>					
7. Monitoring Delegated Credentialing Activities DBMC A.72.b.c.	If credentialing and recredentialing activities are delegated, the DBM: a. Executes a written agreement that specifies the activities and report responsibilities delegated to the subcontractor b. Monitors and evaluates delegated credentialing activities on an ongoing basis	a. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA b. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA Each Variable = 0.50		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
8. Corrective Action Plans for Delegated Credentialing Activities DBMC A.72.d.	If credentialing and recredentialing activities are delegated, the DBM identifies deficiencies or areas for improvement, and the DBM and subcontractors take corrective action as necessary.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
9. Reporting Quality Deficiencies DBMC A.119.g.	Through the review of policies and procedures there is evidence that the DBM established a mechanism for reporting serious quality deficiencies resulting in suspension or termination of a practitioner, to the appropriate authorities.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					

2016 Annual Network Adequacy—Evaluation Tool DBM					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by DBM*	Element	
				Value	Score
<b>Credentialing/Recredentialing</b>					
10. Denial of Provider Credentialing DBMC A.119.e.4.	If credentialing is denied, the provider must be notified in writing and the reasons for the denial must be specified (view denial letter).	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
11. Appeals Process DBMC A.119.h.	The DBM has written policies and procedures for providers to appeal determinations that reduce, suspend or terminate a provider’s privileges.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
12. Current Dental Licenses DBMC A.119.	The DBM ensures that a copy of the current, valid license is maintained on file at the Contractor’s location for every dental professional in the network since dental licenses are renewed every two years.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
13. Credentialing Site Visits DBMC A.119.e.5.	A site review will be required for a dentist’s office for which the DBM receives a complaint from an enrollee.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					

2016 Annual Network Adequacy—Evaluation Tool DBM					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by DBM*	Element	
				Value	Score
<b>Credentialing/Recredentialing</b>					
14. Credentialing Timeline DBMC A.119.a.	The DBM has written policies and procedures to ensure that the DBM completely processes credentialing applications within 30 calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement/contract.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
<b>Standard Score for Credentialing/Recredentialing</b>			<###>%	14.0	0.0

2016 Annual Network Adequacy—Evaluation Tool DBM					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by DBM <sup>‡</sup>	Element	
				Value	Score
<b>Standards for Availability and Accessibility</b>					
1. Statewide Network DBMC A. 18.	The DBM has a statewide provider network, including general dentists and dental specialists.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
2. Standards for Access DBMC A.19.	Through a review of policies and procedures, committee minutes and reports, there is evidence that the DBM has established standards for access such as routine, urgent and emergency care. Performance concerning access is assessed against these standards.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
3. Emergency Services DBMC A.19.	The DBM is responsible for the provision of treatment for emergency medical conditions 24-hours a day, seven days a week.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					

<sup>‡</sup> This column was submitted by the DBM to HSAG for review. HSAG has not altered the content or made grammatical corrections. This column does not include any attachments provided with the DBM tool.

2016 Annual Network Adequacy—Evaluation Tool DBM					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by DBM <sup>‡</sup>	Element	
				Value	Score
<b>Standards for Availability and Accessibility</b>					
4. Access to Care DBMC A.19.	Through a review of provider contracts and policies and procedures there is evidence that the DBM requires that its contracted providers offer adequate access to covered services. At a minimum, the DBM must maintain a network of dental providers with a sufficient number of providers who accept new TennCare members in accordance with the required standards:  a. Appointment wait times do not exceed three weeks for regular appointments  b. Appointment wait times do not exceed 48 hours for urgent care	a. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA <sup>§</sup>  b. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA  Each Variable = 0.50		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
5. Hours of Operation DBMC A.19.	The network providers must offer hours of operation that are no less than the hours of operation offered to commercial members.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					

<sup>§</sup> Responses found to be not applicable (NA) do not receive a point value and are not counted against the DBM.

2016 Annual Network Adequacy—Evaluation Tool DBM					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by DBM <sup>†</sup>	Element	
				Value	Score
<b>Standards for Availability and Accessibility</b>					
6. Transport Distance DBMC A.20.	Through a review of provider contracts and policies and procedures there is evidence that transportation time to dental providers will be the usual and customary, not to exceed 30 miles, except in rural areas, where community standards, as defined by TennCare, will apply. Exceptions must be justified and documented.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
7. Office Wait Time DBMC A.21.	Through a review of provider contracts and policies and procedures there is evidence that the office wait time does not exceed 45 minutes.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
8. Provider Choice DBMC A.22.	Through a review of provider contracts and policies and procedures there is evidence that each member is permitted to obtain covered services from any general or pediatric dentist in the DBM's network who is accepting new patients.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					

2016 Annual Network Adequacy—Evaluation Tool DBM					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by DBM <sup>†</sup>	Element	
				Value	Score
<b>Standards for Availability and Accessibility</b>					
<b>Recommendations:</b>					
9. Access for Urgent Services DBMC A.36.	Through a review of provider contracts and policies and procedures there is evidence that the DBM ensures access to services for urgent dental and oral conditions or injuries based on the professional judgment of the member’s treating dentist, other dental professional, primary care provider or triage nurse who is trained in dental care and oral healthcare.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
10. Out-of-Network Providers DBMC A.23.	If the DBM is unable to provide necessary medical services covered under the contract, the DBM must adequately and timely cover the services out-of-network for the member for as long as the DBM is unable to provide the services.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
11. Limited English Proficiency/ Cultural Competence DBMC A.24.	The DBM participates in the State’s efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool DBM					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by DBM <sup>†</sup>	Element	
				Value	Score
<b>Standards for Availability and Accessibility</b>					
	and diverse cultural and ethnic backgrounds.				
<b>Findings:</b>					
<b>Recommendations:</b>					
12. Nondiscrimination DBMC A.56. DBMC A.155.	The DBM develops written policies and procedures that demonstrate: a. Nondiscrimination in the provision of services to members b. Nondiscrimination in the selection and/or retention of providers specializing in conditions that require costly treatment	a. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA b. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA Each Variable = 0.50		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
13. Dental Referrals DBMC A.38.	The general dentist or pediatric dentist: a. Must refer members to a dental specialist (e.g., endodontists, oral surgeons, orthodontists, periodontists or prosthodontists) for the initial visit for services requiring specialized expertise b. Does not need to provide separate referrals for subsequent visits to the same specialist in a course of treatment.	a. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA b. <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA Each Variable = 0.50		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					

2016 Annual Network Adequacy—Evaluation Tool DBM					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by DBM <sup>†</sup>	Element	
				Value	Score
<b>Standards for Availability and Accessibility</b>					
14. Second Opinions DBMC A.38.a.	The DBM provides for a second opinion from a qualified healthcare professional within the network or arranges for the member to obtain a second opinion outside the network at no cost to the member.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
15. Direct Access to Specialists DBMC A.38.b.	The DBM has a mechanism to allow special needs members and members who require an ongoing course of treatment direct access to specialists, as appropriate.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
16. Non-Traditional Fluoride Varnish and Dental Screening Program DBMC A.4.d.	The DBM implements a program that allows non-traditional providers (such as primary care physicians, pediatricians, physician assistants, nurse practitioners and public health nurses) to conduct dental screenings and apply fluoride varnish to the teeth of TennCare members two through four years of age.	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
<b>Standard Score for Availability and Accessibility</b>			<###>%	16.0	0.0

2016 Annual Network Adequacy—Evaluation Tool DBM					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by DBM **	Element	
				Value	Score
<b>Benefits Review—Member (Evidence of benefits located in the member handbook, explanation of benefits or another location described.)</b>					
<b>Covered services for TENNCARE-eligible members younger than 21 years of age.</b> Covered services consist of preventive, diagnostic and treatment services as follows:					
<b>Preventive Services</b>	In general, preventive services include the following:				
1.	Education concerning measures to promote a member’s oral health and prevent oral disease  DBMC A.98.	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
2.	Oral health assessments	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
3.	Examinations of the teeth and oral cavity	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
4.	Topical fluoride	<input type="checkbox"/> Member Handbook		1.0	0.0

\*\* This column was submitted by the DBM to HSAG for review. HSAG has not altered the content or made grammatical corrections. This column does not include any attachments provided with the DBM tool.

2016 Annual Network Adequacy—Evaluation Tool DBM					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by DBM **	Element	
				Value	Score
<b>Benefits Review—Member (Evidence of benefits located in the member handbook, explanation of benefits or another location described.)</b>					
<b>Covered services for TENNCARE-eligible members younger than 21 years of age.</b>					
Covered services consist of preventive, diagnostic and treatment services as follows:					
	DBMC A.5.	<input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)			
<b>Findings:</b>					
<b>Recommendations:</b>					
5.	Application of dental sealants DBMC A.5.	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
6.	Dental prophylaxis services DBMC A.5.	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
7.	Space maintainers	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					

2016 Annual Network Adequacy—Evaluation Tool DBM					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by DBM **	Element	
				Value	Score
<b>Benefits Review—Member (Evidence of benefits located in the member handbook, explanation of benefits or another location described.)</b>					
<b>Covered services for TENNCARE-eligible members younger than 21 years of age.</b> Covered services consist of preventive, diagnostic and treatment services as follows:					
<b>Treatment and Restorative Services</b>	In general, dental treatment includes the following items:				
8.	Radiographic, laboratory and other diagnostic services	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
9.	Restorative services to include amalgams, resin and crowns DBMC A.5.	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
10.	Orthodontic services DBMC A.38. DBMC A.43.a. DBMC A.44.	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
11.	Endodontic services DBMC A.38.	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool DBM						
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by DBM **	Element		
				Value	Score	
<b>Benefits Review—Member (Evidence of benefits located in the member handbook, explanation of benefits or another location described.)</b>						
<b>Covered services for TENNCARE-eligible members younger than 21 years of age.</b> Covered services consist of preventive, diagnostic and treatment services as follows:						
<b>Findings:</b>						
<b>Recommendations:</b>						
12.	Oral surgery DBMC A.38.	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0	
<b>Findings:</b>						
<b>Recommendations:</b>						
13.	Periodontic services DBMC A.38.	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0	
<b>Findings:</b>						
<b>Recommendations:</b>						
14.	Oral pathology services	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0	
<b>Findings:</b>						
<b>Recommendations:</b>						
15.	Anesthesia services DBMC A.40.	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Explanation of Benefits <input type="checkbox"/> Other (Describe)		1.0	0.0	

2016 Annual Network Adequacy—Evaluation Tool DBM					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by DBM **	Element	
				Value	Score
<b>Benefits Review—Member (Evidence of benefits located in the member handbook, explanation of benefits or another location described.)</b>					
Covered services for TENNCARE-eligible members younger than 21 years of age. Covered services consist of preventive, diagnostic and treatment services as follows:					
<b>Findings:</b>					
<b>Recommendations:</b>					
<b>Standard Score for Benefit Review—Member</b>			<###>%	15.0	0.0

2016 Annual Network Adequacy—Evaluation Tool DBM					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by DBM <sup>††</sup>	Element	
				Value	Score
<b>Benefits Review—Provider (Evidence of benefits located in the provider manual, contract or another location described.)</b>					
<b>Covered services for TENNCARE-eligible members younger than 21 years of age.</b> Covered services consist of preventive, diagnostic and treatment services as follows:					
<b>Preventive Services</b>	In general, preventive services include the following:				
1.	Education concerning measures to promote a member’s oral health and prevent oral disease  DBMC A.98.a.(1)	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
2.	Oral health assessments	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
3.	Examinations of the teeth and oral cavity	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
4.	Topical fluoride  DBMC A.5	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract		1.0	0.0

<sup>††</sup> This column was submitted by the DBM to HSAG for review. HSAG has not altered the content or made grammatical corrections. This column does not include any attachments provided with the DBM tool.

2016 Annual Network Adequacy—Evaluation Tool DBM					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by DBM <sup>++</sup>	Element	
				Value	Score
<b>Benefits Review—Provider (Evidence of benefits located in the provider manual, contract or another location described.)</b>					
Covered services for TENNCARE-eligible members younger than 21 years of age. Covered services consist of preventive, diagnostic and treatment services as follows:					
		<input type="checkbox"/> Other (Describe)			
<b>Findings:</b>					
<b>Recommendations:</b>					
5.	Application of dental sealants DBMC A.5	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
6.	Dental prophylaxis services DBMC A.5	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
7.	Space maintainers	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
<b>Treatment and Restorative Services</b>	In general, dental treatment includes the following items:				
8.	Radiographic, laboratory and other diagnostic services	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract		1.0	0.0

2016 Annual Network Adequacy—Evaluation Tool DBM					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by DBM <sup>++</sup>	Element	
				Value	Score
<b>Benefits Review—Provider (Evidence of benefits located in the provider manual, contract or another location described.)</b>					
Covered services for TENNCARE-eligible members younger than 21 years of age. Covered services consist of preventive, diagnostic and treatment services as follows:					
		<input type="checkbox"/> Other (Describe)			
<b>Findings:</b>					
<b>Recommendations:</b>					
9.	Restorative services to include amalgams, resin and crowns DBMC A.5	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
10.	Orthodontic services DBMC A.38	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
11.	Endodontic services DBMC A.38	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
12.	Oral surgery DBMC A.38	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					

2016 Annual Network Adequacy—Evaluation Tool DBM					
Evaluation Elements	Criteria	Criteria Met	Documentation/Evidence as Provided by DBM <sup>++</sup>	Element	
				Value	Score
<b>Benefits Review—Provider (Evidence of benefits located in the provider manual, contract or another location described.)</b>					
Covered services for TENNCARE-eligible members younger than 21 years of age. Covered services consist of preventive, diagnostic and treatment services as follows:					
<b>Recommendations:</b>					
13.	Periodontic services DBMC A.38	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
14.	Oral pathology services	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
15.	Anesthesia services DBMC A.40	<input type="checkbox"/> Provider Manual <input type="checkbox"/> Contract <input type="checkbox"/> Other (Describe)		1.0	0.0
<b>Findings:</b>					
<b>Recommendations:</b>					
<b>Standard Score for Benefit Review—Provider</b>			<###>%	15.0	0.0

**Contract File Review Tools: DBM**

General Dental Practitioner (GDP)

<b>DBM Name:</b>	<Abbreviated DBM Name>
<b>Date of Review:</b>	<Date Range>
<b>Reviewer:</b>	<Surveyor Name, Credentials>

Provider #	1			2			3			4			5			6			7			8			9			10		
Provider ID #																														
Other Provider or Contract Information																														
Contract Available																														
Item in Signed Agreement *	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P			
A. Specify that the provider may not refuse to provide medically necessary or covered services to a TennCare enrollee under this contract for nonmedical reasons, including, but not limited to, failure to pay applicable cost-sharing responsibilities. The contractor specifies that an enrollee who is subject to a copayment requirement be requested to pay applicable TennCare cost-sharing responsibilities prior to receiving nonemergency services. However, the provider is not to be required to accept or continue treatment of a member with whom the provider feels he/she cannot establish and/or maintain a professional relationship.  A.55.f.																														

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

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Provider #	1			2			3			4			5			6			7			8			9			10					
Provider ID #																																	
Other Provider or Contract Information																																	
Contract Available																																	
Item in Signed Agreement *	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P
B. Specify the functions and/or services to be provided by the provider and ensure that the functions and/or services are within the scope of his or her professional/technical practice.  A.55.g.																																	
C. Specify the amount, duration and scope of services to be provided by the provider.  A.55.h.																																	
D. Provide that emergency services for eligible enrollees younger than 21 years of age be rendered without the requirement of prior authorization. However, the required documentation must be submitted post-treatment for retro authorizations in order for the dentist to receive payment.  A.55.i.																																	
E. If the provider performs laboratory services, the provider must meet all applicable requirements of the <i>Clinical Laboratory Improvement Act (CLIA) of 1988</i> at such time that CMS mandates the enforcement of the provisions of CLIA.  A.55.j.																																	
F. Specify that the contractor monitors the quality of services delivered under the agreement and initiates corrective action when necessary to improve quality of care in accordance with the level of medical care recognized as acceptable																																	



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Provider #	1			2			3			4			5			6			7			8			9			10					
Provider ID #																																	
Other Provider or Contract Information																																	
Contract Available																																	
Item in Signed Agreement *	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P
external quality management/ improvement, utilization review, peer review and appeal procedures established by the contractor and/or TennCare. A.55.o.																																	
K. Provide that TennCare, the U.S. Department of Health and Human Services, the Tennessee State Board of Dentistry, the Tennessee Bureau of Investigation (TBI) State auditors, and other agencies designated by TennCare, have the right to evaluate through inspection, whether announced or unannounced, or by other means any records pertinent to this contract related to quality, appropriateness and timeliness of services. Such evaluation, when performed, must be with the cooperation of the dental provider. Upon request, the dental provider assists in such reviews including the provision of complete copies of records, reports or any other media, whether electronic or hard copy. A.55.m.																																	
L. Require dental providers to safeguard information about enrollees according to applicable state and federal laws and all <i>Health Insurance Portability &amp; Accountability of 1996</i> regulations. A.55.r.																																	

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Provider #	1			2			3			4			5			6			7			8			9			10					
Provider ID #																																	
Other Provider or Contract Information																																	
Contract Available																																	
Item in Signed Agreement *	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P
Total Number of Points																																	
Maximum Number of Points																																	
Score																																	

DBM Abbrev Contract File Review Totals for All Reviewed GDPs				
Provider	Points Awarded	Total Points	Maximum Points	Score
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Specialty Dental Providers (SDPs)

<b>DBM Name:</b>	<Abbreviated DBM Name>
<b>Date of Review:</b>	<Date Range>
<b>Reviewer:</b>	<Surveyor Name, Credentials>

Provider #	1	2	3	4	5	6	7	8	9	10														
Provider ID #																								
Other Provider or Contract Information																								
Contract Available																								
Item in Signed Agreement <sup>26</sup>	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P
A. Specify that the provider may not refuse to provide medically necessary or covered services to a TennCare enrollee under this contract for nonmedical reasons, including, but not limited to, failure to pay applicable cost-sharing responsibilities. The contractor specifies that an enrollee who is subject to a copayment requirement be requested to pay applicable TennCare cost-sharing responsibilities prior to receiving nonemergency services. However, the provider is not to be required to accept or continue treatment of a member with whom the provider feels he/she cannot establish and/or maintain a professional relationship.  A.55.f.																								
B. Specify the functions and/or services to be provided by the provider and ensure that the functions and/or services are																								

<sup>26</sup> Y = Yes, N = No, P = Partial

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Provider #	1	2	3	4	5	6	7	8	9	10															
Provider ID #																									
Other Provider or Contract Information																									
Contract Available																									
Item in Signed Agreement <sup>26</sup>	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	
within the scope of his or her professional/technical practice. A.55.g.																									
C. Specify the amount, duration and scope of services to be provided by the provider. A.55.h.																									
D. Provide that emergency services for eligible enrollees younger than 21 years of age be rendered without the requirement of prior authorization. However, the required documentation must be submitted post-treatment for retro authorizations in order for the dentist to receive payment. A.55.i.																									
E. If the provider performs laboratory services, the provider must meet all applicable requirements of the <i>Clinical Laboratory Improvement Act (CLIA) of 1988</i> at such time that CMS mandates the enforcement of the provisions of CLIA. A.55.j.																									
F. Specify that the contractor monitors the quality of services delivered under the agreement and initiates corrective action when necessary to improve quality of care in accordance with the level of medical care recognized as acceptable professional practice in the respective community in which the provider																									

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Provider #	1	2	3	4	5	6	7	8	9	10															
Provider ID #																									
Other Provider or Contract Information																									
Contract Available																									
Item in Signed Agreement <sup>26</sup>	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	
practices and/or in accordance with the standards established by TennCare. A.55.p.																									
G. Require that the provider comply with corrective action plans initiated by the contractor or be subject to recoupment of funds, termination or other penalties determined by TennCare. A.55.p.2.																									
H. Ensure that all provider agreements include language that informs providers of the package of benefits that EPSDT offers and the periodicity schedule from which those benefits must be provided. All provider agreements must contain language that references the EPSDT benefit package and periodicity schedule. A.55.kk.																									
I. Ensure that all provider agreements include a provision stating that providers are not permitted to encourage or suggest, in writing or verbally, that TennCare children be placed into State custody to receive medical or behavioral services covered by TennCare. A.55.II.																									
J. Whether announced or unannounced, provide for the participation in and cooperation with any internal and external quality management/ improvement, utilization review, peer																									

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Provider #	1	2	3	4	5	6	7	8	9	10															
Provider ID #																									
Other Provider or Contract Information																									
Contract Available																									
Item in Signed Agreement <sup>26</sup>	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	
review and appeal procedures established by the contractor and/or TennCare. A.55.o.																									
K. Provide that TennCare, the U.S. Department of Health and Human Services, the Tennessee State Board of Dentistry, the Tennessee Bureau of Investigation (TBI) State auditors, and other agencies designated by TennCare, have the right to evaluate through inspection, whether announced or unannounced, or by other means any records pertinent to this contract related to quality, appropriateness and timeliness of services. Such evaluation, when performed, must be with the cooperation of the dental provider. Upon request, the dental provider assists in such reviews including the provision of complete copies of records, reports or any other media, whether electronic or hard copy. A.55.m.																									
L. Require dental providers to safeguard information about enrollees according to applicable state and federal laws and all <i>Health Insurance Portability &amp; Accountability of 1996</i> regulations. A.55.r.																									

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Provider #	1			2			3			4			5			6			7			8			9			10					
Provider ID #																																	
Other Provider or Contract Information																																	
Contract Available																																	
Item in Signed Agreement <sup>26</sup>	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P	Y	N	P
Total Number of Points																																	
Maximum Number of Points																																	
Score																																	

DBM Abbrev Contract File Review Totals for All Reviewed SDPs				
Provider	Points Awarded	Total Points	Maximum Points	Score
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

**Credentialing File Review Tool: DBM**

<b>DBM Name:</b>	<Abbreviated MCO Name>
<b>Date of Review:</b>	<Date Range>
<b>Reviewer:</b>	<Surveyor Name, Credentials>

Provider ID Number					
#	#	#	#	#	#
#	#	#	#	#	#
#	#	#	#	#	#
#	#	#	#	#	#
#	#	#	#	#	#
#	#	#	#	#	#
#	#	#	#	#	#

Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA				
<b>Current, valid TN license</b>  <i>DBMC A.119.e.1.(a)</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
<b>Work history: Five years—verbal explanation for gaps greater than six months; written explanation for gaps greater than one year</b>  <i>DBMC A.119.e.2.(a)</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							

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Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA	
<b>Valid DEA/CDS certificate, if applicable; verified within 180 calendar days prior to the credentialing date</b>  <i>DBMC A.119.e.1.(b)</i> <i>DBMC A.119.e.3.</i>	#1				#8				#15				#22				#29				#36				
	#2				#9				#16				#23				#30				#37				
	#3				#10				#17				#24				#31				#38				
	#4				#11				#18				#25				#32				#39				
	#5				#12				#19				#26				#33				#40				
	#6				#13				#20				#27				#34								
	#7				#14				#21				#28				#35								
<b>Highest level of education/training (including board certification, if applicable)</b>  <i>DBMC A.119.e.1.(c)</i>	#1				#8				#15				#22				#29				#36				
	#2				#9				#16				#23				#30				#37				
	#3				#10				#17				#24				#31				#38				
	#4				#11				#18				#25				#32				#39				
	#5				#12				#19				#26				#33				#40				
	#6				#13				#20				#27				#34								
	#7				#14				#21				#28				#35								
<b>Current malpractice insurance coverage and coverage limits</b>  <i>DBMC A.119.e.2.(d)v.</i>	#1				#8				#15				#22				#29				#36				
	#2				#9				#16				#23				#30				#37				
	#3				#10				#17				#24				#31				#38				
	#4				#11				#18				#25				#32				#39				
	#5				#12				#19				#26				#33				#40				
	#6				#13				#20				#27				#34								
	#7				#14				#21				#28				#35								
<b>Professional liability/claims history: NPDB, HIPDB (past five years)</b>  <i>DBMC A.119.e.1.(d)</i>	#1				#8				#15				#22				#29				#36				
	#2				#9				#16				#23				#30				#37				
	#3				#10				#17				#24				#31				#38				
	#4				#11				#18				#25				#32				#39				
	#5				#12				#19				#26				#33				#40				
	#6				#13				#20				#27				#34								
	#7				#14				#21				#28				#35								

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Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA
<b>State sanctions/ restrictions/censure (TennCare and/or Tennessee Board of Dentistry)</b>  <i>DBMC A.119.e.1.(e)</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
<b>Medicare/Medicaid sanctions</b>  <i>DBMC A.119.e.1.(e)</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
<b>Statement: Physical or mental health problems that may affect current ability to provide dental care</b>  <i>DBMC A.119.e.2.(d)i.</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
<b>Statement: History of chemical dependency/ substance abuse</b>  <i>DBMC A.119.e.2.(d)ii.</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							

Appendix B | 2016 Sample Assessment Tools—ANA

Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA	
<b>Statement: History of loss, revocation, or suspension of license (including state license, DEA/number or CDS certificate) and/or felony convictions</b> <i>DBMC A. 119.e.1.(g)</i> <i>DBMC A. 119.e.2.(d)iii.</i>	#1				#8				#15				#22				#29				#36				
	#2				#9				#16				#23				#30				#37				
	#3				#10				#17				#24				#31				#38				
	#4				#11				#18				#25				#32				#39				
	#5				#12				#19				#26				#33				#40				
	#6				#13				#20				#27				#34								
	#7				#14				#21				#28				#35								
<b>Statement: Current malpractice coverage and limits</b>  <i>DBMC A. 119.e.2.(d)v.</i>	#1				#8				#15				#22				#29				#36				
	#2				#9				#16				#23				#30				#37				
	#3				#10				#17				#24				#31				#38				
	#4				#11				#18				#25				#32				#39				
	#5				#12				#19				#26				#33				#40				
	#6				#13				#20				#27				#34								
	#7				#14				#21				#28				#35								
<b>Statement: History of loss or limitation of privileges or disciplinary activity</b>  <i>DBMC A. 119.e.2.(d)iv.</i>	#1				#8				#15				#22				#29				#36				
	#2				#9				#16				#23				#30				#37				
	#3				#10				#17				#24				#31				#38				
	#4				#11				#18				#25				#32				#39				
	#5				#12				#19				#26				#33				#40				
	#6				#13				#20				#27				#34								
	#7				#14				#21				#28				#35								
<b>Attestation statement: Correctness and completeness of the application</b>  <i>DBMC A. 119.e.2.(d)vi</i>	#1				#8				#15				#22				#29				#36				
	#2				#9				#16				#23				#30				#37				
	#3				#10				#17				#24				#31				#38				
	#4				#11				#18				#25				#32				#39				
	#5				#12				#19				#26				#33				#40				
	#6				#13				#20				#27				#34								
	#7				#14				#21				#28				#35								

Appendix B | 2016 Sample Assessment Tools—ANA

Item Verified?		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA
<b>Credentialing completed within 30 days of receipt of a completed application</b> (For delegated entities, the provider must be loaded into the MCO's provider system within 30 days) <i>DBMC A.119.a.</i>	#1				#8				#15				#22				#29				#36			
	#2				#9				#16				#23				#30				#37			
	#3				#10				#17				#24				#31				#38			
	#4				#11				#18				#25				#32				#39			
	#5				#12				#19				#26				#33				#40			
	#6				#13				#20				#27				#34							
	#7				#14				#21				#28				#35							
<b>FINAL SCORE</b>	<b>YES</b>			<b>NO</b>			<b>SCORE</b>						<b>PERCENTAGE</b>											
	<b>XX</b>			<b>X</b>			<b>XX/XX</b>						<b>XX%</b>											

## AQS

The following assessment tools were used for the AQS evaluation of MCCs:

- ◆ 2016 AQS QP Standards Survey Tools ([MCO](#) and [DBM](#))
- ◆ [MCC Appeals \(Grier\) File Review Tool](#)
- ◆ [MCC UM Denials \(ages 20 and younger only\) File Review Tool](#)
- ◆ [EPSDT Information System Tracking File Review Tool](#)
- ◆ [CHOICES Annual Level of Care Assessment File Review Tool](#)
- ◆ [Transition of CHOICES Members Between MCOs: Criteria for Receiving MCOs File Review Tool](#)
- ◆ [MCC Complaints File Review Tool](#)

## QP Standards Tools

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Network: Contracting, Availability, Access and Documentation</b>					
1. Specialist Termination  *CRA and TSA § 2.11.10.1.4 (MCO Statewide Contract (MSC) and TCS)	The MCO provides timely notification (no less than 30 days prior when possible) to its members affected by the termination of a specialist and/or entire specialty group.	<input type="checkbox"/> Yes <input type="checkbox"/> No	0.250 0.000	0.250	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
2. Notice of Provider Termination  CRA and TSA § 2.11.10.1.2 (MSC and TCS)	If a primary care physician ceases participation in the MCO, the MCO immediately provides written notice-no less than 30 calendar days prior to the effective date of the termination and no more than 15 calendar days after receipt or issuance of the termination notice-to each member who has chosen the provider as his or her primary care provider (PCP).	<input type="checkbox"/> Yes <input type="checkbox"/> No	0.250 0.000	0.250	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
<b>Standard Score for Network: Contracting, Availability, Access and Documentation</b>			0.0 %	0.500	0.000

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>QI Activities</b>					
1. Coordination Between Physical and Behavioral Health  CRA and TSA § 2.9.9.1; 2.9.9.3.2 (MSC and TCS)	The MCO possesses policies and procedures and ensures continuity and coordination between physical, behavioral health and long-term care (LTC) services by including key elements to the right.	<input type="checkbox"/> Screening for behavioral health needs <input type="checkbox"/> Referral to physical health, behavioral health and LTC providers <input type="checkbox"/> Screening for LTC needs <input type="checkbox"/> Exchange of information <input type="checkbox"/> Confidentiality <input type="checkbox"/> Assessment <input type="checkbox"/> Treatment plan development <input type="checkbox"/> Collaboration <input type="checkbox"/> Care Coordination and Population Health (PH) <input type="checkbox"/> Provider training <input type="checkbox"/> Encourages PCPs and other providers to use State-approved behavioral health screening tool <input type="checkbox"/> Monitoring implementation and outcomes	<b>0.500</b>  <b>0.500</b>  <b>0.500</b> <b>0.500</b> <b>0.500</b> <b>0.500</b> <b>0.500</b> <b>0.500</b> <b>0.500</b> <b>0.500</b> <b>0.500</b> <b>0.500</b> <b>0.500</b>	<b>6.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>QI Activities</b>					
2. Mental Health Services Following Inpatient/ Residential Treatment  CRA and TSA § 2.7.2.6.5.2 (MSC and TCS)	The MCO has a process in place to ensure that members discharged from psychiatric inpatient hospitals and psychiatric residential treatment facilities are evaluated for mental health case management services and provided with appropriate behavioral health follow-up services.	<input type="checkbox"/> Members evaluated for mental health case management services <input type="checkbox"/> Members provided with appropriate follow-up services	0.500  0.500	1.000	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>QI Activities</b>					
3. Integrated Population Health (PH)  CRA and TSA § 2.8.1; 2.8.2.1-.2; 2.8.2.1.5; 2.8.2.2.1; 2.8.4.2.2 (MSC and TCS)	<p>The MCO has an integrated PH Program that is based upon risk stratification of its members. Each month new members are systematically stratified using predictive modeling and are enrolled into specific programs based upon risk rather than disease-specific categories. The predictive modeling uses a combination of claims data, pharmacy data and laboratory results, supplemented by referrals, utilization management (UM) data and/or health risk assessment (HRA) results. The risk levels range from 0-2.</p> <p>Risk Level 0- Wellness Program Risk Level 1- Low Risk Maternity, Health Risk Management and Care Coordination Program Risk Level 2- Chronic Care Management (CCM), High Risk Pregnancy and Complex Case Management (voluntary programs)</p> <p>For members to be stratified into Level 0, there must be no identified health risks, no chronic care conditions, no indication of pregnancy or no claims history.</p> <p>Pregnant members are stratified into low- or high-risk pregnancy programs based on the MCO's obstetrical assessment. The MCO transitions low-risk pregnancy program members into the high risk pregnancy program when ongoing member monitoring identifies an increased health risk.</p>	<input type="checkbox"/> Process in place to identify members <input type="checkbox"/> Staff demonstrates knowledge of the member stratification process <input type="checkbox"/> Ongoing assessment for low-risk pregnancy program members <input type="checkbox"/> High-risk pregnancy members include those with history of tobacco and substance abuse or other high-risk indicators	0.500 0.500 0.500 0.500	2.000	0.000

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>QI Activities</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
4. Outreach to Members Stratified for Chronic Care and Complex Case Management  CRA and TSA § 2.8.4.5.2; 2.8.4.7.2 (MSC and TCS)	The MCO makes three outreach attempts to each newly identified member eligible for chronic care and complex case management to offer enrollment into the program. Outreach attempts must occur within three months of the member's identification for chronic care or complex case management. When the MCO is unable to get in contact with the member after the three outreach attempts and the member appears on the refreshed list, the MCO is not obligated to make another attempt for 180 days.	<input type="checkbox"/> Three attempts made to enroll <input type="checkbox"/> Attempts made within required time	0.500 0.500	1.000	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>QI Activities</b>					
5. Screening for Risk Factors in High Risk Pregnancy  CRA and TSA § 2.8.4.6.1 (MSC and TCS)	The MCO provides screening for risk factors which includes screening for mental health and substance abuse.	<input type="checkbox"/> Yes <input type="checkbox"/> No	1.000 0.000	1.000	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
6. Face-to-Face Visit for High-Risk Members  CRA and TSA § 2.8.3.4 (MSC and TCS)	For members identified as potential participants in voluntary Level 2 PH programs, assessment shall include whether a member needs a face-to-face visit. In cases where a need is identified, the visit shall be conducted following consent of the member.	<input type="checkbox"/> Yes <input type="checkbox"/> No	1.000 0.000	1.000	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>QI Activities</b>					
7. Transitioning of Members into Higher/Lower Levels of Care  CRA and TSA § 2.8.4.5.6; 2.8.4.7.5 (MSC and TCS)	After enrollment into one of the voluntary programs, the MCO will continue to provide ongoing member assessment for transition into higher- or lower-risk classification or to CCM programs for services.	<input type="checkbox"/> Yes <input type="checkbox"/> No	1.000 0.000	1.000	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
8. Implementation of PH  CRA and TSA § 2.8.2.1.1; 2.8.3.1 (MSC and TCS)	The MCO makes reasonable attempts to assess each member's health risks by utilizing an approved common mini-health survey approved by the Bureau, Population Health staff or a Comprehensive Health Risk Assessment (HRA).	<input type="checkbox"/> Yes <input type="checkbox"/> No	1.000 0.000	1.000	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>QI Activities</b>					
9. Enrollment of CHOICES Members in PH Programs  CRA and TSA § 2.8.11.1 (MSC); 2.8.10.1 (TCS)	The MCO has a systematic process in place to identify and enroll eligible members in each PH program including CHOICES members, through the same process used for identification of non-CHOICES members and the CHOICES care coordination process.	<input type="checkbox"/> Process in place to identify and enroll CHOICES members <input type="checkbox"/> Process the same as that used for non-CHOICES members	0.500  0.500	1.000	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
10. PH Treatment Plans for CHOICES Members  CRA and TSA § 2.8.4.3.1; 2.8.11.3.6 (MSC); 2.8.4.3.1; 2.8.10.3.6 (TCS)	Each PH program includes the development of program content plans (also known as treatment plans) that serve as the outline for all activities and interventions. Appropriate elements of the program content plans are individualized and integrated into the CHOICES member's plan of care to facilitate better management of the member's condition. At a minimum, activities and interventions associated with treatment plans address the following: <ul style="list-style-type: none"> <li>• condition monitoring</li> <li>• patient compliance and treatment protocols</li> <li>• consideration of other co-morbidities</li> <li>• condition-related lifestyle issues</li> </ul>	<input type="checkbox"/> Treatment plans outline activities and interventions. <input type="checkbox"/> Elements of program content plans are individualized and integrated into the CHOICES plan of care. <input type="checkbox"/> Condition monitoring addressed <input type="checkbox"/> Patient adherence addressed <input type="checkbox"/> Co-morbidities addressed <input type="checkbox"/> Lifestyle issues addressed	0.250  0.250  0.250 0.250 0.250	1.500	0.000

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>QI Activities</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
11. Integration of PH Program into CHOICES Members' Plans of Care  CRA & TSA § 2.8.11.3.5 (MSC); 2.8.10.3.5 (TCS)	The PH program descriptions address how the MCO will ensure that the Care Coordinator integrates aspects of the PH program that will enhance management of the member's condition into the plan of care.	<input type="checkbox"/> Yes <input type="checkbox"/> No	0.500 0.000	0.500	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
12. Stratification of CHOICES Members in PH Programs  CRA and TSA § 2.8.11.4 (MSC); 2.8.10.4 (TCS)	In addition to stratifying PH program members by condition severity or by clinical- or member-provided information, the MCO also stratifies CHOICES members by the type of setting where LTC services are delivered (e.g., nursing facility or home- or community-based residential alternative or home-based). The MCO tailors program content and education activities for each stratification level, including interventions based on the setting in which the CHOICES member resides.	<input type="checkbox"/> Stratification included condition severity, clinical- and member-provided information and service setting. <input type="checkbox"/> Program content, education activities and interventions were based on stratification and service setting.	0.500 0.500	1.000	0.000

## 2016 Annual Quality Survey - Quality Process Standards

### MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>QI Activities</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
13. PH and CHOICES Care Coordination  CRA and TSA § 2.8.11.2 (MSC); 2.8.10.2 (TCS)	The MCO's PH program descriptions address how the MCO ensures that PH activities are integrated with CHOICES care coordination processes and functions and how it confirms that the member's Care Coordinator has primary responsibility for coordination of all the member's physical health, behavioral health and LTC services, including appropriate management of chronic conditions.	<input type="checkbox"/> Program descriptions address the integration of CHOICES care coordination processes and functions.  <input type="checkbox"/> CHOICES program descriptions indicate that the Care Coordinator has primary responsibility.	0.500  0.500	1.000	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>QI Activities</b>					
14. Care Coordinator Responsibilities for CHOICES Members  CRA and TSA § 2.8.11.3.6 (MSC); 2.8.10.3.6 (TCS)	The PH program descriptions address how the MCO will ensure that the Care Coordinator is responsible for coordinating with the member's providers regarding the development and implementation of an individualized treatment plan. The treatment plan is integrated into the member's plan of care and includes the following: <ul style="list-style-type: none"> <li>• monitoring of the member's condition</li> <li>• ensuring compliance with treatment protocols</li> <li>• lifestyle changes</li> </ul>	<input type="checkbox"/> Care Coordinator and providers involved in development and implementation of treatment plan <input type="checkbox"/> Treatment plan integrated into plan of care <input type="checkbox"/> Treatment plan included condition monitoring <input type="checkbox"/> Treatment plan included compliance with protocols <input type="checkbox"/> Treatment plan included lifestyle changes	0.300  0.300  0.300  0.300	1.500	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
15. Keeping Care Coordinator Informed  CRA and TSA § 2.8.11.3-.3.3 (MSC); 2.8.10.3-.3.3 (TCS)	The MCO's program descriptions address how the member's Care Coordinator will receive the following: <ul style="list-style-type: none"> <li>• notification of the member's participation in a PH program</li> <li>• information collected about the member through PH programs</li> <li>• educational materials given to the member through PH programs</li> </ul>	<input type="checkbox"/> Participation notification sent <input type="checkbox"/> Information collected <input type="checkbox"/> Materials given	0.250  0.250  0.250	0.750	0.000

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>QI Activities</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
16. Care Coordinator Review  CRA and TSA § 2.8.11.3.4 (MSC); 2.8.10.3.4 (TCS)	The MCO's PH program descriptions ensure that the Care Coordinator completes the following: <ul style="list-style-type: none"> <li>• verbal reviews of the information listed in Element #15 with the member and the member's caregiver and/or representative</li> <li>• coordination of necessary follow-up regarding the PH program, such as scheduling screenings or appointments</li> </ul>	<input type="checkbox"/> Information verbally reviewed <input type="checkbox"/> Follow-up coordinated	<b>0.500</b> <b>0.500</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>QI Activities</b>					
17. Identification of Increase in Member Needs During Transition  CRA and TSA § 2.9.2.1.4.3; 2.9.3.5 (MSC and TCS)	If the MCO becomes aware of an increase in the member's needs prior to conducting a comprehensive needs assessment (for new CHOICES members, CHOICES members transferring between MCOs and members currently receiving LTC services during CHOICES implementation), the following occurs: <ul style="list-style-type: none"> <li>• A comprehensive needs assessment is immediately conducted.</li> <li>• The plan of care is updated.</li> <li>• The changes in services are implemented within 10 days of the MCO becoming aware of the change in needs.</li> </ul>	<input type="checkbox"/> Comprehensive needs assessment conducted <input type="checkbox"/> Plan of care updated <input type="checkbox"/> Service changes implemented within 10 days of MCO's knowledge of change in needs	0.250  0.250  0.250	0.750	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
18. Transition of CHOICES Group 2 Members in Community-Based Residential Alternative (CBRA) Settings  CRA and TSA § 2.9.6.2.5.2 (MSC and TCS)	For members in CHOICES Group 2 who are currently receiving services in a CBRA setting, the MCO performs all of the following within 10 business days of receipt of a member's enrollment: <ul style="list-style-type: none"> <li>• A CHOICES Care Coordinator conducts a face-to-face visit with the member.</li> <li>• A comprehensive needs assessment is performed.</li> <li>• A plan of care is developed.</li> <li>• Additional home and community-based services (HCBS) are authorized and initiated.</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No	0.500  0.000	0.500	0.000

## 2016 Annual Quality Survey - Quality Process Standards

### MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>QI Activities</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
19. Transition of CHOICES Group 3 Members to or From CHOICES Group 2 or CHOICES Group 1  CRA and TSA § 2.9.6.3.14; 2.9.6.8.6-.7; 2.9.6.8.11-.12 (MSC and TCS)	For members in CHOICES Group 3 who are transitioned to or from Group 1 or 2, the MCO performs all of the following as required by the CRA to ensure the member is receiving the appropriate level of care in the right setting: <ul style="list-style-type: none"> <li>Ensures that the level of care is accurate and complete</li> <li>Satisfies all technical requirements specified by TennCare</li> <li>Accurately reflects the member's current medical and functional status</li> <li>A CHOICES Care Coordinator conducts a face-to-face visit with the member.</li> <li>A comprehensive needs assessment is performed.</li> <li>A plan of care is developed.</li> <li>Additional HCBS are authorized and initiated.</li> </ul>	<input type="checkbox"/> Level of care accurate and complete <input type="checkbox"/> Technical requirements met <input type="checkbox"/> Reflects member's current medical and functional status <input type="checkbox"/> Face-to-face visit conducted <input type="checkbox"/> Comprehensive needs assessment performed <input type="checkbox"/> Plan of care developed <input type="checkbox"/> Home and community-based services are authorized and initiated	0.250  0.250  0.250  0.250  0.250  0.250	1.750	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>QI Activities</b>					
20. Transition of CHOICES Members from Nursing Facilities  CRA and TSA § 2.9.6.8.21 (MSC and TCS)	When member transitions from a nursing facility to a CBRA or to live with a relative or other caregiver, the Care Coordinator makes contact with the member within the first 24 hours of transition and visits the member in his or her new residence within seven days of transition. During the initial 90 days post-transition period the Care Coordinator contacts the member at least monthly by telephone to ensure the plan of care is being followed, member needs are met and transition to the community has been successful. Additional face-to-face assessments are conducted when additional needs are identified and to confirm member needs are met.	<input type="checkbox"/> Member contact within the first 24 hours <input type="checkbox"/> Visit made to residence within 7 days <input type="checkbox"/> At least monthly telephone contact within the initial 90 days post-transition <input type="checkbox"/> Needs met	0.250 0.250 0.250 0.250	1.000	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
21. Telephonic Screening for CHOICES Referrals  CRA and TSA § 2.9.6.3.3.1 (MSC and TCS)	If the MCO uses a telephone screening process for members referred to CHOICES, the following process is in place and documented: <ul style="list-style-type: none"> <li>• Three attempts are made to contact a member by phone.</li> <li>• If telephone attempts are unsuccessful, a letter with CHOICES information on how to obtain a screening for CHOICES is sent to the member's most recently reported address.</li> </ul>	<input type="checkbox"/> Three attempts by phone <input type="checkbox"/> Letter sent after unsuccessful phone attempts	0.500 0.500	1.000	0.000

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>QI Activities</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
22. CHOICES Level of Care Assessment  CRA and TSA § 2.9.6.10.3.1.1 (MSC and TCS)	The MCO conducts a level of care assessment at least annually and within five business days of awareness of a change in a member's functional or medical status that could potentially affect level of care eligibility.	<input type="checkbox"/> Level of care assessment conducted annually <input type="checkbox"/> Level of care assessment conducted within five business days as applicable	0.500  0.500	1.000	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
23. High Utilization of Services  CRA and TSA § 2.9.6.10.3.4 (MSC and TCS)	The MCO has policies and procedures in place that address high utilization of Emergency Department and behavioral health services. The Care Coordinator facilitates appropriate utilization of these services (e.g., communication with the member's providers, member education, conducting needs assessments and/or updating the member's plan of care).	<input type="checkbox"/> Policy and Procedure <input type="checkbox"/> Evidence of Monthly UM reports <input type="checkbox"/> Evidence of CC notification	0.500 0.500 0.500	1.500	0.000

## 2016 Annual Quality Survey - Quality Process Standards MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>QI Activities</b>					
Findings:					
Strength:					
Area of Noncompliance:					
Suggestion:					
<b>Standard Score for QI Activities</b>			<b>0.0 %</b>	<b>29.750</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Clinical Criteria for Utilization Management (UM) Decisions</b>					
1. Availability of Criteria  CRA and TSA § 2.18.5.2.8 and .18 (MSC); 2.18.5.3.8 and .18 (TCS)	The MCO includes the following information in its provider manuals: <ul style="list-style-type: none"> <li>• medical necessity standards and clinical practice guidelines</li> <li>• prior authorization, referral and other UM requirements and procedures</li> </ul>	<input type="checkbox"/> medical necessity standards and clinical practice guidelines included  <input type="checkbox"/> prior authorization, referral and other UM requirements included	0.500  0.500	1.000	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Clinical Criteria for Utilization Management (UM) Decisions</b>					
2. Transition to Other Care  CRA and TSA § 2.9.5.1-.1.2 (MSC and TCS)	<p>The MCO assists members in transitioning to another provider when a provider currently treating their condition or providing prenatal services terminates participation with the MCO. Assistance is provided to members with the following conditions:</p> <ul style="list-style-type: none"> <li>• chronic or acute medical conditions</li> <li>• behavioral health conditions</li> <li>• currently receiving LTC services</li> <li>• pregnancy</li> </ul> <p>For members in their second or third trimester of pregnancy, the MCO allows continued access to the prenatal care provider and to any provider treating the member's chronic or acute medical or behavioral health condition through the postpartum period. For all other members, continuation of care is provided up to 90 calendar days or until the member may be reasonably transferred to another provider without disruption of care, whichever is less.</p>	<input type="checkbox"/> Assistance provided to specific members <input type="checkbox"/> Continuation of current prenatal provider through postpartum period <input type="checkbox"/> Continuation of care up to 90 calendar days or until transfer without disruption of care for all other members <input type="checkbox"/> Staff able to demonstrate knowledge of transition requirements and provide examples	0.500  0.500  0.500  0.500	2.000	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
<b>Standard Score for Clinical Criteria for Utilization Management (UM) Decisions</b>			0.0 %	3.000	0.000

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Member Rights and Responsibilities</b>					
1. Member Handbook Development and Distribution  CRA and TSA § 2.17.4.1, .2 and .4 (MSC and TCS)	The Member Handbook is developed and updated annually based on TennCare provided templates. It is distributed to the following: <ul style="list-style-type: none"> <li>to members within 30 calendar days of receiving notice of enrollment in the MCO</li> <li>to all contracted providers upon initial credentialing</li> <li>redistributed to all members and providers annually and as updates occur</li> </ul>	<input type="checkbox"/> Developed/Updated using TennCare templates <input type="checkbox"/> Sent to members within 30 calendar days of enrollment <input type="checkbox"/> Sent to providers upon credentialing <input type="checkbox"/> Redistributed annually <input type="checkbox"/> Redistributed as updated	0.200 0.200 0.200 0.200 0.200	1.000	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
2. Complaint Procedures  CRA and TSA § 2.19.1.1 (MSC and TCS)	In accordance with TennCare rules and regulations, the TennCare waiver, consent decrees or court orders governing the appeals process, the MCO has internal complaint procedures for its members.	<input type="checkbox"/> Yes <input type="checkbox"/> No	0.500 0.000	0.500	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Member Rights and Responsibilities</b>					
3. Communication of Rights and Responsibilities in Member Handbook  CRA and TSA § 2.17.4.6.18; .22-.23; .27-.31; .34-.37 and .39 (MSC); 2.17.4.7.18; .22-.23; .27-.31; .34-.37 and .39 (TCS)	The Member Handbook informs members of their right (or responsibility) to the following: a. to file a complaint and to the provision of a complaint form on which to do so b. to file an appeal c. to request reassessment of eligibility-related decisions related directly to TennCare d. responsibility to notify the MCO and TennCare with each change of address e. to change MCOs f. to disenroll from TennCare g. to amend their data in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations h. to obtain information regarding the structure and operation of the MCO and physician incentive plans i. to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand j. to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation	<input type="checkbox"/> a. File a complaint and form provided <input type="checkbox"/> b. File an appeal <input type="checkbox"/> c. Request reassessment of eligibility-related decisions <input type="checkbox"/> d. Responsibility to notify MCO and TennCare of address change <input type="checkbox"/> e. Change MCOs <input type="checkbox"/> f. Disenroll from TennCare <input type="checkbox"/> g. Amend their data <input type="checkbox"/> h. Obtain information on MCO structure/operation and physician incentive plans <input type="checkbox"/> i. Be informed of available treatment options and alternatives <input type="checkbox"/> j. Be free from restraint or seclusion	<b>0.200</b>  <b>0.200</b>  <b>0.200</b>  <b>0.200</b>  <b>0.200</b>  <b>0.200</b>  <b>0.200</b>  <b>0.200</b>  <b>0.200</b>	<b>2.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Member Rights and Responsibilities</b>					
4. Member Handbook Inclusions  CRA and TSA § 2.17.4.6.3-.5; .8-.10, .12, .15-.17; .21; .25-.26; .32 and .38 (MSC); 2.17.4.7.3-.6; .8-.10, .12; .15-.17; .21, .25-.26; .32 and .38 (TCS)	The Member Handbook includes, at a minimum, the following: a. a description of services provided, including benefit limits, exclusions and use of non-contract providers b. financial responsibilities of member, explained and a provider may take steps to collect any co-pays member may owe c. indications that members may not be billed for covered services except for the amounts of the specified TennCare cost-share responsibilities and indications of their right to appeal in the event that they are billed d. procedures for obtaining required services, including procedures for obtaining referrals to network specialists and providers outside of the plan e. information advising members that if they need a service that is not available within the plan, they will be referred to a provider outside of the plan, and any co-payment requirements would be the same as if this provider were in the plan f. an explanation on how members will be notified of member-specific information, such as the effective date of enrollment g. a member notice indicating that enrollment in the MCO's plan invalidates any prior authorization for services granted by another plan but not utilized prior to enrollment in the new MCO and notice of continuation of an active treatment plan or pregnancy h. information on how to access the 24-hour nurse	<input type="checkbox"/> a. Service parameters <input type="checkbox"/> b. Financial responsibilities of member, explanation regarding collection and steps taken to collect any co-pays member may owe <input type="checkbox"/> c. Billing for covered services and appeal of billed services <input type="checkbox"/> d. Obtaining services and referrals in- and out-of-plan <input type="checkbox"/> e. Out-of-plan referral and co-pay requirements <input type="checkbox"/> f. Member notification methods <input type="checkbox"/> g. Service continuation/discontinuations <input type="checkbox"/> h. PCP and nurse line 24/7 access <input type="checkbox"/> i. Emergency services access information <input type="checkbox"/> j. Preventive services information <input type="checkbox"/> k. Advance directives information <input type="checkbox"/> l. Required toll-free telephone numbers and notice that members may contact the MCO or TennCare with questions <input type="checkbox"/> m. Information on appropriate prescription drug usage	0.200 0.200 0.200 0.200 0.200 0.200 0.200 0.200 0.200 0.200 0.200 0.200 0.200	3.200	0.000

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Member Rights and Responsibilities</b>					
	<p>line and how to access the PCP on a 24-hour basis</p> <p>i. an explanation of emergency services and how to obtain them in and out of the MCO's service area, including but not limited to the use of 911 and locations of emergency settings and services</p> <p>j. information about preventive services for adults and children, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for Medicaid-eligible members, listing of preventive services and notice that preventive services are at no cost and without cost-share responsibilities</p> <p>k. written information concerning advance directives</p> <p>l. member services toll-free telephone numbers, including the TennCare Hotline, the MCO's customer service line and the MCO's 24/7 Nurse Triage Line with a statement indicating that the member may contact the plan or TennCare regarding questions about TennCare as well as the service/information that may be obtained from each line</p> <p>m. information on appropriate prescription drug usage</p> <p>n. explanation of how members can change PCPs</p> <p>o. information about how to report suspected abuse, neglect and exploitation of members who are adults and suspected brutality, abuse or neglect of members who are children, including the phone number to call to report suspected abuse</p> <p>p. includes information for CHOICES members on the Care Coordination Program</p>	<p><input type="checkbox"/> n. Information on how to change PCP</p> <p><input type="checkbox"/> o. Required telephone numbers and how to report suspected abuse, neglect or exploitation</p> <p><input type="checkbox"/> p. Role of the CHOICES Care Coordinator</p>	0.200		
			0.200		
			0.200		

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Member Rights and Responsibilities</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
5. Notice of Right to File a Complaint  CRA and TSA § 2.17.5.3.5 (MSC and TCS)	A notice of members' right to file complaints is included in quarterly newsletters sent by the MCO. The notice includes a contractor phone number for doing so and is written in English and Spanish.	<input type="checkbox"/> Notice in English and Spanish <input type="checkbox"/> Required information in each quarterly newsletter <input type="checkbox"/> Phone number for complaints	<b>0.333</b>  <b>0.333</b>  <b>0.334</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
6. Notification of Changes to Written Materials  CRA and TSA § 2.17.2.9 (MSC and TCS)	The MCO provides written notice to members of any changes in policies or procedures described in written materials previously sent to members at least 30 days before the effective date of change.	<input type="checkbox"/> Written notice to members <input type="checkbox"/> Members notified at least 30 days before effective date of change	<b>0.500</b>  <b>0.500</b>	<b>1.000</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Member Rights and Responsibilities</b>					
Findings:					
Strength:					
Area of Noncompliance:					
Suggestion:					
7. Translation Services  CRA and TSA § 2.17.4.6.33 (MSC); 2.17.4.7.33 (TCS); 2.17.5.2.1.1.1; 2.17.5.3.4; 2.18.1.3; 2.18.2.1-.3; 2.28.2; 2.28.2.1 (MSC and TCS)	The MCO provides translation services for members as demonstrated by the following: <ul style="list-style-type: none"> <li>Member Handbooks include information on how to obtain information in alternative formats or how to access interpretation services, as well as a statement indicating that interpretation and translation services are free.</li> <li>Quarterly newsletters include the procedure on how to obtain information in alternative formats or how to access interpretation services, as well as a statement indicating that interpretation and translation services are free.</li> <li>The MCO develops a written procedure for providing a members language interpretation and translation services, including but not limited to members with hearing impairment and/or Limited English Proficiency (LEP).</li> <li>The MCO's member services telephone line handles calls from callers with hearing impairment and LEP.</li> <li>The MCO's Non-Discrimination Compliance Coordinator provides instruction for MCO staff, including but not limited to all providers and direct service subcontractors, regarding the procedure.</li> </ul>	<input type="checkbox"/> Information in handbook <input type="checkbox"/> Information in all quarterly newsletters <input type="checkbox"/> Procedure for language interpretation and translation services <input type="checkbox"/> Member services handles calls from hearing impaired and LEP members <input type="checkbox"/> Instruction to staff, providers and subcontractors	0.200 0.200 0.200 0.200 0.200	1.000	0.000

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Member Rights and Responsibilities</b>					
Findings:					
Strength:					
Area of Noncompliance:					
Suggestion:					
8. Translated Vital Documents  CRA and TSA § 2.17.2.6 (MSC and TCS)	All vital MCO documents and the Member Handbook are translated and available in Spanish. Within 90 calendar days of notification from TennCare, all vital MCO documents are translated and available to each LEP group identified by TennCare that constitutes five percent of the TennCare population or 1,000 members, whichever is less.	<input type="checkbox"/> All vital documents translated <input type="checkbox"/> Vital documents translated within 90 days	0.500 0.500	1.000	0.000
Findings:					
Strength:					
Area of Noncompliance:					
Suggestion:					
<b>Standard Score for Member Rights and Responsibilities</b>			0.0 %	10.700	0.000

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
1. New Member Calls  CRA and TSA § 2.7.6.2.2.1 (MSC and TCS)	The MCO conducts telephone calls to all new members under the age of 21 to inform them of TennCare Kids services, including the availability of assistance with appointment scheduling and transportation. (This is not applicable if the MCO's TennCare Kids screening rate is above 90 percent, as determined in the most recent Centers for Medicare & Medicaid Services [CMS]-416 report.)	<input type="checkbox"/> Yes or Not Applicable (CMS-416 screening rate above 90 percent) <input type="checkbox"/> No	1.000  0.000	1.000	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
2. Outreach Contacts  CRA and TSA § 2.7.6.2.2; 2.7.6.2.2.2 (MSC and TCS)	The MCO distributes six outreach contacts a year, which include the following: <ul style="list-style-type: none"> <li>Member Handbook sent within 30 days of enrollment (annually thereafter upon the member's anniversary date of enrollment, the MCO sends an updated handbook, a supplemental update to the handbook, or a reminder of EPSDT services)</li> <li>four quarterly newsletters</li> <li>one reminder before screens are due (with transportation and scheduling assistance offered)</li> <li>at least one of the six outreach attempts identified above advising members who are blind, deaf, illiterate or non-English speaking regarding how to request and/or access such assistance and/or information</li> </ul>	<input type="checkbox"/> Member Handbook sent within 30 days of enrollment <input type="checkbox"/> Quarterly newsletters <input type="checkbox"/> Screening due reminders <input type="checkbox"/> Annual reminder of EPSDT services <input type="checkbox"/> Annually informed regarding availability of information in alternative formats	0.125  0.125 0.125 0.125  0.250	0.750	0.000

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
3. Documenting Outreach  CRA and TSA § 2.7.6.2.4 (MSC and TCS)	The MCO has policies and procedures in place as well as process for following up with members who do not get their screenings timely. It includes provisions for documenting all outreach attempts with a mechanism for maintaining records of efforts to reach members who miss screenings appointments or who have failed to receive regular check-ups. This includes a different method of outreach effort, at least quarterly, in excess of the six "outreach contacts" to accomplish a missed screening. MCO staff demonstrates knowledge of the outreach efforts used for each quarter.	<input type="checkbox"/> Process in place <input type="checkbox"/> Different outreach method for each quarter <input type="checkbox"/> Staff demonstrates knowledge	0.500 0.500 0.500	1.500	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
4. Re-Notification If No Services Used  CRA and TSA § 2.7.6.2.5 (MSC and TCS)	The MCO maintains a process for determining whether someone eligible for EPSDT has used services within a year. The MCO follows up with two reasonable attempts to re-notify the member. One of the attempts may be a referral to the Health Department for a screen. These two attempts are in addition to the required quarterly attempts outlined in Element #3. The attempts are different in format or message.	<input type="checkbox"/> Maintains process <input type="checkbox"/> Two additional re-notifications <input type="checkbox"/> Attempts in different format or message	0.250 0.250 0.250	0.750	0.000

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
5. Declined Services  CRA and TSA § 2.7.6.2.6 (MSC and TCS)	The MCO requires providers to maintain a process for documenting services declined by a parent, guardian or mature, competent child, specifying the service declined. Internal medical record review reflects the MCO's assessment of provider documentation.	<input type="checkbox"/> Process in place <input type="checkbox"/> Evidence of monitoring by MCO	0.500 0.500	1.000	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
6. Undeliverable Mail  CRA and TSA § 2.7.6.2.7 (MSC and TCS)	The MCO documents a minimum of two reasonable attempts to find a member when mail is returned as undeliverable. One of the two attempts is made within 30 days of receipt of mail returned as undeliverable, and the second is made within 90 days. At least one attempt is made by phone.	<input type="checkbox"/> Attempts made within required time frame <input type="checkbox"/> Oral attempt <input type="checkbox"/> Other attempt	0.250 0.250 0.250	0.750	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
7. Accurate Provider Lists  CRA and TSA § 2.7.6.2.8 (MSC and TCS)	The MCO makes available to families accurate lists of names and phone numbers of contract providers who are currently accepting TennCare.	<input type="checkbox"/> Yes <input type="checkbox"/> No	0.500 0.000	0.500	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
8. Targeted Activities  CRA and TSA § 2.7.4.1.3; 2.7.6.2.2.1-.2; 2.7.6.2.5; 2.7.6.2.9; 2.17.5.2 (MSC and TCS)	<p>The MCO has established criteria for determining when to target specific informing activities for each of the following groups:</p> <ul style="list-style-type: none"> <li>• Pregnant women</li> <li>• Families with newborns</li> <li>• Adolescents</li> <li>• First-time eligible members</li> <li>• Those not using the program within a year</li> <li>• Illiterate, blind, deaf and LEP members</li> </ul> <p>Pregnant women are informed about the availability of EPSDT for their children prior to the delivery date (provided the MCO is informed of the pregnancy) and are offered EPSDT services for the child when it is born. The MCO treats a woman's request for EPSDT services during pregnancy as a request for EPSDT services for the child at birth.</p>	<input type="checkbox"/> Criteria established for when to target informing activities for each of the specified groups <input type="checkbox"/> Pregnant women informed about EPSDT services prior to delivery and offered services for children when born	0.500 0.500	1.000	0.000

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
9. Outreach to Individuals Who Need Alternative Communication Methods  CRA and TSA § 2.7.6.2.2.2 (MSC and TCS)	The MCO customizes communication assistance methods to inform illiterate individuals or those with disabilities, such as visual or hearing impairments or LEP, about the availability of EPSDT services.	<input type="checkbox"/> Customized methods <input type="checkbox"/> Items distributed to identified members	0.250 0.250	0.500	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
10. Prenatal Appointment Assistance  CRA and TSA § 2.7.5.2.1; 2.11.4.2 (MSC and TCS)	The MCO has processes in place and provides information on covered services to prenatal members who enter TennCare through presumptive eligibility. On the day eligibility is determined, the MCO offers individual assistance in making a timely first prenatal appointment; for a woman past her first trimester, this appointment occurs within 15 days.	<input type="checkbox"/> Process in place <input type="checkbox"/> Provides information on covered services <input type="checkbox"/> On the day eligibility is determined, offers appointment assistance <input type="checkbox"/> For a woman past her first trimester, appointment occurs within 15 days	0.500 0.500 0.500 0.500	2.000	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
11. Referrals from One Level of Screening to Another  CRA and TSA § 2.7.6.1.3; 2.7.6.1.5.2 (MSC and TCS)	The MCO has a policy and procedure in place to ensure that providers make and document appropriate referrals from one level of screening or diagnosis to another more sophisticated level. These referrals are made as needed to determine medically necessary services for the child's physical health, behavioral health and developmental needs. This is done regardless of whether the required services are covered by the MCO.	<input type="checkbox"/> Policy and procedure in place <input type="checkbox"/> Evidence ensuring provider compliance	0.500 0.750	1.250	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
12. Notify MCO If Unable to Make Referral  CRA and TSA § 2.7.6.1.6 (MSC and TCS)	Procedures are in place that direct providers to notify the MCO if a screening reveals the need for other healthcare and the provider is unable to make an appropriate referral. These procedures include the MCO securing an appropriate referral and contacting the member to offer scheduling assistance and transportation.	<input type="checkbox"/> Yes <input type="checkbox"/> No	1.000 0.000	1.000	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
13. Medically Necessary Services  CRA and TSA § 2.6.3.5; 2.7.6.1.5.3 (MSC and TCS)	The MCO has procedures in place to provide all medically necessary EPSDT services as required by law. The MCO has procedures to educate providers about the necessity of documenting all components of a screen with accurate coding and demonstrates that provider education has occurred.	<input type="checkbox"/> EPSDT services provided <input type="checkbox"/> Procedures to educate providers in place <input type="checkbox"/> Evidence of provider education	0.500 0.500 0.500	1.500	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
14. Rehabilitation Services  CRA and TSA § 2.7.6.1.1; 2.7.6.4.8; 2.7.6.4.8.3 (MSC and TCS)	Rehabilitation services include "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts for maximum reduction of physical or mental disability and restoration of a recipient to the best possible functional level." These services may be, where medically necessary to do so, delivered in conjunction with the services listed in the Service Chart (2.7.6.4.8) of the CRA. Covered services must be medically necessary and include treatment to correct or ameliorate, or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, regardless of whether the required service is a covered benefit.	<input type="checkbox"/> Yes <input type="checkbox"/> No	0.500 0.000	0.500	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
15. Medical Necessity  CRA and TSA § 2.6.3.1 and .5 TCA § 71-5-144 (MSC and TCS)	The MCO has a process concerning issues of medical necessity which ensures that consistent decisions are rendered and that they are compliant with federal and state laws.	<input type="checkbox"/> Process in place <input type="checkbox"/> Definition of medical necessity same as contract or no more restrictive <input type="checkbox"/> Evidence of consistent decisions (e.g., inter-rater reliability [IRR] testing) <input type="checkbox"/> Appropriate follow-up as applicable	0.500 0.500 0.500 0.500	2.000	0.000

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
16. Limitations/ Capitations/ Delays  CRA and TSA § 2.6.3.2-.5 (MSC and TCS)	The MCO demonstrates that it does not impose benefit limitations, duration/scope limitations or monetary capitations upon EPSDT services. Services are provided based on each child's individual needs. Utilization controls do not unreasonably delay the initial or continued receipt of services.	<input type="checkbox"/> No limits or capitations imposed <input type="checkbox"/> Services based on individual needs <input type="checkbox"/> UM controls do not delay services	<b>0.500</b>  <b>0.500</b>  <b>0.500</b>	<b>1.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
17. Qualified UM Personnel  CRA and TSA § 2.14.1.8 (MSC and TCS)	The MCO has a process in place guaranteeing that only qualified personnel with education, training or experience in child and adolescent health are employed to make utilization review and prior authorization decisions for members age 20 and under. Personnel making utilization review and prior authorization decisions for members 20 and under are trained or experienced as described above.	<input type="checkbox"/> Process in place <input type="checkbox"/> Staff trained/educated	<b>0.500</b>  <b>2.500</b>	<b>3.000</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
18. Services Without Prior Authorization  CRA and TSA § 2.7.6.1.7; 2.7.6.4.8 (MSC and TCS)	The MCO ensures that all covered medically necessary services (including continuation of services) are provided, whether the condition existed prior to any screening and regardless of whether the need for such services was identified by a provider whose services had received prior authorization from the MCO or via an in-network provider.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.250</b> <b>0.000</b>	<b>1.250</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
19. Specialist List  CRA and TSA § 2.14.3.5.1 (MSC and TCS)	The MCO demonstrates that it provides PCPs participating in EPSDT with a hard copy of an up-to-date list of specialists and behavioral health providers to whom referrals may be made for screens, lab tests, further diagnostic service and corrective treatment. The list is supplemented and mailed quarterly to indicate additions and deletions. The MCO also maintains an updated electronic, web-accessible version of the referral provider listing.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>0.750</b> <b>0.000</b>	<b>0.750</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
Findings:					
Strength:					
Area of Noncompliance:					
Suggestion:					
20. Mental Health CM Services  CRA and TSA § 2.7.2.6.2 (MSC and TCS)	Mental health CM services, for children whose behavioral health needs require these services, are provided to all TennCare children for whom they are medically necessary.	<input type="checkbox"/> Yes <input type="checkbox"/> No	1.000 0.000	1.000	0.000
Findings:					
Strength:					
Area of Noncompliance:					
Suggestion:					
21. CM Central Function  CRA and TSA § 2.7.6.4.5 (MSC and TCS)	EPSDT CM activities are a central function of the MCO, as evidenced by CM activities being integrated throughout the operations of the MCO. CM activities are individualized based on needs of the child and are not used only as a tool for prior authorizations.	<input type="checkbox"/> Integrated throughout MCO <input type="checkbox"/> Activities individualized	0.750 0.750	1.500	0.000
Findings:					
Strength:					
Area of Noncompliance:					
Suggestion:					

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
22. Family Involvement and Accessible Services  CRA and TSA § 2.6.1.1; 2.7.2; 2.7.2.1.4; 2.11.1.1; Attachment I-Behavioral Health Specialized Service Descriptions (MSC and TCS)	Parents and family members are involved, to the greatest extent possible, in the determination of behavioral health services to be delivered to a particular child. The MCO provides access to behavioral health providers for the provision of covered services in accordance with the geographic, appointments and wait times access standards.	<input type="checkbox"/> Parent/Family involvement <input type="checkbox"/> Comprehensive/Appropriate scope <input type="checkbox"/> Geographically accessible	0.500 0.500 0.500	1.500	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
23. Follow-Up After Inpatient or Residential Treatment  CRA and TSA § 2.9.10.3.2 (MSC and TCS)	The MCO ensures through coordination efforts with its contracted facilities that psychiatric hospital and residential treatment facility discharges do not occur without a discharge plan in which the member, his or her family, or other caregivers, clinicians and social worker(s) have participated. This discharge plan includes an outpatient visit scheduled before discharge, which ensures access to proper provider/medication follow-up. Also, an appropriate placement or housing site is secured prior to discharge.	<input type="checkbox"/> Discharge plan completed <input type="checkbox"/> Required persons participated <input type="checkbox"/> Outpatient appointment scheduled <input type="checkbox"/> Appropriate placement or housing secured	0.500 0.500 0.500 0.500	2.000	0.000

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
24. Screening Components Including Follow-Up  CRA and TSA § 2.7.6.1.4 (MSC and TCS)	The MCO has procedures in place for ensuring that all TennCare Kids screens contain all required components, including follow-up components if all components of a screen cannot be completed in a single visit or whenever concerns or questions remain after the screening process.	<input type="checkbox"/> Yes <input type="checkbox"/> No	0.500 0.000	0.500	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
25. Interperiodic Screen  CRA and TSA § 2.6.1.3; 2.7.6.1.7; 2.7.6.3.2 (MSC and TCS)	The MCO demonstrates that any encounter with a health professional practicing within the scope of his or her practice is considered an interperiodic screen and that any person who suspects a problem may refer a child for an interperiodic screen.	<input type="checkbox"/> Yes <input type="checkbox"/> No	0.500 0.000	0.500	0.000

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
26. Prior Authorization Prohibited  CRA and TSA § 2.7.6.1.7 (MSC and TCS)	The MCO does not impose prior authorization requirements on interperiodic screens conducted by the PCP.	<input type="checkbox"/> Yes <input type="checkbox"/> No	0.500 0.000	0.500	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
27. Screening Standards Met  CRA and TSA § 2.7.6.1.1; 2.7.6.2.3-4 (MSC and TCS)	The MCO demonstrates that EPSDT screening standards are met or that all children who have not received complete screenings have been subject to outreach efforts reasonably calculated to ensure participation. In the event that screening rates do not meet compliance standards, the MCO may demonstrate compliance by showing that such failure to achieve standards was due to factors beyond its control. MCO screening rates are based upon the CMS-416 report calculated by TennCare.	<input type="checkbox"/> Yes <input type="checkbox"/> No	1.500 0.000	1.500	0.000

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
28. Transportation  CRA and TSA § 2.7.6.4.6 and Attachment XI: 1.2-.3; 4.1.1 (MSC and TCS)	The MCO has protocols and procedures for ensuring access to non-emergency transportation services. The MCO does not place blanket restrictions or requirements on age or lack of parental accompaniment. Transportation assistance includes related travel expenses, meals, lodging and cost of an attendant to accompany the child, if necessary. The MCO has protocols and procedures for making referrals to TennCare transportation providers.	<input type="checkbox"/> Protocols and procedures <input type="checkbox"/> No blanket restrictions <input type="checkbox"/> Assistance is inclusive of identified components <input type="checkbox"/> Protocols for transportation referral	<b>0.500</b> <b>0.500</b> <b>0.500</b> <b>0.500</b>	<b>2.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
29. Program Coordination  CRA and TSA § 2.7.6.1.3 (MSC and TCS)	The MCO has policies and procedures that coordinate TennCare Kids outreach, screening and treatment services with other children's health and education services and programs. Staff is able to describe and demonstrate coordination efforts by the MCO.	<input type="checkbox"/> Policies and procedures in place <input type="checkbox"/> Coordination described/ demonstrated	<b>0.500</b> <b>0.500</b>	<b>1.000</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)					
Findings:					
Strength:					
Area of Noncompliance:					
Suggestion:					

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
30. Individual Education Plans (IEPs)  TENnderCARE Connection Policy; CRA and TSA § 2.9.16.7.1-.2.3 (MSC) 2.9.17.7.1-.2.3 (TCS)	<p>The MCO has a process to facilitate coordination of EPSDT services when TennCare-enrolled children have been identified as needing to receive medically related services in an educational setting, as listed in their IEPs. Annually, TennCare sends a letter to all School Directors and Special Education Directors requesting the IEPs on behalf of the MCOs. If the MCO becomes aware that a member has an IEP (for example, through the internal CM process), then the MCO is obligated to request a copy of the IEP from the school.</p> <p>After receipt of the IEP, the MCO completes the following actions:</p> <ul style="list-style-type: none"> <li>• either accepts the IEP as an indication of a medical problem and treats the IEP as a request for service to which the MCO responds within 14 days or assists in making an appointment to have the child appropriately evaluated within the time frames specified in the TennCare Waiver Terms and Conditions for access to care</li> <li>• sends a copy of the IEP and related information to the PCP</li> <li>• notifies the designated school contact of the ultimate disposition of the request</li> </ul> <p>Coordination by the MCO is calculated to reduce gaps and overlaps in services.</p>	<input type="checkbox"/> Requests IEPs <input type="checkbox"/> Accepts problem or has tested <input type="checkbox"/> Shares with PCP <input type="checkbox"/> Notifies school contact of disposition of request <input type="checkbox"/> Coordination calculated to reduce gaps and overlaps	<b>0.200</b> <b>0.200</b> <b>0.200</b> <b>0.200</b> <b>0.200</b>	<b>1.000</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
31. Tracking System  CRA and TSA § 2.7.6.1.8; 2.7.6.2.3--4 (MSC and TCS)	Tracking system data are used to take action to improve the EPSDT services. The tracking system information has been utilized to contact providers regarding the need to set appointments for the individual member. The tracking system information has been used to contact parents/guardians/members regarding the need to make an appointment and receive EPSDT services. (For more detailed information, refer to the EPSDT Information System Tracking Review Tool.)	<input type="checkbox"/> Contact providers <input type="checkbox"/> Contact parent/guardian/member	1.000 1.000	2.000	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
32. EPSDT Language in Contracts  CRA and TSA § 2.7.6.3.3-.5; 2.12.9.63 (MSC and TCS)	All contracts with appropriate providers contain language requiring the EPSDT elements: <ul style="list-style-type: none"> <li>comprehensive health and developmental history</li> <li>comprehensive physical exam</li> <li>laboratory testing</li> <li>vision and hearing testing</li> <li>dental assessment</li> <li>health education</li> <li>immunizations</li> </ul>	<input type="checkbox"/> Comprehensive health history <input type="checkbox"/> Comprehensive physical exam <input type="checkbox"/> Laboratory testing <input type="checkbox"/> Vision and hearing testing <input type="checkbox"/> Dental screening <input type="checkbox"/> Health education <input type="checkbox"/> Immunizations	0.250 0.250 0.250 0.250 0.250 0.250 0.250	1.750	0.000

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
Findings:					
Strength:					
Area of Noncompliance:					
Suggestion:					
33. EPSDT Contract Review  CRA and TSA § 2.12.8; 2.12.9.6 (MSC and TCS)	Review of contracts ensures that there are no provisions which would encourage violations of the EPSDT mandate.	<input type="checkbox"/> Yes (no provisions) <input type="checkbox"/> No	0.500 0.000	0.500	0.000
Findings:					
Strength:					
Area of Noncompliance:					
Suggestion:					
<b>Standard Score for Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>			<b>0.0 %</b>	<b>39.750</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Grier Revised Consent Decree</b>					
1. Appeals Unit  Grier Revised CD; CRA and TSA § 2.19.3.3 (MSC and TCS)	The MCO has sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting members.	<input type="checkbox"/> Yes <input type="checkbox"/> No	1.500 0.000	1.500	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
2. Grier/Appeals Procedures  CRA and TSA § 2.19.1; 2.19.3.3 (MSC and TCS)	In accordance with TennCare rules and regulations, the TennCare waiver and consent decrees or court orders governing the appeals process, the MCO has internal appeal procedures for its members. Appeals staff demonstrates the procedures that ensure compliance with the appeals process.	<input type="checkbox"/> Internal procedures in place <input type="checkbox"/> Procedures demonstrated	1.000 1.000	2.000	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
<b>Standard Score for Grier Revised Consent Decree</b>			0.0 %	3.500	0.000

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Non-Discrimination Compliance</b>					
1. Non-Discrimination Compliance Plan  CRA and TSA § 2.30.22.2 (MSC and TCS)	There is documentation of the MCO's annual submission of a Non-Discrimination Compliance Plan to TennCare, no later than 90 days after the end of the calendar year.	<input type="checkbox"/> Yes <input type="checkbox"/> No	0.250 0.000	0.250	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
2. Assurance of Non-Discrimination  CRA and TSA § 2.26.7 (MSC and TCS)	There is documentation of the MCO's annual submission of its Assurance of Non-Discrimination Certification, which has been signed and dated. The annual signature date of the Assurance coordinates with the annual signature date of the Non-Discrimination Compliance Plan as documented in Element #1. (The certification is the MCO's assurance of compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 [prohibits discrimination on the basis of age and religion], the Church Amendments, Public Health Service Act Sec. 245 and the Weldon Amendments.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	0.250 0.000	0.250	0.000

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Non-Discrimination Compliance</b>					
Findings:					
Strength:					
Area of Noncompliance:					
Suggestion:					
3. Display of Non-Discrimination Posters  CRA § D.7 (MSC) TSA § 5.32.3 (TCS)	Posters informing MCO employees of their rights and obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II and Title III of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 are displayed in conspicuous places, such as breakrooms, lunchrooms, human resource offices and near elevators.	<input type="checkbox"/> Yes <input type="checkbox"/> No	0.250 0.000	0.250	0.000
Findings:					
Strength:					
Area of Noncompliance:					
Suggestion:					

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Non-Discrimination Compliance</b>					
4. Non-Discrimination Written Materials  CRA § 1 - Vital Documents defined and 2.17.2.6-.8 (MSC and TCS)	All vital MCO documents and member materials are made available to members in compliance with the LEP requirements of Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act of 1990.  There is evidence that they are being provided as noted in the following: <ul style="list-style-type: none"> <li>All vital MCO documents and member materials are translated and available in Spanish. Within 90 calendar days of notification from TennCare, all vital MCO documents are translated and available to each LEP group identified by TennCare that constitutes five percent of the TennCare population or 1,000 members, whichever is less.</li> <li>All written materials are made available in alternative formats for persons with special needs, or appropriate interpretation/translation services are provided by the health plan at no cost to the member.</li> <li>The MCO can show proof of its capability to provide vital documents to members with impaired sensory skills (visual) that require communication assistance in alternative formats.</li> </ul>	<input type="checkbox"/> Documents translated as described <input type="checkbox"/> Written materials made available in alternate formats at no cost	0.250  0.250	0.500	0.000
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Non-Discrimination Compliance</b>					
5. Written Policy and Procedure  CRA and TSA § 2.18.1.3; 2.28.2-.3; 2.30.22 (MSC and TCS)	<p>The MCO has a written policy and procedure on file for the provision of language interpretation and translation services for any member with LEP. It addresses the provision of language assistance for members who require communication assistance in alternative formats (e.g., members who are visually impaired, hearing impaired or both). It has been approved by TennCare.</p> <p>The MCO shows that it does the following:</p> <ul style="list-style-type: none"> <li>instructs its staff, including but not limited to all providers and direct service subcontractors, regarding the policy and procedure</li> <li>has available language/communication help-lines with specific numbers that are made known to its members and subcontractors for the provision of member translation services and communication</li> </ul>	<input type="checkbox"/> Language interpretation and translation services addressed <input type="checkbox"/> Communication assistance in alternative formats addressed <input type="checkbox"/> Staff, providers and direct service subcontractors instructed <input type="checkbox"/> Proof of available help-lines demonstrated <input type="checkbox"/> Phone numbers made known to members and subcontractors	<b>0.200</b>  <b>0.200</b>  <b>0.200</b>  <b>0.200</b>  <b>0.200</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Non-Discrimination Compliance</b>					
6. Complaint Resolution and Reporting  CRA and TSA § 2.28.3; 2.28.6-.6.2; 2.30.22.3 and .3.2 (MSC and TCS)	The MCO has on file a written policy and procedure, approved by TennCare, for monitoring, assisting with initial investigations and implementing TennCare's resolutions for discrimination complaints. The MCO has the written documentation that is required as part of the discrimination complaint process (e.g., proof that TennCare's resolution has been implemented). The MCO submits a quarterly Non-Discrimination Compliance Report to TennCare. The report lists all complaints of alleged discrimination filed against the MCO by employees, members, providers and subcontractors.	<input type="checkbox"/> Policy and procedure <input type="checkbox"/> Approved by TennCare <input type="checkbox"/> Complaints documented, investigated and resolved <input type="checkbox"/> Quarterly report submitted, including required information	<b>0.200</b> <b>0.200</b> <b>0.300</b> <b>0.300</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
7. Member Handbook Notification and Complaint Form  CRA and TSA § 2.17.4.6.18 (MSC); 2.17.4.7.18 (TCS)	The MCO has included a notice of the right to file a discrimination complaint and a copy of a Discrimination Complaint Form in its English and Spanish Member Handbooks.	<input type="checkbox"/> Notice of right placed in Member Handbooks <input type="checkbox"/> Copy of form placed in English and Spanish Member Handbooks	<b>0.250</b> <b>0.250</b>	<b>0.500</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

## MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Non-Discrimination Compliance</b>					
Findings:					
Strength:					
Area of Noncompliance:					
Suggestion:					
8. Quarterly Newsletter Notification  CRA and TSA § 2.17.5.3.5 (MSC and TCS)	Each quarterly newsletter sent by the MCO to members includes a notice of the right to file a complaint and a contractor phone number for doing so, as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II and Title III of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 and Title IX of the Education Amendments of 1972. The notice is in English and Spanish.	<input type="checkbox"/> Notice of right and a phone number for making complaint <input type="checkbox"/> Notice is in English and Spanish	0.250  0.250	0.500	0.000
Findings:					
Strength:					
Area of Noncompliance:					
Suggestion:					
9. Subcontractor Compliance Education  CRA and TSA § 2.26.7 (MSC and TCS)	The MCO can document that its subcontractors have been made aware of their obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II and Title III of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981.	<input type="checkbox"/> Yes <input type="checkbox"/> No	0.500  0.000	0.500	0.000

## 2016 Annual Quality Survey - Quality Process Standards

### MCO Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Non-Discrimination Compliance</b>					
Findings:					
Strength:					
Area of Noncompliance:					
Suggestion:					
<b>Standard Score for Non-Discrimination Compliance</b>			0.0 %	4.750	0.000

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Written QMP Description</b>					
1. Quality Monitoring/ Improvement Program (QMP)  DBMC 114; 122	There is a written QMP description, which clearly defines its quality improvement structures, processes and related activities to pursue opportunities for improvement on an ongoing basis.	<input type="checkbox"/> Clearly defined <input type="checkbox"/> Quality improvement structure <input type="checkbox"/> Defined processes <input type="checkbox"/> Person(s) responsible included	<b>0.250</b> <b>0.250</b> <b>0.250</b> <b>0.250</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
2. QMP  DBMC 122.d	QMP takes appropriate action to address service delivery including continuity and coordination of care, access to care, utilization of services, health education, and emergency services, patient safety, provider and other QMP issues as they are identified.	<input type="checkbox"/> Appropriate action to address service delivery <input type="checkbox"/> Availability <input type="checkbox"/> Accessibility <input type="checkbox"/> Coordination and continuity	<b>0.250</b> <b>0.250</b> <b>0.250</b> <b>0.250</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
3. QMP Work Plan  DBMC 122.a.2	An annual work plan that identifies QMP activities, yearly objectives, time frames for completion, and person(s) responsible for oversight of QMP activities and objectives is in place.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>0.500</b> <b>0.000</b>	<b>0.500</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Written QMP Description</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
4. Quality of Care Studies/ Activities  DBMC 122.c-.d	The written QMP includes a description of the quality of care studies and other activities to be undertaken over a prescribed period of time. The written description also includes the methodologies and organizational arrangements to be used to accomplish studies/activities. Individuals responsible for the studies are clearly identified and are appropriate.	<input type="checkbox"/> Description of studies/activities <input type="checkbox"/> Timelines <input type="checkbox"/> Methodologies <input type="checkbox"/> Organizational arrangements <input type="checkbox"/> Individuals identified and appropriate	<b>0.200</b>  <b>0.200</b>  <b>0.200</b>  <b>0.200</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
5. Continuous Activity Performance and Tracking  DBMC 114; 122	The written QMP description includes, and there is evidence of, continuous performance of the quality of care activities and tracking of issues over time.	<input type="checkbox"/> Continuous performance <input type="checkbox"/> Tracking of issues over time	<b>0.500</b>  <b>0.500</b>	<b>1.000</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Written QMP Description</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
6. Peer Review  DBMC 117.a-f	The Peer Review Committee reviews and provides detailed written findings, recommendations and appropriate corrective action for any participating dental provider who has provided inappropriate care.	<input type="checkbox"/> By dentists <input type="checkbox"/> By other dental professionals	<b>0.750</b>  <b>0.750</b>	<b>1.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
7. Feedback  DBMC 116.b and .d.3	The QMP provides for feedback (to dental professionals and DBM staff) regarding performance and patient activity.	<input type="checkbox"/> To dental professionals <input type="checkbox"/> To DBM staff	<b>0.500</b>  <b>0.500</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Written QMP Description</b>					
8. Dental Outcomes DBMC 117	The QMP methodology addresses existing technology, review of processes, outcomes and appropriateness of dental care.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.500</b> <b>0.000</b>	<b>1.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
9. Guideline Dissemination DBMC 45.f	The QMP guidelines are disseminated to all affected providers and, upon request, to members and potential members.	<input type="checkbox"/> To providers <input type="checkbox"/> To members when requested	<b>0.500</b> <b>0.500</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
<b>Standard Score for Written QMP Description</b>			<b>0.0 %</b>	<b>9.500</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Systematic Process of Quality Assessment and Improvement</b>					
1. Population Served  DBMC 122; 123	The QMP has written guidelines for its quality of care studies and related activities that specify that the monitoring and evaluation of care reflect the DBM's population in terms of age groups and special risk status.	<input type="checkbox"/> Age groups <input type="checkbox"/> Special risk status	<b>0.250</b>  <b>0.250</b>	<b>0.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
2. Clinical Care Standards/ Practice Guidelines  DBMC 45	Clinical Care Standards/Practice Guidelines are based on valid and reasonable evidence or consensus of health professionals in a particular field and are developed and/or reviewed by plan providers.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>0.750</b>  <b>0.000</b>	<b>0.750</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
3. Standards/ Guidelines Focus  DBMC 45	Standards/Guidelines focus on the process and outcomes of dental care delivery, as well as access to care.	<input type="checkbox"/> Process <input type="checkbox"/> Outcomes <input type="checkbox"/> Access to care	<b>0.250</b> <b>0.250</b> <b>0.250</b>	<b>0.750</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Systematic Process of Quality Assessment and Improvement</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
4. Updating Guidelines  DBMC 45.e	The DBM has a mechanism in place for continuously updating the standards/guidelines.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>0.500</b> <b>0.000</b>	<b>0.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
5. Updates Disseminated  DBMC 44; 45.f	Standards/Guidelines are included in DBM provider manuals or are otherwise disseminated to providers (as they are adopted).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>0.250</b> <b>0.000</b>	<b>0.250</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Systematic Process of Quality Assessment and Improvement</b>					
6. Address Preventive Health  DBMC 45; 97; 122	Standards/Guidelines address preventive dental services.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>0.250</b> <b>0.000</b>	<b>0.250</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
7. Address Full Population  DBMC 45; 122	Standards/Guidelines are developed for the full spectrum of populations enrolled in the plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>0.250</b> <b>0.000</b>	<b>0.250</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
8. Used to Evaluate Care  DBMC 122.b	Through its QMP, the DBM uses the Standards/Guidelines to evaluate the quality of care provided by DBM providers, whether the providers are organized in groups or practice as individuals.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>0.500</b> <b>0.000</b>	<b>0.500</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Systematic Process of Quality Assessment and Improvement</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
9. Analysis of Clinical Care and Related Services  DBMC 117; 122.b	Appropriate clinicians monitor and evaluate quality through the review of individual cases (where there are questions about care) and through studies analyzing patterns of clinical care and related services. For quality issues identified in the QMP's targeted clinical areas, the analysis includes identified quality indicators and uses Clinical Care Standards/Practice Guidelines to make determinations.	<input type="checkbox"/> Review of individual cases <input type="checkbox"/> Review of studies analyzing patterns of clinical care and related services <input type="checkbox"/> Analysis includes identified indicators and uses standards/guidelines to make determinations	<b>0.250</b>  <b>0.250</b>  <b>0.250</b>	<b>0.750</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
10. Multi-Disciplinary Teams  DBMC 116.b; 122	Multi-disciplinary teams are used, where indicated, to analyze and address systems issues.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>0.500</b>  <b>0.000</b>	<b>0.500</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Systematic Process of Quality Assessment and Improvement</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
11. Remedial/ Corrective Action Procedures  DBMC 122.b	<p>The QMP includes written procedures for taking remedial action when, as determined by the QMP, inappropriate or substandard services are furnished, or when services that should have been furnished were not.</p> <p>Written remedial/corrective action procedures include the following:</p> <ul style="list-style-type: none"> <li>a. Specific types of problems requiring remedial/corrective action</li> <li>b. Specific person(s) or body responsible for making final determinations regarding quality problems</li> <li>c. Specific actions to be taken</li> <li>d. Methodology for providing feedback to appropriate dental professionals and staff</li> <li>e. Schedule of tasks to be completed, due dates and persons responsible for implementing corrective actions</li> <li>f. Methodology for modifying corrective actions if improvements do not occur</li> <li>g. Procedures for terminating DBM affiliation with a dental professional when warranted</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> a. Specific types of problems requiring action</li> <li><input type="checkbox"/> b. Party responsible for final determinations</li> <li><input type="checkbox"/> c. Specific actions to take</li> <li><input type="checkbox"/> d. Method for providing feedback to providers and staff</li> <li><input type="checkbox"/> e. Schedule and persons responsible for implementing actions</li> <li><input type="checkbox"/> f. Method of modifying corrective actions if no improvements</li> <li><input type="checkbox"/> g. Procedures for terminating a provider when warranted</li> </ul>	<p><b>0.200</b></p> <p><b>0.200</b></p> <p><b>0.200</b></p> <p><b>0.200</b></p> <p><b>0.200</b></p> <p><b>0.200</b></p> <p><b>0.300</b></p>	<b>1.500</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Systematic Process of Quality Assessment and Improvement</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
12. Assessment of Effectiveness of Corrective Actions  DBMC 122.b	As corrective actions are taken to improve care, there is monitoring and evaluation of these actions to ensure that appropriate changes have been made. There is also evidence that changes in practice patterns are tracked.	<input type="checkbox"/> Actions monitored <input type="checkbox"/> Actions evaluated <input type="checkbox"/> Practice patterns tracked	<b>0.250</b>  <b>0.250</b>  <b>0.250</b>	<b>0.750</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
13. Corrective Action Follow-Up  DBMC 122.b -.c	The DBM follows up on identified issues to ensure that actions for improvement have been effective.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>0.750</b>  <b>0.000</b>	<b>0.750</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Systematic Process of Quality Assessment and Improvement</b>					
14. QMP Evaluation DBMC 122.e	At least annually the DBM conducts an assessment of the scope and content of the QMP to ensure that it covers all types of services in all settings.	<input type="checkbox"/> Assessment of scope and content <input type="checkbox"/> At least annually	<b>0.500</b> <b>0.500</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
15. Annual Evaluation DBMC 122.e	An annual report is prepared at the end of each year that addresses: <ul style="list-style-type: none"> <li>• studies and other activities completed;</li> <li>• trending of clinical and service indicators and other performance data;</li> <li>• demonstrated improvements in quality;</li> <li>• areas of deficiency and recommendations for corrective action; and</li> <li>• an evaluation of the overall effectiveness of the QMP.</li> </ul>	<input type="checkbox"/> Studies and other activities completed <input type="checkbox"/> Trending of clinical and service indicators and other performance data <input type="checkbox"/> Demonstrated improvements in quality <input type="checkbox"/> Areas of deficiency and recommendations for corrective actions <input type="checkbox"/> Evaluation of the overall effectiveness of the QMP	<b>0.200</b> <b>0.200</b> <b>0.200</b> <b>0.200</b> <b>0.200</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Systematic Process of Quality Assessment and Improvement</b>					
16. Required Topics for Quality Improvement (QI) Studies  DBMC 122.c-.d	Literature review and discussion with health authorities have led to the identification of certain priority areas of concern (e.g., clinical and health services delivery). These include continuity/coordination of care and access to early and periodic screening, diagnosis and treatment (EPSDT) services, which require continuous evaluation and study.	<input type="checkbox"/> Continuity/Coordination of care <input type="checkbox"/> Access to EPSDT services	<b>0.500</b>  <b>0.500</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
17. Reporting Requirements  DBMC 127; Attachment C	The DBM submits reports to TennCare as requested for each of the required QI studies.	<input type="checkbox"/> Study # 1 <input type="checkbox"/> Study # 2	<b>0.500</b>  <b>0.500</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
<b>Standard Score for Systematic Process of Quality Assessment and Improvement</b>			<b>0.0 %</b>	<b>12.000</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Accountability to the Governing Body</b>					
1. Governing Body DBMC 116.d	The governing body that is accountable for the DBM's QMP is the Board of Directors or, where the Board's participation with the QMP is not direct, a designated committee of DBM senior management.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>2.000</b> <b>0.000</b>	<b>2.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
2. Oversight of QMP DBMC 116.d.1	The governing body is accountable for monitoring, evaluating and making improvements to care. There is documentation (i.e., meeting minutes with discussion and signature) showing that the governing body approves the written QMP and annual work plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.750</b> <b>0.000</b>	<b>1.750</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
3. Oversight Entity DBMC 116.d	An accountable entity or entities within the DBM have been formally designated by the governing body to provide oversight of quality monitoring (QM), or the governing body has formally decided to provide such oversight as a committee of the whole.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>0.750</b> <b>0.000</b>	<b>0.750</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Accountability to the Governing Body</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
4. QMP Progress Reports  DBMC 116.d.2	Written reports are received at least quarterly by the governing body describing actions taken, progress in meeting QM objectives and improvements made.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>0.750</b> <b>0.000</b>	<b>0.750</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
5. Program Modification  DBMC 116.d.3	Following review of written reports described above, the governing body takes action, as appropriate, and directs that the operational QMP be modified on an ongoing basis to accommodate review findings and issues of DBM concern.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>0.750</b> <b>0.000</b>	<b>0.750</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Accountability to the Governing Body</b>					
6. Follow-Up DBMC 116.d.3	Governing body meeting minutes include documentation in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to QM/QI.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.000</b> <b>0.000</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
<b>Standard Score for Accountability to the Governing Body</b>			<b>0.0 %</b>	<b>7.000</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Active Quality Monitoring Committee</b>					
1. QM Committee DBMC 116.a	The written QMP establishes and defines a committee responsible for performing QM functions within the organization.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>2.000</b> <b>0.000</b>	<b>2.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
2. Frequency DBMC 116.b and .e	The committee has meetings on a regular basis to oversee QMP activities. The frequency of meetings is sufficient to demonstrate committee follow-up on all findings and required actions, but in no case are meetings held less than quarterly.	<input type="checkbox"/> Meetings held at least quarterly <input type="checkbox"/> Follow-up demonstrated on all findings and required actions	<b>0.750</b> <b>0.750</b>	<b>1.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
3. Documentation DBMC 116.f	There are records (minutes) documenting the committee's activities, findings, recommendations and actions. The minutes are signed and dated.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.500</b> <b>0.000</b>	<b>1.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Active Quality Monitoring Committee</b>					
4. Accountability DBMC 116.d	The committee is accountable to the governing body and submits reports on activities, findings, recommendations and actions to the governing body (or its designee) on a scheduled basis.	<input type="checkbox"/> Accountability to the governing body <input type="checkbox"/> Submission of reports to governing body (or designee) on a scheduled basis	<b>0.750</b>  <b>0.750</b>	<b>1.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
5. Membership DBMC 116.a and .g	There is active participation in the QM Committee from DBM providers, who are representative of the composition of DBM providers. Membership includes a representative of the TennCare Office of the Dental Director, who is a non-voting member.	<input type="checkbox"/> Active TennCare provider participation <input type="checkbox"/> TennCare Dental Director participation	<b>0.750</b>  <b>0.750</b>	<b>1.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
6. Committee Approval of QMP DBMC 116.c	The QMP Committee will review and approve the written QMP and associated work plan prior to submission to TennCare.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.000</b>  <b>0.000</b>	<b>1.000</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Active Quality Monitoring Committee</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
<b>Standard Score for Active Quality Monitoring Committee</b>			<b>0.0 %</b>	<b>9.000</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Quality Monitoring Supervision</b>					
1. Senior Executive Responsibility  DBMC 116.a	The governing body has designated a senior executive to be responsible for QMP implementation.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>2.000</b> <b>0.000</b>	<b>2.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
2. Dental Director Involvement  DBMC 17.b; 116.a	The DBM's Dental Director has substantial involvement in QM activities.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>3.000</b> <b>0.000</b>	<b>3.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
3. External Advisory Committee  DBMC 118	The DBM will participate in an Advisory Committee empowered to review and make recommendations to the DBM and TennCare concerning the dental program.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.000</b> <b>0.000</b>	<b>1.000</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Quality Monitoring Supervision</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
<b>Standard Score for Quality Monitoring Supervision</b>			<b>0.0 %</b>	<b>6.000</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Adequate Resources</b>					
1. Resources and Staffing DBMC 122.a.3	The DBM has designated sufficient material resources and staff with the necessary education, experience or training to effectively carry out QMP activities.	<input type="checkbox"/> Material resources <input type="checkbox"/> Staffing, including transportation coordinator(s) <input type="checkbox"/> Necessary education, experience or training	<b>3.333</b> <b>3.333</b> <b>3.334</b>	<b>10.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
<b>Standard Score for Adequate Resources</b>			<b>0.0 %</b>	<b>10.000</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Provider Participation in the QMP</b>					
1. Informed Providers DBMC 122.f	Participating dentists are kept informed about the written QMP.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.500</b> <b>0.000</b>	<b>1.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
2. QMP Cooperation DBMC 122.f	The DBM includes language requiring cooperation with the QMP in all of its provider contracts and employment agreements with dentists and non-dentist providers.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>2.000</b> <b>0.000</b>	<b>2.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
3. Dental Record Access DBMC 125.a.1	The DBM contracts with hospitals and other contractors require DBM access to dental records of its members for purposes of quality reviews conducted by agencies or agents thereof.	<input type="checkbox"/> Hospital contracts <input type="checkbox"/> Other contracts	<b>0.750</b> <b>0.750</b>	<b>1.500</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Provider Participation in the QMP</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
<b>Standard Score for Provider Participation in the QMP</b>			<b>0.0 %</b>	<b>5.000</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Delegation of QMP Activities</b>					
1. Written Description DBMC 64 and .72	The QMP includes a written description of delegated activities, including accountability for delegated activities and frequency of reporting to the DBM.	<input type="checkbox"/> Delegated activities <input type="checkbox"/> Accountability <input type="checkbox"/> Reporting frequency	<b>0.333</b> <b>0.333</b> <b>0.334</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
2. Written Procedures DBMC 64 and .72	The QMP includes written procedures for monitoring and evaluating implementation of delegated functions and for verifying the actual quality of care being provided.	<input type="checkbox"/> Monitoring <input type="checkbox"/> Evaluating <input type="checkbox"/> Verifying	<b>0.500</b> <b>0.500</b> <b>0.500</b>	<b>1.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
3. Ongoing Evaluation DBMC 64	There is evidence of continuous and ongoing evaluation of delegated activities, including approval of QI plans and regular specified reports.	<input type="checkbox"/> Continuous, ongoing evaluation of activities <input type="checkbox"/> Approval of delegated QI plans <input type="checkbox"/> Regular specified reports	<b>0.500</b> <b>0.500</b> <b>0.500</b>	<b>1.500</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Delegation of QMP Activities</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
<b>Standard Score for Delegation of QMP Activities</b>			<b>0.0 %</b>	<b>4.000</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Member Rights and Responsibilities</b>					
1. Policy on Member Rights  DBMC 124.a; D.7	<p>The DBM has established policies and procedures to protect member rights.</p> <p>The written policy recognizes the member's right to be:</p> <p>a. treated with respect, including recognition of his or her dignity and need for privacy;</p> <p>b. provided with information about the DBM, its services, the practitioners providing care, and members' rights and responsibilities;</p> <p>c. able to choose dentists, within the limits of the plan network, including the right to refuse care from specific practitioners;</p> <p>d. a participant in decision-making regarding his or her dental care;</p> <p>e. free to voice complaints or appeals about the DBM or care provided;</p> <p>f. guaranteed the right to request and receive a copy of his or her records; and to request that they be amended or corrected as specified in the Code of Federal Regulations (CFR), Title 45 Part 164;</p> <p>g. free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;</p> <p>h. free to exercise his or her rights, and that the exercising of those rights does not adversely affect the way the DBM and its providers or the state agency treat the member;</p> <p>i. provided information on available treatment options and alternatives presented in a manner appropriate to the member's condition and ability to understand; and</p> <p>j. provided services without discrimination due to age, sex, race, color, religion and national origin.</p>	<p><input type="checkbox"/> a. Treated with respect, dignity and privacy</p> <p><input type="checkbox"/> b. Provided with listed information</p> <p><input type="checkbox"/> c. Able to choose dentists and refuse care</p> <p><input type="checkbox"/> d. Participate in decision-making</p> <p><input type="checkbox"/> e. Voice complaints or appeals</p> <p><input type="checkbox"/> f. Request and receive a copy of records, and request that they be amended or corrected</p> <p><input type="checkbox"/> g. Be free from any form of restraint or seclusion</p> <p><input type="checkbox"/> h. Exercise his or her rights</p> <p><input type="checkbox"/> i. Receive information on treatment options/ alternatives in an appropriate and understandable manner</p> <p><input type="checkbox"/> j. Receive services without discrimination due to age, sex, race, color, religion and national origin</p>	<p><b>0.200</b></p>	<b>2.000</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Member Rights and Responsibilities</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
2. Policy on Member Responsibilities  DBMC 124.b	The DBM has a written policy that addresses the member's responsibility for cooperating with those providing dental care services. The policy includes responsibility for providing, to the extent possible, information needed by professional staff in caring for the member and for following instructions and guidelines given by those providing dental care services.	<input type="checkbox"/> Addresses responsibility for providing needed information <input type="checkbox"/> Addresses responsibility for following instructions and guidelines	<b>0.500</b>  <b>0.500</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
3. Communication of Policies to Providers  DBMC 124.c	A copy of the DBM's policies on member rights and responsibilities is provided to all participating providers.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>0.750</b>  <b>0.000</b>	<b>0.750</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Member Rights and Responsibilities</b>					
4. Communication of Policies to Members  DBMC 124.d.3-.6 and .8-.9	Members are provided a written statement upon enrollment that includes information on the following: <ul style="list-style-type: none"> <li>• Provisions for after-hours coverage and emergency coverage</li> <li>• The organization's policy on referrals for specialty care</li> <li>• Charges to enrollees, if applicable, including (a) policy on payment of charges and (b) co-payment and fees for which the enrollee is responsible</li> <li>• Procedures for notifying members affected by the termination of or change to any benefits, services or service delivery office/site</li> <li>• Procedures for changing practitioners</li> <li>• Procedures for voicing complaints/grievances and/or appeals</li> </ul>	<input type="checkbox"/> Provisions for after-hours and emergency coverage <input type="checkbox"/> Policy on referrals for specialty care <input type="checkbox"/> Policy on payment charges and co-payment/fees <input type="checkbox"/> Procedures for notifying members about changes to benefits, services or service delivery offices/sites <input type="checkbox"/> Procedures for changing practitioners <input type="checkbox"/> Procedures for voicing complaints/grievances and/or appeals	<b>0.125</b>  <b>0.125</b>  <b>0.125</b>  <b>0.125</b>  <b>0.125</b>  <b>0.125</b>	<b>0.750</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
5. Member Handbook  DBMC 9.a	The Member Handbook is distributed to members within 30 days of receipt of notice of enrollment in the DBM Plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.500</b>  <b>0.000</b>	<b>1.500</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Member Rights and Responsibilities</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Member Rights and Responsibilities</b>					
6. Member Handbook Inclusions DBMC 9.c	The Member Handbook includes the following: a. Table of contents b. An explanation on how members will be notified of member-specific information such as effective date of enrollment c. A description of services provided including limitations, exclusions and out-of-plan use d. Financial responsibilities of the member, explaining collection and steps taken to collect any co-pays a member may owe e. Information about preventive services for children, including listing of such services and a notice that they are at no cost and without cost share responsibilities f. Procedures for obtaining required services, including procedures for obtaining referrals to specialists and to providers outside of the plan; the handbook should advise members that if they need a provider who is not available within the plan, they will be referred to a provider outside of the plan, and any co-payment requirements would be the same as if this provider were in the plan g. An explanation that prior authorization is required for some services, including non-emergency services provided by a non-contract provider; such services will be covered and reimbursed only if such prior authorization/service authorization is received before the service is provided; that all prior authorizations/service authorizations are null and void upon expiration of a member's TennCare eligibility; and that the member shall be responsible for payment for any services provided after the member's eligibility has expired	<input type="checkbox"/> a. Table of contents <input type="checkbox"/> b. Process for notifying members of their specific information <input type="checkbox"/> c. Services provided including limits, exclusions and out-of-plan use <input type="checkbox"/> d. Financial responsibilities of the member, explaining collection and steps taken to collect any co-pays a member may owe <input type="checkbox"/> e. Preventive services for children <input type="checkbox"/> f. Procedures for obtaining services, including referrals outside of plan <input type="checkbox"/> g. Explanation of prior authorization <input type="checkbox"/> h. Emergency services and how to obtain them in and out of the DBM service area <input type="checkbox"/> i. Appeal procedures <input type="checkbox"/> j. Right to request reassessment of eligibility-related decisions <input type="checkbox"/> k. Policies on rights and responsibilities <input type="checkbox"/> l. Notification by member when they move	<b>0.200</b> <b>0.200</b> <b>0.200</b> <b>0.200</b> <b>0.200</b> <b>0.200</b> <b>0.200</b> <b>0.200</b> <b>0.200</b> <b>0.200</b> <b>0.200</b> <b>0.200</b> <b>0.200</b> <b>0.200</b> <b>0.200</b>	<b>3.400</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Member Rights and Responsibilities</b>					
	<ul style="list-style-type: none"> <li>h. An explanation of emergency services and procedures on how to obtain these services both in and out of the DBM's service area</li> <li>i. Appeal procedures</li> <li>j. Notice to the member that, in addition to the right to file an appeal for actions taken by the DBM, he or she shall have the right to request reassessment of eligibility-related decisions directly to the Tennessee Department of Human Services</li> <li>k. Written policies on member rights and responsibilities</li> <li>l. Notice that it is the member's responsibility to notify the Contractor, TennCare, and DHS (or for SSI eligibles, SSA) each and every time the member moves to a new address and that failure to notify could result in member not receiving important eligibility and/or benefit information</li> <li>m. The toll-free telephone number for TennCare with a statement that the member may contact the DBM or TennCare regarding questions about TennCare</li> <li>n. Details on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free</li> <li>o. Information educating members on their rights and necessary steps to amend their data in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations</li> <li>p. Information on requirements for accessing services to which they are entitled under the contract, including factors such as physical access and non-English languages spoken</li> <li>q. Notice of right to file a complaint</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> m. Toll-free number for contacting TennCare</li> <li><input type="checkbox"/> n. Way to obtain information in alternative formats or access interpretation services and a statement such services are free</li> <li><input type="checkbox"/> o. Information regarding member rights and necessary steps to amend data in accordance with HIPAA regulations</li> <li><input type="checkbox"/> p. Requirements for accessing entitled services including special factors</li> <li><input type="checkbox"/> q. Notice of right to file a complaint</li> </ul>	<p><b>0.200</b></p> <p><b>0.200</b></p> <p><b>0.200</b></p> <p><b>0.200</b></p> <p><b>0.200</b></p>		

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Member Rights and Responsibilities</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
7. Complaint and Appeal System  DBMC 124.e	The DBM has system(s) linked to the QMP for resolving member complaints and appeals. The system includes: <ul style="list-style-type: none"> <li>procedures for registering and responding to complaints and appeals in a timely fashion;</li> <li>documentation of the substance of complaints or appeals, and actions taken;</li> <li>procedures to ensure a resolution of the complaint or appeal;</li> <li>aggregation and analysis of complaint and appeal data and use of the data for quality improvement; and</li> <li>an appeal process for adverse actions.</li> </ul>	<input type="checkbox"/> System was in place <input type="checkbox"/> Staff demonstrated knowledge of complaint and appeal system and how it relates to QMP <input type="checkbox"/> Procedures for timely registration and response <input type="checkbox"/> Documentation of complaints and appeals, and actions taken <input type="checkbox"/> Procedures ensuring resolution <input type="checkbox"/> Aggregation, analysis and use of the data for quality improvement <input type="checkbox"/> Appeal process for adverse actions	<b>0.250</b> <b>0.250</b> <b>0.250</b> <b>0.250</b> <b>0.250</b> <b>0.250</b>	<b>1.750</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Member Rights and Responsibilities</b>					
8. Steps to Ensure Accessibility of Services  DBMC 124.f.2	The DBM takes steps to promote accessibility of services offered to members. These steps include ensuring that information regarding the points of access to dental services, specialty care and hospital or ambulatory surgical center services is identified for members who, at a minimum, are given information about: <ul style="list-style-type: none"> <li>• services during regular hours of operation;</li> <li>• emergency and after-hours care; and</li> <li>• the names, qualifications and titles of the professionals providing and/or responsible for their care.</li> </ul>	<input type="checkbox"/> Member points of access are identified  <input type="checkbox"/> Members are given information regarding services during regular business hours, emergency and after-hours care; and information about their providers	<b>0.250</b>  <b>0.750</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
9. Written Information for Members  DBMC 4.a; 12.a; 124.g; Grier Revised Consent Decree (CD) B.13	Member information (e.g., subscriber brochures, announcements, handbooks) is written in prose that is readable and easily understood. (All material shall be worded at a sixth-grade reading level unless TennCare approves otherwise.)	<input type="checkbox"/> Yes, or approved by TennCare <input type="checkbox"/> No	<b>0.500</b>  <b>0.000</b>	<b>0.500</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Member Rights and Responsibilities</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
10. Information for Major Population or Limited English Proficiency (LEP) Groups  DBMC 9.c.16; 12.e; 124.g.2	<p>The DBM ensures the following:</p> <ul style="list-style-type: none"> <li>Written information is available as needed in the languages of the major population groups served. A major population group is one that represents at least 10 percent of the plan's population, or 3,000 members, whichever is less.</li> <li>All vital DBM documents, including the Member Handbook, are available in Spanish.</li> <li>All vital DBM documents are also available to LEP groups identified by TennCare that constitute five percent of the TennCare population, or 1,000 members, whichever is less.</li> <li>Information is included in the Member Handbook on how to obtain communications in alternate formats or how to access interpretation or translations services free of charge.</li> </ul>	<input type="checkbox"/> Written information available in the languages of the major population groups  <input type="checkbox"/> Vital DBM documents available in Spanish  <input type="checkbox"/> Vital DBM documents available to LEP groups  <input type="checkbox"/> Member Handbook explains how to obtain communications in alternate formats and access interpretive services	<b>0.250</b>  <b>0.250</b>  <b>0.250</b>  <b>0.250</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					



## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Member Rights and Responsibilities</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
12. Member Satisfaction DBMC 32.b.7	The DBM conducts periodic surveys of member satisfaction with its services. The surveys include content on perceived problems in the quality, availability and accessibility of care.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>0.250</b> <b>0.000</b>	<b>0.250</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
<b>Standard Score for Member Rights and Responsibilities</b>			<b>0.0 %</b>	<b>14.650</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Standards for Facilities</b>					
1. DBM Standards  DBMC 120; E.7-.8	<p>The DBM maintains standards for facilities (e.g., provider offices, surgery centers) in which patients receive ambulatory care.</p> <p>Those standards include the following:</p> <ul style="list-style-type: none"> <li>• Compliance with existing state and local laws regarding safety and accessibility</li> <li>• Availability of emergency equipment (applicable to site)</li> <li>• Storage of medications (including samples)</li> <li>• Inventory control for expired medications</li> <li>• Compliance with HIPAA regulations</li> </ul>	<input type="checkbox"/> Compliance with state laws <input type="checkbox"/> Availability of emergency equipment <input type="checkbox"/> Storage of medications <input type="checkbox"/> Inventory control <input type="checkbox"/> Compliance with HIPAA	<b>0.400</b>  <b>0.400</b>  <b>0.400</b>  <b>0.400</b>  <b>0.400</b>	<b>2.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
<b>Standard Score for Standards for Facilities</b>			<b>0.0 %</b>	<b>2.000</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Dental Records Standards</b>					
1. Appropriate Access to Records  DBMC 125.a	The DBM includes language in its contracts with providers that allows appropriate access to DBM member dental records for the purposes of quality reviews conducted by the Secretary (Department of Health and Human Services, or DHHS), TennCare agencies or agents thereof.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.250</b> <b>0.000</b>	<b>1.250</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Dental Records Standards</b>					
2. Dental Records Standards DBMC 125.b	<p>The DBM has written standards for the maintenance of dental records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review.</p> <p>At a minimum, dental record standards include the following requirements:</p> <p>a. Each page includes the patient's name or ID number.</p> <p>b. Patient data include age, sex, address, employer, home and work telephone numbers, and marital status.</p> <p>c. All entries are dated.</p> <p>d. Written submission of treatment for every date of service.</p> <p>e. All entries are identified as to author.</p> <p>f. Records are legible to the reader. Any record determined by one reviewer to be illegible should be evaluated by a second reviewer. If still not legible, it is deficient.</p> <p>g. Any adverse medication reactions and/or medication allergies or absence of allergies (no known allergies - NKA) are noted in an easily recognizable location.</p> <p>h. The record contains an easily identified past medical history for patients seen three or more times. The history includes serious accidents, operations and illnesses.</p> <p>i. For patients age 12 and under, there is a completed immunization record or notation that immunizations are up to date.</p> <p>j. The record contains diagnostic information.</p> <p>k. The record contains current medication</p>	<p><input type="checkbox"/> a. Patient identification</p> <p><input type="checkbox"/> b. Personal/Biographical data</p> <p><input type="checkbox"/> c. Entries dated</p> <p><input type="checkbox"/> d. Dated written submission of treatment</p> <p><input type="checkbox"/> e. Identified author</p> <p><input type="checkbox"/> f. Legible records</p> <p><input type="checkbox"/> g. Noted allergies</p> <p><input type="checkbox"/> h. Past medical history</p> <p><input type="checkbox"/> i. Immunization record</p> <p><input type="checkbox"/> j. Diagnostic information</p> <p><input type="checkbox"/> k. Medication information</p> <p><input type="checkbox"/> l. Current problems</p> <p><input type="checkbox"/> m. Substance use/abuse</p> <p><input type="checkbox"/> n. Referrals and specialist notations</p> <p><input type="checkbox"/> o. Emergency care</p>	<p><b>0.125</b></p>	<b>1.875</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Dental Records Standards</b>					
	information. l. Information on current significant illnesses, medical conditions and health maintenance concerns is documented. m. For patients 12 years and over, and seen three or more times, there is a notation concerning cigarette and alcohol use and substance abuse. n. There are notations of any specialist reports, referrals and results thereof. o. Any emergency dental care rendered is noted.				
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Dental Records Standards</b>					
3. Patient Visit Data DBMC 125.b.2	Documentation of patient visits, at a minimum, includes: a. history and physical examination: appropriate subjective and objective information for the presenting complaints; b. plan of treatment; c. diagnostic tests, when required for services rendered; d. therapies and other prescribed regimens; e. monitoring when in-office sedation is administered; f. charting of conditions and treatment; g. follow-up: Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to call or return is noted as days, weeks, months or as needed (PRN); h. unresolved concerns from previous visits are addressed in subsequent visits; i. Consultations, referrals and specialist reports: Notes from any consultations are in the record. Consultation, lab and x-ray reports filed in the chart have the ordering dentist's/physician's initials or other documentation signifying review. Consultations and significantly abnormal lab and imaging study results specifically note follow-up plans. Consultations for speech/language pathology include supporting documentation that the condition must be non-responsive to speech therapy without orthodontic treatment; and j. all other aspects of patient care, including ancillary services.	<input type="checkbox"/> a. History and physical <input type="checkbox"/> b. Plan of treatment <input type="checkbox"/> c. Diagnostic tests <input type="checkbox"/> d. Therapies and other prescribed regimens <input type="checkbox"/> e. In-office sedation monitored <input type="checkbox"/> f. Conditions and treatment charted <input type="checkbox"/> g. Follow-up visit noted <input type="checkbox"/> h. Unresolved concerns from previous visits are addressed <input type="checkbox"/> i. Consultations, referrals, results: evidence of consult notes, review and follow-up noted where required <input type="checkbox"/> j. All other aspects of care	<b>0.250</b> <b>0.250</b> <b>0.250</b> <b>0.250</b> <b>0.250</b> <b>0.250</b> <b>0.250</b> <b>0.250</b> <b>0.250</b> <b>0.250</b>	<b>2.500</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Dental Records Standards</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
4. Record Review Process  DBMC 125.c	The DBM has a written process for assessing dental records for legibility, organization and completion. An assessment tool is utilized to ensure that records conform to DBM standards.	<input type="checkbox"/> Legibility <input type="checkbox"/> Organization <input type="checkbox"/> Completion <input type="checkbox"/> Conformance	<b>0.250</b>  <b>0.250</b>  <b>0.250</b>  <b>0.250</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
<b>Standard Score for Dental Records Standards</b>			<b>0.0 %</b>	<b>6.625</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Utilization Review</b>					
1. Written Policies and Procedures DBMC 32	The DBM has written utilization management (UM) policies and procedures that include, at a minimum: <ul style="list-style-type: none"> <li>procedures to evaluate medical necessity;</li> <li>criteria used;</li> <li>information sources;</li> <li>the process used to review and approve the provision of dental services; and</li> <li>any delegated activities and the process by which such activities will be monitored and evaluated (if applicable).</li> </ul>	<input type="checkbox"/> Procedures to evaluate medical necessity <input type="checkbox"/> Criteria used <input type="checkbox"/> Information sources <input type="checkbox"/> Process to review and approve <input type="checkbox"/> Delegated activities and process to monitor and evaluate	<b>0.500</b>  <b>0.500</b>  <b>0.500</b>  <b>0.500</b>	<b>2.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
2. Under-Utilization DBMC 32.a	The program has mechanisms including specific, ongoing activities to detect under-utilization.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>2.000</b>  <b>0.000</b>	<b>2.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Utilization Review</b>					
3. Over-Utilization DBMC 32.a	The program has mechanisms including specific, ongoing activities to detect over-utilization.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>2.000</b> <b>0.000</b>	<b>2.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
4. Coverage Limits DBMC 32.b.1; Grier Revised CD ¶ C.4	For pre-authorization or medical necessity review, the DBM does NOT employ or permit others acting on its behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individual determination of medical necessity based on the needs of the member and his or her history.	<input type="checkbox"/> Yes (does not) <input type="checkbox"/> No	<b>0.750</b> <b>0.000</b>	<b>0.750</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
5. Qualified Dental Professionals DBMC 32.b.2-.3	Pre-authorization and medical necessity review decisions are supervised by qualified dental professionals. Efforts are made to obtain all necessary information, including pertinent clinical information, and to consult with the treating dentists as appropriate. Staff is able to demonstrate and describe authorization process.	<input type="checkbox"/> Decisions supervised appropriately <input type="checkbox"/> Necessary information obtained <input type="checkbox"/> Authorization process demonstrated and described	<b>1.000</b> <b>0.750</b> <b>0.750</b>	<b>2.500</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Utilization Review</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
6. Review Decisions  DBMC 32.b.4	When conducting pre-authorization and medical necessity review, the reasons for decisions are clearly documented and available to the member.	<input type="checkbox"/> Clearly documented <input type="checkbox"/> Made available to the member	<b>0.750</b>  <b>0.750</b>	<b>1.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
7. Appeals Mechanisms  DBMC 32.b.5	There are well-publicized and readily available appeals mechanisms for both providers and members.	<input type="checkbox"/> Members <input type="checkbox"/> Providers	<b>0.750</b>  <b>0.750</b>	<b>1.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Utilization Review</b>					
8. Retrospective Utilization Review  DBMC 35; 117	A retrospective treatment utilization review is conducted and includes basic provider profiling, test edits and statistical process controls (thresholds) to flag potential under- and over-utilization. Cases identified as outliers are forwarded to a Peer Review Committee. The DBM Peer Review Committee meets a minimum of quarterly. Its reports include a summary of its investigation and actions taken based upon results.	<input type="checkbox"/> Profiling conducted <input type="checkbox"/> Outliers sent for peer review <input type="checkbox"/> Quarterly reports include summary of investigation <input type="checkbox"/> Actions taken also reported	<b>0.250</b> <b>0.250</b> <b>0.250</b> <b>0.250</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
9. Mechanisms to Evaluate  DBMC Attachment C	The mechanisms to evaluate the effects of the program include using data on member satisfaction, provider satisfaction or other appropriate measures.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.000</b> <b>0.000</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
<b>Standard Score for Utilization Review</b>			<b>0.0 %</b>	<b>14.750</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>QMP Documentation</b>					
1. Documentation DBMC 122.e	The DBM monitors the quality of care across all services and all treatment modalities according to its written QMP.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.500</b> <b>0.000</b>	<b>1.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
2. Report Access DBMC 122.e	The DBM maintains and makes available to the State all studies, reports, protocols, standards, worksheets, minutes and/or other documentation (as appropriate) concerning its QMP activities, corrective actions and overall effectiveness.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.500</b> <b>0.000</b>	<b>1.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
<b>Standard Score for QMP Documentation</b>			<b>0.0 %</b>	<b>3.000</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coordination of QM Activity w/Other Management Activity</b>					
1. Reporting Findings  DBMC 116.a-.b, .2-.3 and .f .d	QM activity findings, conclusions, recommendations, actions taken and results of actions taken are documented and reported to appropriate DBM individuals through established QM channels.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.500</b> <b>0.000</b>	<b>1.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
2. QM Findings Used in Recredentialing Activities  DBMC 119.f.4	QM findings and conclusions are used in recredentialing, recontracting and/or annual performance evaluations.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.500</b> <b>0.000</b>	<b>1.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coordination of QM Activity w/Other Management Activity</b>					
3. QM Activity Coordination  DBMC 100; 116.b and .d.3; 122.c-d	QM activities are coordinated with other performance-monitoring activities, including UM, risk management, and resolution and monitoring of member complaints and grievances. There is evidence of coordination in meeting minutes or staff interviews.	<input type="checkbox"/> QM and other activities coordinated <input type="checkbox"/> Meeting minutes/interviews reflected coordination <input type="checkbox"/> Meeting minutes or staff interviews reflect reporting and follow-up discussion of performance-monitoring activities and their outcome.	<b>0.750</b>  <b>0.750</b>  <b>0.750</b>	<b>2.250</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
4. QM Linked to Other Functions  DBMC 116.b and d.3, 122.c-d	QM activities link with other DBM management functions such as network changes, benefits redesign, medical management systems (e.g., pre-certification), practice feedback to dentists, member education and member services.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.000</b>  <b>0.000</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
<b>Standard Score for Coordination of QM Activity w/Other Management Activity</b>			<b>0.0 %</b>	<b>6.250</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
1. Outreach Contacts  DBMC 9.a-.b; 9.d; 98.a.6 and .b	The DBM distributes six outreach contacts a year, which include: <ul style="list-style-type: none"> <li>Member Handbook sent within 30 days of enrollment;</li> <li>four quarterly newsletters;</li> <li>annual notice informing enrollees of their dental benefit encouraging them to schedule an appointment.</li> </ul>	<input type="checkbox"/> Member Handbook <input type="checkbox"/> Quarterly Newsletters <input type="checkbox"/> Annual reminder to schedule an appointment	<b>0.250</b>  <b>0.250</b>  <b>0.250</b>	<b>0.750</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
2. Re-Notification, If No Services Used  DBMC 9.f	The DBM shall be responsible for distributing dental appointment notices annually to the heads of households for all TennCare enrollees who have not had a dental service within the past year.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>0.500</b>  <b>0.000</b>	<b>0.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
3. Accurate Provider List  DBMC 9.e; 30	The DBM makes available to families accurate lists of the names and phone numbers of contract providers who are currently accepting TennCare (sent within 30 days of enrollment, annually and upon request).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>0.500</b>  <b>0.000</b>	<b>0.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
4. Documenting Outreach  DBMC 29; 42; CFR § 441.56(a) (2)(iv); 42 CFR § 441.59(a); 42 CFR § 441.62.b	The DBM shall assist enrollees in obtaining appointments for covered services, including facilitation of enrollee contact with a Participating Dental Provider who will establish an appointment. The DBM shall track the number of requests for assistance to obtain an appointment, including the service area in which the enrollee required assistance.	<input type="checkbox"/> Contact providers <input type="checkbox"/> Contact parent/guardian/member	<b>0.750</b>  <b>0.750</b>	<b>1.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
5. Prior Authorization DBMC 33	<p>Policies and procedures must clearly identify any services for which the DBM will require network providers to obtain authorization prior to the provision of the service as well as any additional submissions (such as radiographs) that may be required for approval of service. Dental management policies and procedures must be consistent with the following requirements:</p> <p>a. Requests for prior approvals that are denied by the DBM must be denied in writing within fourteen (14) days of receipt.</p> <p>b. Prior approval is not required for referrals from the Public Health Screening Program, Primary Care Physicians, and for preventive services.</p> <p>c. Utilization management activities may not be structured so as to provide incentives for the individual provider or DBM to deny, limit, or discontinue medically necessary services to any enrollee.</p>	<input type="checkbox"/> a. Denials in writing and within fourteen (14) days of receipt  <input type="checkbox"/> b. No referrals required for Public, Health Screening Program, Primary Care Physicians, and for preventive services  <input type="checkbox"/> c. Utilization management activities structured so no incentives are provided;	<p><b>1.000</b></p> <p><b>1.000</b></p> <p><b>1.000</b></p>	<b>3.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
6. Referrals from One Level of Screening/ Diagnosis to Another  DBMC 38; 125.b.1.n; 125.b.2.h	The DBM has methods in place to ensure providers make and document appropriate referrals from one level of screening or diagnosis to another more sophisticated level (e.g., general dentist to specialist) as needed to determine medically necessary services. This is done regardless of whether the required services are covered by the DBM.	<input type="checkbox"/> Methods in place <input type="checkbox"/> Evidence ensuring provider compliance	<b>0.500</b>  <b>0.750</b>	<b>1.250</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
7. Medically Necessary Services  TCA 71-5-144; DBMC 3-.4.a	The DBM has a process in place to provide all medically necessary EPSDT services as required by law and to educate providers about EPSDT services.	<input type="checkbox"/> Process for providing all services <input type="checkbox"/> Process for educating providers	<b>0.500</b>  <b>0.500</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
8. Provider Education DBMC 43.a	The DBM holds at least two training sessions per year for each Grand Region in the state. Training, at a minimum, addresses: a. the extent and limits of TennCare dental and orthodontic coverage rules and medical necessity rule; and b. Federal EPSDT law, Children and Youth with Special Needs (CYSHCN), and services under the Grier Revised CD and TennCare rules.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.250</b> <b>0.000</b>	<b>1.250</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
9. Medical Necessity TCA 71-5-144; DBMC 91	The DBM has a process concerning issues of medical necessity, which ensures that consistent decisions are rendered, and that they are compliant with federal and State laws.	<input type="checkbox"/> Process in place <input type="checkbox"/> Definition of medical necessity same as DBMC or no more restrictive <input type="checkbox"/> Evidence of consistent decisions (e.g., inter-rater reliability) <input type="checkbox"/> Appropriate follow-up as applicable	<b>0.500</b> <b>0.500</b> <b>0.500</b> <b>0.500</b>	<b>2.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
10. Limits/ Capitations/ Delays  DBMC 91	The DBM demonstrates that it does not impose benefit limitations, duration/scope limitations or monetary capitations upon EPSDT services. Services are provided based upon each child's individual needs. Utilization controls do not unreasonably delay the initial or continued receipt of services.	<input type="checkbox"/> No limits or capitations imposed <input type="checkbox"/> Services based on individual needs <input type="checkbox"/> UM controls do not delay services	<b>0.500</b>  <b>0.500</b>  <b>0.500</b>	<b>1.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
11. Qualified UM Personnel  DBMC 92	<p>The DBM has a process in place that guarantees only qualified personnel with education, training or experience in child and adolescent health are employed to make utilization review and prior authorization decisions for members 20 and under.</p> <p>Personnel making such decisions are trained or experienced as described above.</p>	<input type="checkbox"/> Process <input type="checkbox"/> Staff trained/educated	<b>0.500</b>  <b>2.500</b>	<b>3.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
12. Dentists Supervise  TCA 63-5-108, Rules of Tennessee Board of Dentistry, Rule 0460-02-.11	All dental services are performed by or under the supervision of dentists.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>0.750</b> <b>0.000</b>	<b>0.750</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
13. Compliance with Screening Obligation  DBMC 98.d; 144	The DBM demonstrates that the Annual EPSDT Dental Screening Percentage (DSP) is met. The Contractor's failure to meet this benchmark shall result in significant monetary sanctions and the DBM will be required to implement a corrective action plan. Also, if the Contractor's DSP is below eighty percent (80%), the Contractor shall conduct a new initiative, approved by TennCare, to increase participation of all children who have not received screenings.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.500</b> <b>0.000</b>	<b>1.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
14. Transportation DBMC 40; 95	It is the responsibility of the member's MCO to arrange non-emergency transportation to covered services. The DBM has a process for coordinating with the MCOs to ensure that transportation to a dental service is provided if deemed necessary.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.000</b> <b>0.000</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
15. Coordination with MCOs DBMC 40.a-.b	The DBM makes arrangements with the MCO for services that are not covered by the DBMC. A DBM staff member is designated as lead for coordination of services with each MCO.	<input type="checkbox"/> DBM staff member designated <input type="checkbox"/> Evidence of coordination observed	<b>1.000</b> <b>1.000</b>	<b>2.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
16. Coordination of Dental Services DBMC 96	The DBM has a process ensuring that, when children with urgent dental needs or unmet dental treatment needs are identified through the Department of Health's School-based Dental Prevention Program (SBDPP), the DBM arranges care according to access standards in DBMC § A.19 (urgent within 48 hours and routine within three weeks).	<input type="checkbox"/> Process in place <input type="checkbox"/> Evidence of coordination observed	<b>0.500</b> <b>0.750</b>	<b>1.250</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
17. Tracking System  DBMC 41	The DBM has a process in place for tracking the current screening status, pending preventive services, and screening due dates, referrals for corrective treatment, whether corrective treatment was provided, and dates of service for corrective treatment for each enrollee.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>0.500</b> <b>0.000</b>	<b>0.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
18. EPSDT Provisions  DBMC 55.kk	All contracts with dental providers contain language that informs providers of the EPSDT benefit package and periodicity schedule, including information as described in DBMC § A.97 and .98.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.000</b> <b>0.000</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>					
19. Contract Review: Preventive Guidelines  DBMC 97	All contracts with dental providers contain language requiring providers to follow guidelines for preventive health services identified by TennCare, including EPSDT.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.000</b> <b>0.000</b>	<b>1.000</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
<b>Standard Score for Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>			<b>0.0 %</b>	<b>25.250</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Grier Revised Consent Decree</b>					
1. Grier/Appeals Unit  Grier Revised CD ¶13; DBMC 100, .102-.103	The DBM has sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting members.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.500</b>  <b>0.000</b>	<b>1.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
2. Grier/Appeals Procedures  DBMC 100	The DBM has internal appeal procedures for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees or court orders governing the appeals process. Appeals staff demonstrate the procedures that ensure compliance with the appeals process.	<input type="checkbox"/> Internal procedures in place <input type="checkbox"/> Procedures demonstrated	<b>0.750</b>  <b>0.750</b>	<b>1.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
<b>Standard Score for Grier Revised Consent Decree</b>			<b>0.0 %</b>	<b>3.000</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Non-Discrimination Compliance</b>					
1. Non-Discrimination Compliance Plan  DBMC A.163	There is documentation of the DBM's annual submission of a Non-Discrimination Compliance Plan to TennCare, no later than 90 calendar days after the end of the contract year.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>0.250</b> <b>0.000</b>	<b>0.250</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
2. Assurance of Non-Discrimination  DBMC A.163	There is documentation of the DBM's annual submission of its Assurance of Non-Discrimination Certification. The annual date of the Assurance coordinates with the annual date of the Non-Discrimination Compliance Plan as documented in Element #1 above.	<input type="checkbox"/> Documented submission of signed and dated Assurance <input type="checkbox"/> Date of Assurance coordinates with Non-Discrimination Compliance Plan	<b>0.125</b> <b>0.125</b>	<b>0.250</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Non-Discrimination Compliance</b>					
3. Display of Non-Discrimination Posters  DBMC 153; D.7	Posters informing DBM employees of their rights and obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II and Title III of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 are displayed in conspicuous places, such as breakrooms, lunchrooms, human resource offices and near elevators.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>0.250</b> <b>0.000</b>	<b>0.250</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
4. Complaint Resolution and Reporting  DBMC 159; 164.b	The DBM has on file a written policy and procedure, approved by TennCare, for monitoring, assisting with the initial investigations and implementing TennCare's resolutions for discrimination complaints. The DBM has the written documentation that is required as part of the discrimination complaint process (e.g., proof that TennCare's resolution has been implemented). The DBM submits a quarterly Non-Discrimination Compliance Report to TennCare. The report lists all complaints of alleged discrimination filed against the DBM by employees, members, providers and subcontractors.	<input type="checkbox"/> Complaints documented, investigated and resolved <input type="checkbox"/> Allegations tracked and investigated <input type="checkbox"/> Policy and Procedure approved by TennCare <input type="checkbox"/> Proof TennCare's resolution has been implemented <input type="checkbox"/> Quarterly Non-Discrimination Compliance Reports to TennCare	<b>0.500</b> <b>0.500</b> <b>0.500</b> <b>0.500</b> <b>0.500</b>	<b>2.500</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Non-Discrimination Compliance</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
5. Member Handbook Notification and Complaint Form  DBMC 9.c.19; 160	The DBM has included a notice of the right to file a discrimination complaint and a copy of a Discrimination Complaint Form in its English and Spanish Member Handbooks.	<input type="checkbox"/> Notice of right placed in Member Handbooks <input type="checkbox"/> Copy of form included in English and Spanish Member Handbooks	<b>0.250</b>  <b>0.250</b>	<b>0.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Non-Discrimination Compliance</b>					
6. Non-Discrimination Written Materials  DBMC 12.e-.g	<p>All vital DBM documents and member materials are made available to members in compliance with the Limited English Proficiency (LEP) requirements of Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act of 1990.</p> <p>There is evidence that they are being provided as noted below:</p> <ul style="list-style-type: none"> <li>All vital DBM documents and member materials are translated and available in Spanish. Within 90 calendar days of notification from TennCare, all vital DBM documents are translated and available to each LEP group identified by TennCare that constitutes five percent of the TennCare population or 1,000 members, whichever is less.</li> <li>All written materials are made available in alternative formats for persons with special needs, or appropriate interpretation/translation services are provided by the health plan at no cost to the member.</li> <li>All written materials notify members that auxiliary aids or services are available at no expense to the member and how to access them.</li> <li>The DBM can show proof of its capability to provide vital documents to members with impaired sensory skills (visually impaired) who require communication assistance.</li> </ul>	<input type="checkbox"/> Documents translated as described <input type="checkbox"/> Written materials made available in alternative formats at no cost <input type="checkbox"/> Written materials notify members of auxiliary aids or services at no expense <input type="checkbox"/> Vital documents provided to member	<p><b>0.250</b></p> <p><b>0.250</b></p> <p><b>0.250</b></p> <p><b>0.250</b></p>	<b>1.000</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Non-Discrimination Compliance</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
7. Subcontractor Compliance Education  DBMC 154	The DBM can document that its subcontractors have been made aware of their obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II and III of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and Title IX of the Education Amendments of 1972 and 42 U.S.C.A. § 18116.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>0.500</b> <b>0.000</b>	<b>0.500</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
8. Quarterly Newsletter Notification  DBMC 9.d.3	Each quarterly newsletter sent by the DBM to members includes a notice to members of the right to file a complaint and a contractor phone number for doing so, as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and Title IX of the Education Amendments of 1972 and 42 U.S.C.A. § 18116. The notice is in English and Spanish.	<input type="checkbox"/> Notice of right and a phone number for making a complaint <input type="checkbox"/> Notice is in English and Spanish	<b>0.250</b> <b>0.250</b>	<b>0.500</b>	<b>0.000</b>

## 2016 Annual Quality Survey - Quality Process Standards

### DBM Template

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Non-Discrimination Compliance</b>					
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
9. Written Policy and Procedure  DBMC 27; 155	The DBM has a written policy and procedure on file for the provision of language interpretation and translation services for any member with LEP. The policy and procedure also addresses the provision of language assistance for members who require communication assistance in alternative formats (e.g., members who are visually impaired, hearing impaired, and/or hearing/visually impaired). It has been approved by TennCare.  The DBM shows that it: <ul style="list-style-type: none"> <li>• instructs its staff, including but not limited to, all providers and direct service subcontractors, regarding the policy and procedure; and</li> <li>• has available language/communication help-lines with specific numbers that are made known to its members and subcontractors for the provision of member translation services and communication assistance in alternative formats.</li> </ul>	<input type="checkbox"/> Language interpretation and translation services addressed <input type="checkbox"/> Communication assistance in alternative formats addressed <input type="checkbox"/> Staff, providers and direct service subcontractors instructed <input type="checkbox"/> Proof of available help-lines demonstrated <input type="checkbox"/> Phone numbers made known to members and subcontractors <input type="checkbox"/> Policy and procedure approved by TennCare	<b>0.200</b>  <b>0.200</b>  <b>0.200</b>  <b>0.200</b>  <b>0.200</b>  <b>0.200</b>	<b>1.200</b>	<b>0.000</b>
<b>Findings:</b>					
<b>Strength:</b>					
<b>Area of Noncompliance:</b>					
<b>Suggestion:</b>					
<b>Standard Score for Non-Discrimination Compliance</b>			<b>0.0 %</b>	<b>6.950</b>	<b>0.000</b>

PA File Review Tools

MCC Appeals ( <i>Grier</i> )—File Review Tool																		
MCC:											mm/dd/2016							
1	2	3	4			5			6		7	8	9	10	11		12	
File #	Case ID*	Date Appeal Received	Requesting Provider Identified			Reviewed by Same Practitioner Type as Requester			Appeal Investigation Documented		E/S**	Date Member Notified of Decision	# of Days for Resolution	Resolution Time Standard	Resolution Time Standard Met		State-Mandated Letter Used	
			Y	N	NA	Y	N	NA	Y	N				Y	N	Y	N	
1																		
2																		
3																		
4																		
5																		
6																		
7																		
8																		
9																		
10																		
<b>Compliant Answers</b>																		
<b>Applicable Answers</b>																		
														<b>Total Compliant:</b>				
														<b>Total Applicable:</b>				
														<b>Percent Compliant:</b>				

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

\*\*Expedited or Standard

MCC UM Denials (age 20 and younger only)—File Review Tool																	
MCC:											mm/dd/2016						
1	2	3	4		5			6		7		8	9	10	11	12	
File #	Case ID*	Date Request Received	Appropriate Review Criteria Used		Requesting Provider Consulted			Final Denial Decision by Qualified Professional		Decision NOT Arbitrary = Yes		E/S**	Date Notified	# of Days for Notification	Notification Time Standard	Notification Time Standard Met	
			Y	N	Y	N	NA	Y	N	Y	N					Y	N
1																	
2																	
3																	
4																	
5																	
6																	
7																	
8																	
9																	
10																	
<b>Compliant Answers</b>																	
<b>Applicable Answers</b>																	
													<b>Total Compliant</b>				
													<b>Total Applicable</b>				
													<b>Percent Compliant</b>				

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

\*\*Expedited or Standard

EPSDT Information System Tracking—File Review Tool																	
MCC:																	mm/dd/2016
1	2	3	4		5		6			7		8			9		
File #	Case ID*	Medical Record (MR)	Receipt of Screening	Diagnosis Documented	Treatment, Immunization, Lab Work Documented	Ability to Determine Screening Status	Actions Taken to Improve Member's Screenings by Contacting:										
		Information System (IS)					Provider			Parent/Guardian/Member							
			Y	N	Y	N	Y	N	NA	Y	N	Y	N	NA	Y	N	NA
1		MR															
		IS															
2		MR															
		IS															
3		MR															
		IS															
4		MR															
		IS															
5		MR															
		IS															
6		MR															
		IS															
7		MR															
		IS															
8		MR															
		IS															
9		MR															
		IS															
10		MR															
		IS															
<b>Compliant Answers</b>																	
<b>Applicable Answers</b>																	
												<b>Total Compliant</b>					
												<b>Total Applicable</b>					
												<b>Percent Compliant</b>					

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

CHOICES Annual Level of Care Assessment—File Review Tool										
MCC:										mm/dd/2016
1	2	3	4	5		6		7		
File #	Case ID*	CHOICES Group Category	Date of CHOICES Enrollment with MCO	Level of Care Reassessment Conducted		Date of Level of Care Reassessment Documented in Member File		If Reassessment Indicated a Change in Level of Care, It Was Forwarded to TennCare for Determination		
				Y	N	Y	N	Y	N	NA
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
<b>Compliant Answers</b>										
<b>Applicable Answers</b>										
							<b>Total Compliant</b>			
							<b>Total Applicable</b>			
							<b>Percent Compliant</b>			

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

Transition of CHOICES Members Between MCCs: Criteria for Receiving MCCs—File Review Tool														
MCC:												mm/dd/2016		
Row #1		File #	1	2	3	4	5	6	7	8	9	10	Answers	
2	Case ID*												Compliant	Applicable
3	CHOICES Group Category													
4	Date of CHOICES Enrollment with Receiving MCO													
5	Transition of Care Data Requested from Sending MCO	Y												
		N												
		NA												
6	Transition of Care Data from Sending MCO Reviewed	Y												
		N												
		NA												
7	For Group 2 or 3 Members, Svcs. Auth. by Sending MCO Cont'd for Min. 30 Days and Not Reduced until Needs Assessment, Plan of Care, and New Services Auth. and Implemented	Y												
		N												
		NA												
8	For Group 2 or 3 Members, F-to-F Visit, Plan of Care, and Auth. and Implement. of Services within 30 Days	Y												
		N												
		NA												
9	Svcs. Cont'd According to Level of Nursing Facility Svcs. and/or Reimbursement Approved by TennCare for Group 2 Members Rec. Short-Term Nursing (STN) Facility Care	Y												
		N												
		NA												

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

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

Complaints File Review Tool													
MCC: DQ			Time Standard Calculation:								Date:		
1	2	3	4		5		6	7	8	9		10	
File #	Case ID*	Complaint Rcvd. Date	Complaint Documented		Investigation of Complaint		Date Resolved	Number of Days to Resolve	Time Standard	Timeliness Standard Met		Notification of Resolution	
			Y	N	Y	N				Y	N	Y	N
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
<b>Compliant Answers</b>													
<b>Applicable Answers</b>													
										<b>Total Compliant</b>			
										<b>Total Applicable</b>			
										<b>Percent Compliant</b>			

\*Case IDs have been used to protect member information

## APPENDIX C | 2016 Health Plan Meeting Information

Qsource conducts meetings three times a year attended by TennCare and its MCCs that feature keynote presentations and group participation activities, as detailed in **Table C-1**. The meetings held in 2016 offered continuing education credits through seminars about changes to Medicaid, innovations in member communication, and growing risks for patients improperly treated.

Table C-1. 2016 TennCare Health Plan Meetings	
Presentation Title	Presenter
<b>February 2, 2016</b>	
<i>Merit-Based Incentive Payment System (MIPS) Implementation</i>	<ul style="list-style-type: none"> <li>◆ Dawn FitzGerald, MS, MBA, Chief Executive Officer, Qsource</li> </ul>
<i>The ABCs of PIPs</i>	<ul style="list-style-type: none"> <li>◆ Ginger Botts, BSN, RN, Clinical QI Specialist, Qsource</li> <li>◆ Celia Larson, PhD, MS, Biostatistician, Qsource</li> </ul>
<i>Le Bonheur CHAMP: Addressing High-Risk Pediatric Asthma</i>	<ul style="list-style-type: none"> <li>◆ Christie Michael, MD, CHAMP Medical Director, Allergist and Immunologist, Le Bonheur Children’s Hospital</li> <li>◆ Susan Steppe, LAPSW, CHAMP Program Director, Le Bonheur Children’s Hospital</li> </ul>
<i>Member Centric Decision Management (MCDM)</i>	<ul style="list-style-type: none"> <li>◆ Laurie Evans, BSN, Manager, Decision Sciences and Consumer Engagement</li> </ul>
<b>June 28, 2016</b>	
<i>CDI Prevention: Reaching Across the Continuum of Care</i>	<ul style="list-style-type: none"> <li>◆ Eric Sullivan, RN, MSN, Clinical QI Advisor, Qsource</li> <li>◆ Sarah Potter, RT, MBA, QI Advisor, Qsource</li> <li>◆ Patricia Lawson, RN, MS, MPH, Public Health Nurse Consultant, TN Dept of Health</li> </ul>
<i>Emergency Department Utilization: Spotlight on TennCare Utilization</i>	<ul style="list-style-type: none"> <li>◆ Peggy Thomas, RN, Bureau of TennCare, Clinical Quality Review Director, Division of Quality Oversight</li> <li>◆ Tammy L Seay, RN, Public Health Nurse Consultant, Bureau of TennCare, Division of Quality Oversight</li> </ul>
<i>Medicaid Member Communication</i>	<ul style="list-style-type: none"> <li>◆ Neng Bing Doh, MBA, Chief Executive Officer, Healthcrowd</li> </ul>
<i>Advancing Behavioral Health Integration in Primary Care</i>	<ul style="list-style-type: none"> <li>◆ Teasa Thompson, MPH, QI/HIT Advisor, Qsource</li> </ul>

Table C-1. 2016 TennCare Health Plan Meetings	
Presentation Title	Presenter
<b>September 14, 2016*</b>	
<i>Surveillance for Cervical Cancer Precursors in the Era of HPV Vaccine and New Cervical Screening Guidelines</i>	◆ Marie R Griffin, MD, MPH, Professor, Vanderbilt University Medical Center
<i>Harnessing the Power of Community to Improve the Lives of Tennesseans</i>	◆ Manish Sethi, MD, Orthopedic Trauma Surgeon, Vanderbilt University Medical Center
<i>Tennessee Health Care Innovation Initiative</i>	◆ Karly Schledwitz, MPP, Health Policy Associate, Strategic Planning and Innovation Group, Health Care Finance and Administration (HCFA)

\* The September meeting was scheduled for half a day to accommodate attendees of the Tennessee Public Health Association Annual Educational Conference.