TN Division of Health Care Finance & Administration

October 30, 2015

Mr. Patrick Edwards
TennCare Project Officer
Division of State Demonstrations & Waivers
State Demonstrations Group
Center for Medicaid and CHIP Services
Mail Stop S2-02-06
7500 Security Boulevard
Baltimore, Maryland 21244

RE: TennCare II, STC 46, Annual Report

Dear Mr. Edwards:

Enclosed please find the Draft Annual Report for Demonstration Year 13 (July 1, 2014, through June 30, 2015). This report is being submitted in accordance with STC 46 of the TennCare Demonstration.

Please let us know if you have comments or questions.

Sincerely,

[redacted]

Darin J. Gordon
Director, Bureau of TennCare

cc: Andrea Casart, Technical Director, Baltimore Office
Jackie Glaze, Associate Regional Administrator, Atlanta Regional Office
Kenni Howard, Tennessee Coordinator, Atlanta Regional Office
Shantrina D. Roberts, Medicaid and CHIP Policy Branch Manager, Atlanta Regional Office

Draft Annual Report

TennCare II

No. 11-W-00151/4

Demonstration Year (DY) 13

(7/1/2014 – 6/30/2015)

Executive Summary

During Demonstration Year (DY) 13, the Bureau of TennCare continued to pursue its mission of maintaining an exemplary system of high quality health care for eligible Tennesseans within a sustainable and predictable budget.

Major events for the TennCare program in DY 13 included:

- Successful movement from a regional to a statewide model of service delivery by Managed Care Organizations (MCOs).
- The development of Governor Bill Haslam's Insure Tennessee proposal to expand health care coverage within the state, as well as the Tennessee General Assembly's defeat of the proposal.
- Submission of four Demonstration Amendments: two pertaining to Home and Community Based Services, one pertaining to benefits for pregnant women during periods of presumptive eligibility, and one pertaining to hospital pool payments.
- Re-visioning of the Tennessee Eligibility Determination System (TEDS) project.

Enrollees' satisfaction with care received from TennCare remained high. Results from the annual Beneficiary Survey, which is conducted each year by the Center for Business and Economic Research at the University of Tennessee, revealed that the level of beneficiary satisfaction had reached 93 percent, which tied for the third highest satisfaction level in the history of the TennCare program.

The performance of TennCare's MCOs remained strong. The annual HEDIS/CAHPS report showed a variety of areas of health care effectiveness—including several related to children, adolescents, and women—in which the MCOs outperformed both their own results from the previous year as well those achieved by Medicaid programs nationwide. Improvement was evident in such notable categories as immunization rates for adolescents, controlling high blood pressure, breast cancer screening, and follow-ups after hospitalization for mental illness.

A Note to the Reader

Special Term and Condition (STC) 46 of the TennCare Demonstration requires that the State submit a Draft Annual Report documenting accomplishments, project status, quantitative and case study findings, utilization data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration.

This report is organized accordingly:

Section I:	Accomplishments
Section II:	Project Status
Section III:	Quantitative and Case Study Findings
Section IV:	Utilization Data
Section V:	Interim Evaluation Findings
Section VI:	Policy and Administrative Issues and Solutions

Several other STCs mention items that are to be addressed in the Annual Report. These items have been included in the Attachments that follow the narrative section. The Attachments are as follows:

- Attachment A ("Operational Procedures Regarding Reserve Slots in CHOICES 2") is required by STC 32.d.iii.(A).
- Attachment B ("Compliance Measures for HCBS Regulations") is required by STC 43.b.
- Attachment C ("Special Terms and Conditions Report") is an annualized version of a report that TennCare prepares quarterly.
- Attachment D ("The Impact of TennCare: A Survey of Recipients 2014") is a report resulting from the beneficiary survey referenced in STC 47.
- Attachment E presents the annual HEDIS/CAHPS report.
- Attachment F ("Quality Improvement Strategy") is required by STC 43.c.

STC numbers in this report refer to those in effect during DY 13.

One other comment: The period covered by the report is the Demonstration Year, which, in this case, was the period from July 1, 2014, through June 30, 2015. Events and activities that occurred after June 30, 2015, are not included in this report but will be included in next year's Draft Annual Report.

I. Accomplishments

Statistical Successes. TennCare's accomplishments during DY 13 were evident from a variety of statistics gathered throughout the year. Among these accomplishments were the following:

- Enrollment. The size of the TennCare population at the conclusion of DY 12—as reported in last year's Draft Annual Report—was 1,277,591. That number had grown to 1,431,978 by the conclusion of DY 13.

- Enrollee Satisfaction. According to an annual survey conducted by the University of Tennessee's Center for Business and Economic Research, the percentage of respondents expressing satisfaction with services received from TennCare during 2014 was 93 percent. (See "Beneficiary Survey" in Section III for additional details.)

- Controlling Medical Inflation. The budget presentation made by TennCare Director Darin Gordon, Deputy Director Dr. Wendy Long, and Chief Financial Officer Casey Dungan during December 2014 identified TennCare's medical inflation rate as 3.3 percent, as compared with a national Medicaid rate of 6.7 percent, and a commercial rate of 6.8 percent. The budget presentation document remains available at http://www.tn.gov/assets/entities/tenncare/attachments/HCFAbudgetFY16.pdf.

- CHOICES Rebalancing. CHOICES is TennCare's program of managed long-term services and supports (LTSS) for individuals who are elderly or who have physical disabilities. According to TennCare's most recent submission of CHOICES data to CMS, the number of individuals receiving Home and Community Based Services (HCBS) grew from 13,050 on the last day of DY 12 to 13,240 on the last day of DY 13. The number of individuals receiving Nursing Facility (NF) services remained relatively constant, declining slightly from 18,018 on the last day of DY 12 to 17,069 on the last day of DY 13.

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Outreach. TennCare's contract with the Tennessee Department of Health (TDH) to educate families on EPSDT benefits produced significant results during DY 13. TDH made contact with 644,519 people and distributed nearly 659,000 sets of educational materials.

- Accuracy of Encounter Data. TennCare's use of the Edifecs software system for encounter data allows non-compliant encounter claims to be rejected individually instead of as part of a batch. As a result, 99.78 percent of encounter claims were compliant with State standards (including HIPAA) upon initial submission.

Payment Reform. In February 2013, Governor Haslam launched Tennessee's Health Care Innovation Initiative to change the way that health care is paid for in Tennessee. The desired direction is to move from paying for volume to paying for value by rewarding health care providers for certain outcomes such as high quality and efficient treatment of medical conditions, and to help in maintaining people's health over time. Initial funds for the Initiative came from a State Innovation Model (SIM) planning grant.

The Tennessee Health Care Innovation Initiative is located in the Division of Health Care Finance and Administration, which is the agency in which TennCare is located as well. Although its goals transcend Medicaid, there is much emphasis on Medicaid and TennCare as playing a pivotal role in meeting the Initiative's goals. All of TennCare's providers are included in the Initiative.

There are three strategies that are being used to reform health care payment approaches: primary care transformation, episodes of care, and LTSS.

- Primary care transformation focuses on the role of the primary care provider in promoting the delivery of preventive services and managing chronic illnesses over time. The initiative is developing an aligned model for multi-payer Patient Centered Medical Homes (PCMH), Health Homes for TennCare members with Serious and Persistent Mental Illness, and a shared care coordination tool that includes hospital and Emergency Department admission, discharge, and transfer alerts for attributed providers.
- Episodes of care focuses on the health care delivered in association with acute healthcare events, such as a surgical procedure or an inpatient hospitalization. Episodes encompass care delivered by multiple providers in relation to a specific health care event. Each episode has a "quarterback" who leads and coordinates the team of care providers and helps drive improvement through various activities including, but not limited to, care coordination, early intervention, and patient education. The Initiative is introducing new clinical episodes each year, with the goal of implementing 75 episodes by the end of 2019.
- The LTSS component focuses on improving quality and shifting payment to outcomes-based measures for the QuILTSS program and for enhanced respiratory care.

In December 2014, Tennessee was awarded a $65 million SIM grant from CMS. This grant award will further support the goal of the initiative to make health care in Tennessee a value-based system focused on efficiency, quality of care, and the patient experience.

Implementation of Statewide MCO Contracts. On January 1, 2015, following months of intensive preparations, TennCare MCOs Amerigroup, BlueCare, and UnitedHealthcare began delivering physical health services, behavioral health services, and LTSS to enrollees in all three of Tennessee's grand regions. Previously, MCOs had been procured on a regional basis.

Coinciding with this January 1 implementation date was the transfer of approximately 411,000 TennCare members to different health plans to ensure a more even distribution of enrollment among the three statewide MCOs. A second round of enrollee transfers—covering about 6,900 individuals—took place on April 1, 2015. Each affected enrollee had been provided advance notice of the transfer, as well as instructions for remaining with his original MCO if preferred.

The first two quarters of the statewide service delivery model proved successful. TennCare monitored the rollout carefully and found that access to services had not been interrupted and, in particular, that critical care patients continued to receive needed care.

II. Project Status

Insure Tennessee. On December 15, 2014, Tennessee Governor Bill Haslam announced the Insure Tennessee plan, a two-year pilot program to provide health care coverage to certain low-income

Tennesseans who lack access to health insurance or who have limited options in that regard. The program was designed to reward healthy behaviors, prepare members to transition to private coverage, promote personal responsibility, and incentivize choosing preventative and routine care instead of unnecessary use of emergency rooms. The Insure Tennessee plan evolved from Governor Haslam's announcement in March 2013 that he would not expand the traditional Medicaid program but that he would work with the federal government on an alternative plan for Tennessee that would take into consideration program cost, patient engagement, payment reform, and health outcomes.

Following a meeting by Governor Haslam with then-Secretary of Health and Human Services Sebelius in Washington in September 2013, TennCare began to lay the administrative groundwork for Insure Tennessee. Throughout the October-December 2014 quarter, the Bureau held weekly (and occasionally twice weekly) conference calls with CMS to discuss the details of the Demonstration Amendment—Amendment 25—that would be needed to implement the proposal. Following these negotiations, TennCare notified the public on January 8, 2015, of its intent to submit Amendment 25 formally to CMS.

January 8 was also the date on which Governor Haslam issued a proclamation convening a special session of the Tennessee General Assembly to consider a joint resolution on Insure Tennessee. The session began on February 2, 2015, with the governor outlining his proposal to a joint convention of the Senate and the House of Representatives. Following hearings on Insure Tennessee over the next two days, the Tennessee Senate Health and Welfare Committee effectively ended the special session on February 4 by voting 7-4 against Insure Tennessee.

Several weeks after this development, Insure Tennessee was temporarily revived in the regular session of the 109th General Assembly. Senate Joint Resolution 93, which "authorizes the Governor to do all that is necessary to implement Insure Tennessee," passed the Senate Health and Welfare Committee by a 6-2-1 vote on March 25. On March 31, however, the Senate Commerce and Labor Committee defeated the measure by a 6-2-1 vote.

Amendments to the TennCare Demonstration. The Bureau submitted four Demonstration Amendments to CMS during DY 13.

Demonstration Amendment 23. On July 28, 2014, TennCare submitted Demonstration Amendment 23 to CMS. Amendment 23 dealt with the benefits a pregnant woman may receive from TennCare during a period of "presumptive eligibility," which is a period of temporary eligibility granted to low-income pregnant women who would likely qualify for TennCare coverage but who have not yet completed an application. Most members of this population are "presumptives" for only a few short weeks before becoming fully TennCare eligible, when the issue of ambulatory versus non-ambulatory services becomes moot.

Federal regulations limit the Medicaid services that may be furnished to presumptively eligible pregnant women to ambulatory services only. TennCare had long taken the position that all Medicaid services—ambulatory as well as non-ambulatory—were "pregnancy-related services" and should be available to pregnant women to promote their health and the health of their unborn children. Amendment 23 was developed in concert with CMS as a way of resolving this issue and achieving the state's objectives.

On September 5, 2014, CMS issued written approval of Amendment 23.

Demonstration Amendment 24. TennCare submitted Amendment 24 to CMS on March 4, 2015. Amendment 24 proposed to add two community-based residential alternative services to the menu of benefits covered by CHOICES. Both of the services in question—"community living supports" (CLS) and "community living supports-family model" (CLS-FM, an "adult foster care" arrangement)—are alternatives to NF care: each provides access to services and supports in a small shared residential setting, allowing the individual to reside in the community. The proposal was designed to ensure that delivery of CLS and CLS-FM would not increase program expenditures but would adhere to federal regulations governing the provision of HCBS and HCBS settings. CMS approved Amendment 24 on June 24, 2015, and implementation of the services was to begin on July 1, 2015 (the first day of DY 14).

Demonstration Amendment 26. Under the terms of the TennCare Demonstration, the Bureau of TennCare has the expenditure authority (specifically, "Expenditure Authority #4") to make certain payments to providers through "pools" that exist outside the managed care program. The names of the pools are as follows:

- Graduate Medical Education Pool
- Essential Access Hospital Pool
- Critical Access Hospital Pool
- Meharry Medical College Pool
- Unreimbursed Public Hospital Costs Pool for Certified Public Expenditures
- Unreimbursed Hospital Cost Pool
- Public Hospital Supplemental Payment Pool

The recipients of funds from most of the pools are identified groups of Tennessee hospitals. The primary purpose of pool funds is to offset the costs of delivering uncompensated care, but they have some other purposes as well, such as providing support for training medical professionals.

According to the provisions of the TennCare Demonstration, the expiration date for Expenditure Authority #4 is December 31, 2015, which is six months prior to the June 30, 2016, end date of TennCare's current approval period. TennCare relies on the pool payments to support the current array of services that are available to TennCare enrollees and requested that the termination date extend at least until the last day of the current approval period. In Special Term and Condition #69 of the Demonstration, the Bureau is directed to conduct a study of uncompensated care costs for the uninsured, the focus of which is payments being made under the pools. Since one purpose of the study is to evaluate the continuing need for the pools, TennCare determined that it would be counterproductive to make changes to the pools while the study was still being conducted. Therefore, Amendment 26 requested that Expenditure Authority #4 continue through June 30, 2016.

Although the amendment was submitted on April 8, 2015, CMS had not completed its review by the conclusion of DY 13.

Demonstration Amendment 27. On June 23, 2015, the Bureau submitted Amendment 27 to CMS. Amendment 27 outlined a new program—named *Employment and Community First CHOICES*—within the arena of LTSS, a description of which appears in the paragraph below at the opening of the proposal:

> With Amendment 27 to the TennCare demonstration, Tennessee proposes to implement within its existing managed care demonstration an integrated managed long-

term services and supports (MLTSS) program that is specifically geared toward promoting and supporting integrated, competitive employment and independent, integrated community living as the first and preferred option for individuals with intellectual and developmental disabilities (I/DD).

The amendment would apply to individuals with intellectual disabilities and individuals with developmental disabilities who are newly enrolling into HCBS programs. Employment and Community First CHOICES would not, however, alter the manner in which services in an Intermediate Care Facility for Individuals with Intellectual Disabilities are delivered and would not make any immediate changes for individuals served in the three HCBS waiver programs that currently exist outside the TennCare 1115 Demonstration (the Comprehensive Aggregate Cap Waiver, the Statewide Waiver, and the Self-Determination Waiver).

A principal aim of Amendment 27 is to provide services more cost-effectively in order to be able to expand services to more of the 6,000 individuals with intellectual disabilities who are currently on a waiting list for the aforementioned HCBS waiver programs, and an undetermined number of individuals with developmental disabilities who do not qualify for services in the existing HCBS waivers. In laying the groundwork to realize this goal, the proposal identifies four target populations to be served, as well as three benefit packages designed to address the diverse needs of individuals within those populations. To ensure that Employment and Community First CHOICES operates within available state resources, however, each benefit package contains an individual cost limit, and TennCare retains the right to establish enrollment caps as well.

A copy of Amendment 27 is currently available on TennCare's website at http://www.tn.gov/assets/entities/tenncare/attachments/Amendment27ECFCHOICES.pdf. Negotiations between CMS and the State on the proposal were underway at the end of DY 13.

As indicated above, two of the four Demonstration Amendments that TennCare submitted to CMS during DY 13 deal with various forms of HCBS. Additional information about HCBS furnished to TennCare enrollees appears in the Attachments to this report. Attachment A comprises the operational procedures by which the Bureau reserves slots in CHOICES 2 for certain individuals being discharged from a Nursing Facility or an acute care setting. Attachment B details the steps taken by TennCare to ensure compliance with federal regulations governing the provision of HCBS.

Incentives for Providers to Use Electronic Health Records. The Electronic Health Record (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The purpose of the program is to provide financial incentives to Medicaid providers[1] to replace outdated, often paper-based approaches to medical record-keeping with electronic systems that meet rigorous certification criteria and that can improve health care delivery and quality. The federal government provides 100 percent of the funding for the incentive payments and 90 percent of the program's administrative costs.

[1] CMS allows two types of providers to participate in the Medicaid EHR Incentive Program: medical professionals (physicians, nurse practitioners, certified nurse midwives, dentists, and certain kinds of physician assistants) and hospitals (acute care hospitals, critical access hospitals, and children's hospitals).

Tennessee's EHR program remained robust during DY 13 by continuing to distribute payments to some providers while educating others on the advantages of participation. Highlights from the year included the following:

- Payments to providers who had adopted, implemented, or upgraded to certified EHR technology capable of meeting CMS' "meaningful use" standards or who had achieved meaningful use of EHR technology for any period of 90 consecutive days (referred to as "Year 1" payments) exceeded $154 million by June 30, 2015.
- Total payments to providers who had received first-year payments and who subsequently achieved meaningful use of EHR technology for a period of 90 consecutive days ("Year 2" payments) neared $49 million by the conclusion of DY 13.
- Payments to providers who had demonstrated ongoing meaningful use of EHR technology ("Year 3" and "Year 4" payments) surpassed $13 million by June 30, 2015.
- More than 1,200 Tennessee providers received incentive payments during DY 13.

These achievements would not have been possible without the Bureau's multilayered approach to communicating updates and instructions to providers throughout the state. Various facets of this outreach effort included staff participation in meetings, workshops, and conference calls; hosting of webinars and technical assistance calls on the subject of meaningful use; a dedicated section of the TennCare website (complete with a program overview, registration and attestation information, answers to frequently asked questions, audio-enhanced PowerPoint presentations, and a glossary); monthly newsletters distributed by TennCare's EHR ListServ; and automated messaging to providers via the Bureau's Provider Incentive Payment Program ("PIPP") system.

Population Health. "Population Health" (PH) is the model of targeted health care interventions employed by TennCare, key benefits of which include—

- Selection of a much larger portion of the TennCare population than had been possible under previous models of health care intervention;
- Identification of risky behaviors likely to lead to disease in the future (such as poor eating habits, physical inactivity, and drug use);
- Assistance to enrollees in discontinuing such activities; and
- Interventions to assist enrollees who already have a complex chronic condition.

The PH program replaced the much more limited "Disease Management" model, which had typically served about 250,000 individuals. By contrast, the conclusion of DY 13 saw 1,360,720 TennCare enrollees—95 percent of the enrollee population—receiving PH services. Nearly 20,000 of these individuals were pregnant women assigned to either the "Maternity Program" or the "High Risk Pregnancy Management" programs.

Special Terms and Conditions. A summary of activities that occurred with respect to the Special Terms and Conditions is presented in Attachment C.

Enrollment information. STC 49.b. requires that the State include enrollment reporting by Eligibility Group and by Type for the TennCare population. Table 1 summarizes that information.

Table 1
Enrollment Counts for DY 13

State Plan and Demonstration Populations	Total No. of TennCare Enrollees			
	Jul - Sep 2014	Oct - Dec 2014	Jan - Mar 2015	Apr - Jun 2015
EG1 Disabled, Type 1 State Plan eligible	142,947	141,930	141,264	139,803
EG9 H-Disabled, Type 2 Demonstration Population	273	306	306	342
EG2 Over 65, Type 1 State Plan eligible	21	28	30	43
EG10 H-Over 65, Type 2 Demonstration Population	0	0	0	0
EG3 Children, Type 1 State Plan eligible	692,106	707,626	722,454	733,165
EG4 Adults, Type 1 State Plan eligible	338,685	358,447	379,079	394,216
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	136,863	138,654	139,992	140,344
EG6E Expan Adult, Type 3 Demonstration Population	876	861	848	834
EG7E Expan Child, Type 3 Demonstration Population	67	67	66	64
EG8, Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX	0	0	0	0
Med Exp Child, Title XXI Demonstration Population	19,444	19,307	19,102	18,998
EG12E Carryover, Type 3, Demonstration Population	5,353	5,016	4,595	4,169
TOTAL	1,336,635	1,372,242	1,407,736	1,431,978

III. Quantitative and Case Study Findings

Beneficiary Survey. Every year since 1993, the Center for Business and Economic Research (CBER) at the University of Tennessee in Knoxville has conducted a survey of Tennessee citizens—TennCare enrollees, individuals with private insurance, and uninsured individuals alike—to assess their opinions about health care. Respondents provide feedback on a range of topics, including demographics (age, household income, family size, etc.), perceptions of quality of care received, and behavior relevant to health care (the type of provider from whom an individual is most likely to seek initial care, the frequency with which care is sought, etc.).

During DY 13, CBER published a summary of the results of the most recent survey entitled "The Impact of TennCare: A Survey of Recipients 2014." Although the findings of a single survey must be viewed in context of long-term trends, several results from the September 2014 report were noteworthy:

- 93 percent of respondents covered by TennCare expressed satisfaction with the quality of care they had received. This level of satisfaction—the sixth straight year above 90 percent—is tied for the third highest in the program's history.
- The percentage of respondents classifying themselves as uninsured fell to 7.2 percent, a 25 percent decline from 2013's result. Likewise, the percentage of respondents classifying their children as uninsured fell to 2.4 percent, a 35 percent decline from 2013's result.
- Only 1 percent of respondents covered by TennCare reported that they sought initial medical care for their children at the hospital instead of at a doctor's office or clinic. This figure is significant because seeking initial care at the emergency room (in the absence of an emergency) is less cost-effective than seeking this care at a doctor's office or clinic. Redirection of enrollees to the most cost-effective source of care is a primary objective of a managed care program, and the evidence suggests that TennCare has been successful in meeting this goal.

In summary, the report notes, "TennCare continues to receive positive feedback from its recipients, with 93 percent reporting satisfaction with the program, indicating TennCare is providing medical care in a satisfactory manner and up to the expectations of those it serves." The report is presented in Attachment D and is available online at http://cber.bus.utk.edu/tncare/tncare14.pdf.[2]

HEDIS/CAHPS Report. The annual report of HEDIS/CAHPS data—entitled "Comparative Analysis of Audited Results from TennCare MCOs"—was released in August 2014. The full name for HEDIS is Healthcare Effectiveness Data Information Set, and the full name for CAHPS is Consumer Assessment of Health Plans Surveys. This report, which is presented in Attachment E and posted on the TennCare website at http://www.tn.gov/assets/entities/tenncare/attachments/hedis14.pdf, provides data that enables the State to compare the performance of its MCOs against national norms and benchmarks and to compare performance among MCOs.

Improved statewide performance was noted for an array of child health measures, with many also exceeding the HEDIS 2013 National Medicaid Average. Higher success rates were achieved in all of the following categories:

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
- Immunizations for Adolescents
- Lead Screening in Children
- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection
- Frequency of Ongoing Prenatal Care
- Well-Child Visits in the First 15 Months of Life

Improvement was also evident in a variety of health categories applicable to adults, including Adults' Access to Preventive/Ambulatory Health Services, Controlling High Blood Pressure, Adult Body Mass Index (BMI) Assessment, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, and

[2] In compliance with STC 47, the Bureau submitted the Beneficiary Survey report to CMS on September 25, 2014.

Pharmacotherapy Management of COPD Exacerbation. Categories with special relevance to women's health demonstrated progress as well: performance rose in Breast Cancer Screening and Human Papillomavirus Vaccine for Female Adolescents.

HEDIS 2014 was the fifth year of statewide reporting of behavioral health measures following the integration of medical and behavioral health services among TennCare's health plans. Results superior to those in 2013 were achieved in the behavioral health categories of Follow-Up after Hospitalization for Mental Illness and Adherence to Antipsychotic Medications for Individuals with Schizophrenia. The categories of Antidepressant Medication Management and Follow-Up Care for Children Prescribed ADHD Medication, on the other hand, were areas of opportunity for TennCare.

IV. Utilization Data

Utilization information is taken from encounter data submitted by the Managed Care Organizations. It is maintained on a rolling basis reflecting a quarter lag.

Key indicators tracked by TennCare and the measures for each indicator for FYs 2013-2015 are presented in Table 2.

Table 2
Key Indicators Tracked by TennCare, FYs 2013-2015

METRIC	FY 2013	FY 2014	FY 2015
Member Months (FTE)	**1,217,440**	**1,226,875**	**1,363,619**
COST INDICATORS			
PMPM – Physician	**$99**	**$101**	**$93**
PMPM – Facilities	**$132**	**$128**	**$118**
PMPM – Rx (before rebate)	**$60**	**$64**	**$65**
UTILIZATION MEASURES			
Hospital Days/1000	**703**	**650**	**562**
Hospital Admissions (excluding mental health events)/1000	**134**	**126**	**112**
ER Visits/1000	**991**	**943**	**928**
Prescriptions/1000	**12,141**	**11,377**	**10,862**

Source: TennCare's Office of Healthcare Informatics

All utilization measures are calculated per 1,000 Full Time Equivalent (FTE) members.

V. Interim Evaluation Findings

TennCare continues to follow the Interim Evaluation Plan approved by CMS on March 31, 2008, with performance measures updated annually. TennCare's performance measures for the 2013-2016

Demonstration Approval Period may be grouped into seven main objectives. Those objectives, as well as the State's summary of progress on each, are as follows:

Objective 1: Use a managed care approach to provide services to Medicaid state plan and demonstration enrollees at a cost that does not exceed what would have been spent in a Medicaid fee-for-service program.
State's Summary of Progress: Budget neutrality was successfully maintained (and reported in the Quarterly Reports) during DY 13.

Objective 2: Assure appropriate access to care for enrollees.
Objective 3: Provide quality care to enrollees.
Objective 4: Assure enrollees' satisfaction with services.
Objective 5: Improve health care for program enrollees.
State's Summary of Progress: Progress to date on these objectives is summarized in the document entitled *2014 Annual Update Report of the 2013 Quality Assessment and Performance Improvement Strategy* that comprises Attachment F.

Objective 6: Assure that participating health plans maintain stability and viability, while meeting all contract and program requirements.
State's Summary of Progress: The State uses two performance measures for this objective.

- Performance Measure 6.1—By 2016, 100 percent of the TennCare MCOs will have demonstrated compliance with statutory and/or contractual claims processing timeliness standards in at least 10 out of 12 months in a calendar year.
    - Baseline Measure—In Calendar Year 2012, 100 percent of MCOs demonstrated compliance in at least 10 out of 12 months.
    - 2014 Measure—In Calendar Year 2013, 100 percent of MCOs demonstrated compliance in at least 10 out of 12 months.
    - 2015 Measure—In Calendar Year 2014, 100 percent of MCOs demonstrated compliance in at least 10 out of 12 months.
- Performance Measure 6.2—By 2016, the MCOs will report a compliance rate of 95 percent for all contractual claims payment accuracy reports. *Note: MCOs are determined compliant for each of the report types if statistical sampling determines a claims payment accuracy rate of at least 97 percent.*
    - Baseline Measure—In Fiscal Year 2013, the MCOs reported a compliance rate of 99 percent.
    - 2014 Measure—In Fiscal Year 2014, the MCOs reported a compliance rate of 97.8 percent.
    - 2015 Measure—In Fiscal Year 2015, the MCOs reported a compliance rate of 93.2 percent.

  The decline in the compliance rate for Fiscal Year 2015 is attributable to two factors. First, the Amerigroup MCO began delivering services in the East and West Tennessee grand regions on January 1, 2015, after having previously served only the Middle Tennessee grand region. Second, the UnitedHealthcare Community Plan MCO implemented an upgraded version of its claims processing system on January 1, 2015.

In addition, the MCOs' compliance with statutory net worth requirements and company action level requirements is monitored regularly and addressed in each Quarterly Report filed during the Demonstration Year.

Objective 7: Provide appropriate, and cost-effective home and community based services that will improve the quality of life for persons who qualify for nursing facility care, as well as for persons who do not qualify for nursing facility care but who are "at risk" of institutional placement and that will help to rebalance long-term services and supports expenditures.

State's Summary of Progress: The number of TennCare enrollees receiving HCBS in CHOICES 2 (for individuals who meet the nursing facility level of care criteria) or in Interim CHOICES 3 (for individuals who do not meet nursing facility level of care criteria but are at risk of institutionalization) is reported in each Quarterly Report. Of the total TennCare population receiving LTSS, the percentage enrolled in either CHOICES 2 or CHOICES 3 grew from 42 percent at the conclusion of DY 12 to 44 percent at the conclusion of DY 13.

VI. Policy and Administrative Issues and Solutions

Tennessee Eligibility Determination System. On January 12, 2015, TennCare announced plans to select a new vendor for the continued development of the Tennessee Eligibility Determination System (TEDS). The purpose of TEDS is to review applications for health care assistance and identify which persons are eligible for state-sponsored health care assistance, meaning TennCare and CoverKids.

After months of delays and missed benchmarks, the State had decided in 2014 to hire an independent international consulting firm, KPMG LLP, to perform an assessment of the status of the TEDS project. The assessment was to provide—

- A review of progress to date by then-vendor Northrop Grumman Systems Corporation;
- Identification of project deficiencies;
- Determination of potential risks to the TennCare program; and
- Options for resuming development of the TEDS project and leading it to a successful outcome.

In late 2014, KPMG LLP released a comprehensive report to the State. As a result of the detailed findings within the report, TennCare and Northrop Grumman mutually decided it to be in their respective best interests to terminate their contract early. The State then adopted a new approach to the undertaking, one recommended by KPMG: rather than consolidating all aspects of the project under one vendor, TennCare opted to procure three separate contracts with the designations of Technical Advisory Services, Strategic Program Management Office, and Systems Integrator.

By the conclusion of DY 13, the State had moved forward with procurement on the "Technical Advisory Services" element, bidders had submitted proposals, and TennCare had begun scoring the proposals. Furthermore, procurement documents for the "Strategic Program Management Office" element had been developed and were being reviewed for release in the near future. The "Systems Integrator" component will be addressed once the other two contracts have been awarded and are in place.

Evaluation of Eligibility and Enrollment Systems. STC 68 directs the State to "propose data collection and reporting measures designed to assess the ongoing need for retroactive Medicaid eligibility after

changes specified in the Affordable Care Act are effectuated." To address this administrative issue, TennCare entered into a contract with Manatt, Phelps, and Phillips, LLP, on February 1, 2015, to conduct an evaluation of the Bureau's eligibility and enrollment systems. The evaluation was planned to occur in five stages:

1. Proposal of a set of measures and development of a plan for use of the measures;
2. Assessment of readiness activities for collecting and analyzing the data;
3. Completion of an initial analysis of the data;
4. Completion of a final analysis of the data; and
5. Submission of a report to CMS.

From the beginning of the contract period through the end of DY 13 (and thereafter), TennCare and Manatt collaborated extensively on the project. Although a draft of the evaluation was not due until after the conclusion of DY 13, considerable work had been done with regard to collection of information and identification of key principles within that information. As a result of these preparations, the State was able to share an overview of proposed measures with CMS on June 12, 2015.

Evaluation of Uncompensated Care Costs for the Uninsured. STC 69 requires the State to "propose data collection and reporting measures designed to assess the ongoing need for payments to compensate hospitals for providing care to the uninsured after changes specified in the Affordable Care Act are effectuated." The State submitted two drafts of an evaluation design to CMS during DY 12, but CMS ultimately recommended that the State secure a qualified vendor to perform the evaluation. Therefore, on June 1, 2015, TennCare entered into a contract with Public Consulting Group (PCG), Inc., to conduct a five-stage evaluation:

1. Review of aspects of the TennCare program that could potentially contribute to uncompensated care;
2. Submission of a report to the State summarizing the findings of the review;
3. Proposal of a set of measures and development of a plan for use of the measures;
4. Completion of an initial analysis of the data; and
5. Final recommendations for reforms allowing the State to pay providers and ensure access to care and quality of care for beneficiaries without the need for hospital pool funds.

In the final month of DY 13, the Bureau not only worked with PCG to develop the evaluation but also communicated with CMS regarding the State's plans for the evaluation.

Quality Improvement Strategy. As required by federal law,[3] federal regulation,[4] and the State's Demonstration agreement with CMS,[5] TennCare has developed a strategy for evaluating and improving the quality and accessibility of care offered to enrollees through the managed care network. The Bureau submitted its annual update of the strategy—entitled *2014 Annual Update Report of the 2013 Quality Assessment and Performance Improvement Strategy*—to CMS on November 13, 2014. In addition to laying out the measures of quality assurance already in place, the report outlined TennCare's goals and objectives for the year ahead. The document is available online at

[3] 42 U.S.C. § 1396u-2(c)(1)(A)
[4] 42 C.F.R. § 438.202
[5] STC 43.c. of the TennCare Demonstration.

http://www.tn.gov/assets/entities/tenncare/attachments/qualitystrategy.pdf and as Attachment F of this report.

Public Forum on the TennCare Demonstration. In compliance with the federal regulation at 42 CFR § 431.420(c) and the terms of its Demonstration agreement with CMS, TennCare hosted a public forum in downtown Nashville on December 17, 2014. The purpose of the forum was to provide members of the public an opportunity to comment on the progress of the TennCare Demonstration project, which has delivered Medicaid services to eligible Tennesseans under a managed care model since 1994.

The December 17 open meeting was not the only avenue through which feedback could be offered. Notice of the forum, which appeared on the TennCare website, included an email address, a physical address, and a dedicated phone line at which comments would be accepted. Although the Bureau received no comments through any of these outlets, additional opportunities to assess the TennCare Demonstration will be available, as TennCare is required to convene a forum on this subject each year for the foreseeable future.

ATTACHMENT A

OPERATIONAL PROCEDURES REGARDING
RESERVE SLOTS IN CHOICES GROUP 2

Required by STC #32.d.iii.(A)

Note: The function assigned to the Department of Human Services on Page 2 of the procedures is now held by the Member Services division of TennCare.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE AND ADMINISTRATION
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

February 2, 2010

Ms. Kelly Heilman
TennCare Project Officer
Centers for Medicare and Medicaid Services
Center for Medicaid and State Operations
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: TennCare II, STC #34.e.iii(A), CHOICES Deliverable

Dear Kelly:

Pursuant to STC #34.e.iii(A), we are enclosing our operational procedures for determining which individuals may be enrolled in reserve capacity slots for CHOICES Group 2.

Please let us know if you have comments or questions.

Sincerely,

[redacted]

Darin J. Gordon
Director, Bureau of TennCare

cc: Paul Boben, Technical Director, CMSO, Baltimore
Mary Kaye Justis, Acting Associate Regional Administrator, Atlanta Regional Office
Connie Martin, Tennessee Program Officer, Atlanta Regional Office

Reserve Capacity for CHOICES Group 2

Pursuant to STC #34.e.III (A) ***Reserve Capacity*** of the Special Terms and Conditions set forth in the current TennCare Section 1115 Demonstration Waiver, the State will reserve slots in CHOICES Group 2 for:

- Individuals being discharged from a Nursing Facility (NF); and
- Individuals being discharged from an acute care setting who are at imminent risk of being placed in a Nursing Facility setting absent the provision of home and community-based services.

The enrollment target for DY 8 (July 1, 2009, through June 30, 2010) is 7,500. The enrollment target for DY 9 (July 1, 2010, through June 30, 2011) is 9,500. It should be noted that these numbers are considerably higher than the 6,000 slots approved for the current 1915(c) waiver that will be terminated once CHOICES is fully implemented. Thus it appears unlikely that our enrollment targets for the first two years will be met, or any reserve slots utilized.

We are planning to set aside 300 reserve slots under the enrollment target each year. The process described below will be used only when enrollment in Group 2 has reached 7,200 in DY 8 and 9,200 in DY 9.

Once all other available (i.e., unreserved) slots have been filled, individuals who meet specified criteria (including new applicants seeking to establish Medicaid eligibility in an institutional category as well as current SSI-eligible individuals seeking enrollment into CHOICES Group 2) may be enrolled into reserved slots in accordance with the following procedures:

- The Area Agency on Aging and Disability (AAAD) or the Managed Care Organization (MCO), as applicable, must complete and submit a Reserve Capacity Enrollment Justification form to the TennCare Division of Long-term Care, along with supporting documentation.

- The Reserve Capacity Enrollment Justification form will require confirmation of the Nursing Facility or hospital, as applicable, from which the person is being discharged, and in the case of a hospital discharge, a written explanation of the applicant's circumstances that warrant the immediate provision of Nursing Facility services unless HCBS are immediately available. This explanation will include such factors as:
    - The reason for the acute care stay
    - The current medical status of the individual
    - Specific types of assistance needed by the individual upon discharge (medical as well as functional)
    - A description of the applicant's natural support system as it relates to discharge needs.

- The TennCare Division of Long-term Care will review the form and supporting documentation in order to determine whether the person meets specified criteria for enrollment into a reserved slot.

- If documentation is sufficient to demonstrate that the individual meets specified criteria for a reserved slot, TennCare will notify the submitting entity and proceed with the enrollment process. An enrollment form will be generated to the Department of Human Services (DHS) for determination of categorical/financial eligibility (for new Medicaid applicants) and application of federal post-eligibility provisions.

- If documentation is not sufficient to demonstrate that the individual meets specified criteria for a Reserve Capacity slot, TennCare will notify the submitting entity and place the person on a waiting list for Group 2 once unreserved capacity is available. TennCare shall provide notice of the determination to the applicant, which will include the right to request a fair hearing regarding any valid factual dispute pertaining to the State's decision.

ATTACHMENT B

COMPLIANCE MEASURES FOR HCBS REGULATIONS

Required by STC #43.b.

COMPLIANCE WITH HCBS REGULATIONS

Regulation	Topic	Actions
42 CFR 440.180(a)	Description and requirements for HCBS Services, included services	1. The State Rules for TennCare Long-Term Care Programs (1200-13-01) define the HCBS benefits that are available through the CHOICES program and delineate when services may be provided to a CHOICES member. These Rules are available for review at http://share.tn.gov/sos/rules/1200/1200-13/1200-13-01.20150727.pdf 2. Contractor Risk Agreement between the Bureau of TennCare and each Managed Care Organization delineates HCBS services available to CHOICES enrollees, the scope of such services, and contractor requirements for the authorization and initiation of such services. The Contractor Risk Agreement also sets forth reporting requirements by which TennCare monitors the Managed Care Organizations' compliance and penalties to remediate non-compliance. A sample contract is available for review at http://www.tn.gov/assets/entities/tenncare/Attachments/MCOStatewideContract.pdf 3. Provider Agreements between the Managed Care Organizations and network providers delineate the type and scope of services that each provider may provide and requirements for qualified staff.
42 CFR 441.302; (a) (c) (d) (g) (j)	State Assurances: (a) Health and Welfare (c) Evaluation of Need (d) Alternatives (g) Institutionalization Absent Waiver (j) Day treatment or Partial Hospitalization	1. The State Rules for TennCare Long-Term Care Programs (1200-13-01) define the standards for HCBS providers. These Rules are available for review at http://share.tn.gov/sos/rules/1200/1200-13/1200-13-01.20150727.pdf 2. Contractor Risk Agreement between the Bureau of TennCare and each Managed Care Organization includes a. Critical Incident reporting requirements; b. Mandatory elements for all provider agreements; c. Credentialing requirements to ensure a network of qualified providers; d. Mandatory elements of a CHOICES assessment, plan of care, and risk agreement; and e. Maximum timelines for the assessment,

Regulation	Topic	Actions
		development of the plan of care and service initiation for potential and new CHOICES members. 3. Provider Agreements between the Managed Care Organizations and network providers include critical incident reporting requirements. 4. Cost neutrality calculations to ensure that an individual's needs can be met safely and effectively at a cost that is less than or equal to care provided in a NF. If the individual's needs cannot safely and effectively be met with HCBS at a cost that is less than or equal the same level of care in a NF, the individual is eligible for—and may elect to receive services in—a NF. 5. Level of Care is confirmed for each CHOICES member through standard PAE processes, requirements for supporting medical documentation and annual recertification to assure no changes in the level of care 6. Freedom of CHOICE education appears in materials used by the single point of entry, and in the Freedom of CHOICE election form, member handbook, and TennCare website. 7. Please refer to the integrated Quality Improvement Strategy in Attachment F for a list measures used to verify the State Assurances.
42 CFR 441.303; (a) (c) (d) (e)	Supporting Documentation Required: (a) Description of safeguards (c) Description of agency plan for evaluation (d) Description of plan to inform enrollees (e) Description of post-eligibility treatment of income	1. The Single Point of Entry or the Managed Care Organization facilitates CHOICES enrollment through the completion of a PAE. TennCare determines level of care. On an annual basis, each PAE in use by a Medicaid participant must be recertified by the Managed Care Organization to verify that the individual still meets level of care. 2. Please refer to the integrated Quality Improvement Strategy in Attachment F for a list measures used to verify the State Assurances. These data are reported to CMS annually. 3. The Department of Health, Division of Healthcare Facilities rules delineate specific licensure requirements for nursing facilities, assisted care living facilities, and Adult Care Homes-Level 2. http://share.tn.gov/sos/rules/1200/1200-08/1200-08.htm 4. Post-eligibility treatment of income is delineated in the Department of Human Services' Rule 1240-03-03-.06 entitled *Technical and Financial*

Regulation	Topic	Actions
		Eligibility Requirements for Medicaid, which is available at http://share.tn.gov/sos/rules/1240/1240-03/1240-03-03.20101029.pdf. 5. TennCare Rule 1200-13-01-.08 further defines the post-eligibility treatment of income and is available at http://share.tn.gov/sos/rules/1200/1200-13/1200-13-01.20150727.pdf
42 CFR 441.310	Limits on Federal Financial Participation	1. The Contractor Risk Agreement between the Bureau of TennCare and the Managed Care Organizations only allows the Managed Care Organizations to contract with licensed facilities that are eligible to participate in Medicare and Medicaid. 2. Managed Care Organizations may not provide reimbursement for Room and Board and this is delineated in the Long-term Care Program Rules (1200-13-01-.02). 3. CHOICES services do not include prevocational, educational or supported employment services.

ATTACHMENT C

SPECIAL TERMS AND CONDITIONS REPORT

STC Activity Report—DY 13

TennCare maintained compliance with all Special Terms and Conditions during Demonstration Year 13. Specific actions are detailed below.

STCs #6 and 7: The State submitted four Demonstration Amendments to CMS.

- Amendment 23 proposed the addition of expenditure authority for the provision of non-ambulatory services to pregnant women during periods of presumptive eligibility. The State submitted Amendment 23 on July 28, 2014, and CMS issued written approval on September 5, 2014.
- Amendment 24 proposed that two community-based residential alternative services—"community living supports" and "community living supports – family model"—be added to the menu of services covered by the CHOICES program. The State submitted Amendment 24 on March 4, 2015, and CMS issued written approval on June 23, 2015.
- Amendment 26 originally proposed that the expenditure authority for hospital pool payments under the TennCare Demonstration (Expenditure Authority #4) be extended from December 31, 2015, to December 31, 2016. The State submitted this version of Amendment 26 to CMS on April 8, 2015. CMS advised the State that, because the proposed expiration date was after the end date of TennCare's current approval period, Amendment 26 would be treated as a request to extend the Demonstration instead of a request to amend it. The State elected to resubmit Amendment 26 to CMS on April 14, 2015. This version proposed that the expiration date for Expenditure Authority #4 be changed to June 30, 2016, to match the end date of TennCare's current approval period. By the conclusion of DY 13, CMS had not acted on Amendment 26.
- Amendment 27, titled Employment and Community First CHOICES, outlined a new program of managed LTSS that will deliver HCBS to individuals with intellectual and developmental disabilities. The State submitted Amendment 27 on June 23, 2015, and, by the conclusion of DY 13, negotiations between the State and CMS had commenced.

STC #10: On November 17, 2014, the State notified the public of its intention to host a public forum in which comments on the progress of the TennCare Demonstration would be accepted. The State held the forum on December 17, 2014, and included a summary of issues raised in the Quarterly Report submitted to CMS on February 27, 2015.

STC #15: Public notice concerning Demonstration Amendments was provided to Tennessee newspapers and posted on TennCare's website as follows:

- Demonstration Amendment 24: July 23, 2014
- Demonstration Amendment 25: January 8, 2015

Public notice for Demonstration Amendments 26 and 27 was achieved through mechanisms other than publication in newspapers. The proposal in Amendment 26 to change the expiration date for hospital pool payments was included in the public notice activities (publication on State websites, public hearings, etc.) for the Insure Tennessee proposal comprising Amendment 25. For Amendment 27 (*Employment and Community First CHOICES*), the notice process was even more extensive. The Bureau conducted initial meetings with advocacy groups and HCBS provider groups in December 2013; hosted community meetings with consumers, family members, and providers beginning in January 2014 (and posted an online survey for those who could not participate); published a Concept Paper entitled *Renewal and Redesign of Tennessee's Long-Term Services and Supports Delivery System for Individuals*

with Intellectual and Developmental Disabilities in May 2014; and held community meetings with stakeholders to discuss the Concept Paper in June 2014.

STC #29: TennCare's "Cost-Effective Alternatives" policy—BEN 08-001—outlines services TennCare MCOs may provide as cost-effective alternatives to covered Medicaid services. The Bureau updated Policy BEN 08-001 twice during DY 13 (on December 15, 2014, and on June 22, 2015) and published the document on the TennCare website at http://www.tn.gov/assets/entities/tenncare/attachments/ben08001.pdf.

STC 29 requires the State to demonstrate annually that the use of CEAs is cost-effective and reimbursed in accordance with federal managed care regulations. With respect to this requirement, the State offers the following assurance:

With the exception of TennCare Select, all TennCare MCOs have entered a full risk agreement and are paid on a capitated basis. Incentives for risk MCOs are aligned in such a way that there is no logical reason an at-risk MCO would pay for a non-covered service unless it is determined to be a cost-effective alternative to a covered service.

All TennCare MCO Contracts require compliance with our policies and regulations—including the Special Terms and Conditions of the TennCare Demonstration—regarding utilization and payment of cost-effective alternative services. Further, in accordance with terms of the TennCare Select contract, the Bureau is in receipt of a report demonstrating the use of TennCare-approved alternative services and their cost-effectiveness.

The MCO Contracts require and contain capitation payment rates that have been reviewed and certified by actuaries and have been determined to be actuarially sound.

STC #32.d.iii.(A): The operational procedures for determining individuals for whom CHOICES Group 2 reserve capacity slots are to be held are included as Attachment A. The State originally submitted these procedures to CMS on February 2, 2010, and has subsequently included the procedures as an attachment to each Draft Annual Report.

STC #40.a: The State submitted signed Contractor Risk Agreement (CRA) contract amendments to CMS as detailed in the following table:

Submission Date	7/10/2014	3/2/2015	6/20/2015
Middle TN CRA Amendment No.	18	--	--
East/West TN CRA Amendment No.	15	--	--
TennCare Select Contract Amendment No.	35	36	37
Statewide Contract Amendment No.	--	1	2

STC #43.b: A description of the steps taken to ensure compliance with the HCBS regulations identified in this STC is included as Attachment B. The State reviews—and, as needed, updates—this description each year and includes a copy with each Draft Annual Report.

STC #43.c: The State submitted the document entitled *2014 Annual Update Report of the 2013 Quality Assessment and Performance Improvement Strategy* to CMS on November 13, 2014.

STC #43.d.iii: The State addressed data and trends of the designated CHOICES data elements in each of the Quarterly Progress Reports and the Draft Annual Report. Electronic copies of the CHOICES point-in-time data and annual aggregate data were submitted to CMS on August 19, 2014, and June 12, 2015.

STC #44: The State participated in formal Monthly Calls with CMS on August 28, 2014, and June 25, 2015. All other Monthly Calls were cancelled by the CMS Project Officer.

STC #45: The State submitted Quarterly Progress Reports to CMS on August 29, 2014, November 26, 2014, February 27, 2015, and May 29, 2015.

STC #46: The State submitted a Draft Annual Report to CMS on October 31, 2014. CMS has not commented on the Draft Annual Report.

STC #47: The State submitted to CMS the report of beneficiary survey results on September 25, 2014.

STC #49: Enrollment information was reported to CMS by Eligibility Group and Type in the Quarterly Progress Reports and the Draft Annual Report.

STC #52: Member months were reported to CMS by Eligibility Group and Type in each Quarterly Progress Report.

STC #68: On February 1, 2015, the State entered into a contract with Manatt, Phelps, and Phillips, LLP, to advise the State on the evaluation of eligibility and enrollment systems that is required by this STC.

STC #69: On June 1, 2015, the State entered into a contract with Public Consulting Group, Inc. to advise the State on the evaluation of uncompensated care costs for the uninsured that is required by this STC.

Section XIV: The State submitted to CMS an updated version of the Operational Protocol on February 19, 2015.

ATTACHMENT D

THE IMPACT OF TENNCARE: A SURVEY OF RECIPIENTS 2014

Required by STC 47

THE IMPACT OF TENNCARE

A Survey of Recipients, 2014

Prepared by

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September 2014

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The Impact of TennCare: A Survey of Recipients, 2014

Method

The Center for Business and Economic Research (CBER) at the University of Tennessee, under contract with the Department of Finance and Administration of the State of Tennessee, conducted a survey of Tennessee residents to ascertain their insurance status and use of medical facilities. A target sample size of 5,000 households allows for obtaining accurate estimates for subpopulations. CBER prepared the survey instrument in cooperation with personnel from the Bureau of TennCare.

The University of Tennessee Social Work Office of Research and Public Service conducted the survey by randomly selecting potential respondents from a land line and cell phone set of numbers between May and July 2014. Five calls were made to each residence, at staggered times, to minimize nonrespondent bias. The design chosen was a "Household Sample," and the interview was conducted with the head of the household. When Hispanic households were reached, a person fluent in Spanish would call the household at a later time to conduct the survey.

Approximately 55.5 percent and 39.2 percent of those who answered their land line phone and cell phone, respectively, agreed to participate in the survey.[1] The large sample size allowed the weighting of responses by income and age to provide unbiased estimates for the entire population. For all statewide estimates, a correction factor was used to adjust for the degree to which the sample over- or under-represented Tennesseans grouped by household income and head of household age.[2] (Table 1)

This is a follow-up to previous surveys of 5,000 Tennessee households conducted annually since 1993, the last year of Medicaid before Tennessee adopted TennCare. Throughout this report, we make comparisons to findings from the earlier surveys.

[1] In the land line phone sample, there were 4,716 completed surveys and 4,245 refusals. In the cell phone sample, there were 301 completed surveys, and 566 refusals.

[2] Since 2010, the sample has been adjusted by household income and head of household age using the 3-year American Community Survey (ACS). The ACS is a nationwide survey designed to provide reliable and timely estimates of the demographic, social, economic and housing characteristics of the US population. The 3-year ACS data are available for any political division (state, county, city, school district, etc.) with a population greater than 20,000. It is prepared by the United States Census Bureau. In prior years, the sample had been adjusted by household income using the 2000 Census.

TABLE 1: Head of Household Age and Household Income

Age-Householders	Proportion in 2014 Survey (Percent)	Proportion in ACS* (Percent)	Deviation (Percent)
Under 25	2.0	4.4	2.4
25-44	24.3	33.4	9.1
45-64	52.0	39.6	-12.3
65+	21.7	22.5	0.8

Household Income Level	Proportion in 2014 Survey (Percent)	Proportion in ACS* (Percent)	Deviation (Percent)
<10,000	8.4	9.0	0.7
10,000-14,999	8.9	6.9	-2.0
15,000-19,999	7.9	6.6	-1.3
20,000-29,999	12.8	12.6	-0.2
30,000-39,999	9.7	11.4	1.7
40,000-49,999	9.6	9.7	0.1
50,000-59,999	8.1	8.2	0.1
60,000-99,999	20.3	20.4	0.1
100,000+	9.3	9.4	0.1

*Census Bureau, 2011-2013 American Community Survey 3-year Estimates

Estimates for Insurance Status

Estimates for the number of Tennesseans who are uninsured are presented below (Table 2). These statewide estimates are extrapolated from the weighted sample. The estimated 472,008 uninsured represent 7.2 percent of the 6,495,978 Tennessee residents.[3] The 2.4 percentage point decrease in the number of uninsured is also the largest decline and the lowest rate of uninsured in a decade. This decrease coincided with the late 2013 through early 2014 establishment of the Health Insurance Marketplace established as part of the Affordable Care Act. The uninsured rate for children is 2.4 percent, a 1.3 percentage point decrease from last year's rate of 3.7 percent. The uninsured rate for adults decreased from the 2013 rate of 11.4 percent (Table 2a) to 8.7 percent in 2014.

[3] Population estimates are found using United States Census Bureau, 2011-2013 ACS. In prior years (1993-2009), population figures were gathered from the "Interim State Population Projections," also prepared by the United States Census Bureau.

TABLE 2: Statewide Estimates of Uninsured Populations (1994–2014)

	1994	1995	1996	1997	1998	1999	2000
State Total	298,653	303,785	333,268	319,079	335,612	387,584	372,776
Percent	5.7	5.8	6.3	6.1	6.2	7.2	6.5

	2001	2002	2003	2004	2005	2006	2007
State Total	353,736	348,753	371,724	387,975	482,353	649,479	608,234
Percent	6.2	6.1	6.4	6.6	8.1	10.7	10

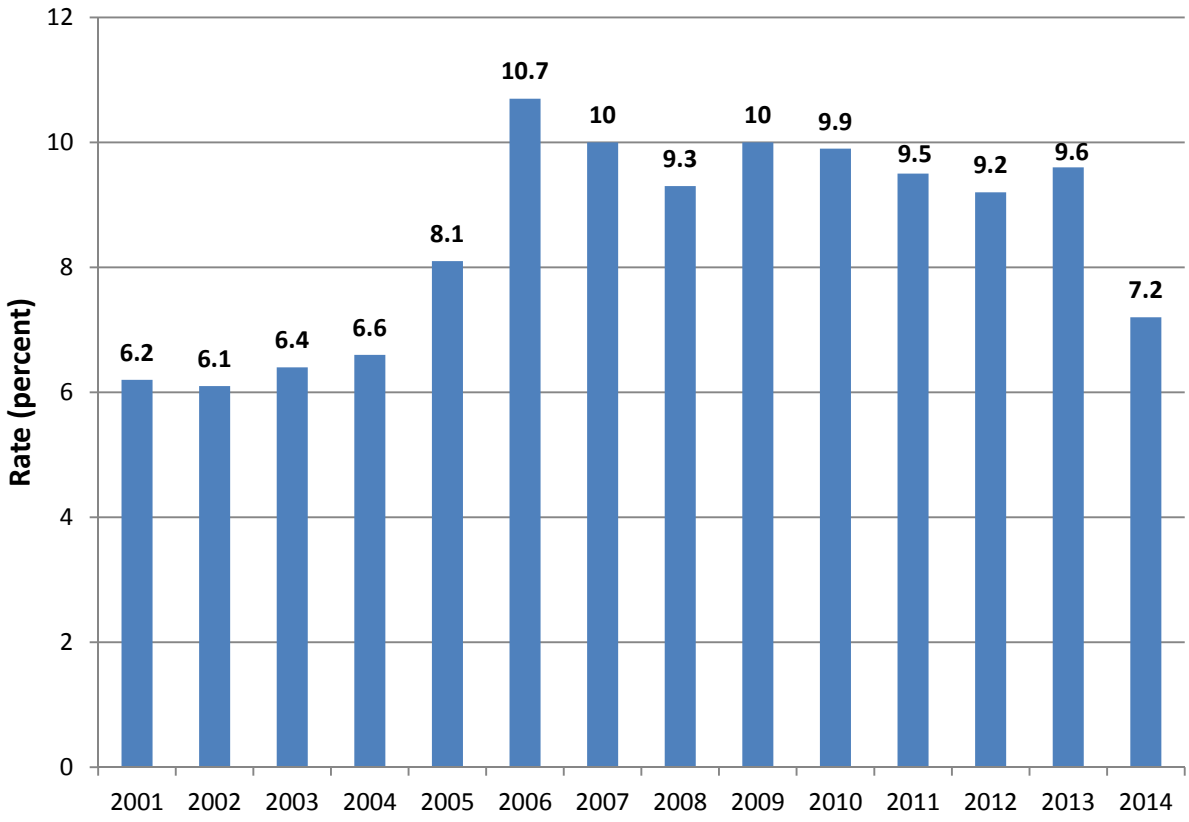
	2008	2009	2010	2011	2012	2013	2014
State Total	566,633	616,967	618,445	604,222	577,813	611,368	472,008
Percent	9.3	10	9.9	9.5	9.2	9.6	7.2

TABLE 2a: Uninsured Tennesseans by Age (2001–2014)

	2001	2002	2003	2004	2005	2006	2007
Under 18 Total	56,141	54,552	46,999	67,772	72,387	82,484	70,096
Under 18 Percent	4	3.9	3.3	4.9	5	5.7	4.8
18+ Total	297,595	297,779	324,725	320,203	409,965	566,955	538,138
18+ Percent	6.9	6.9	7.4	7.2	9.1	12.1	11.7

	2008	2009	2010	2011	2012	2013	2014
Under 18 Total	72,258	54,759	57,912	35,743	40,700	55,319	36,104
Under 18 Percent	4.9	3.7	3.9	2.4	2.7	3.7	2.4
18+ Total	494,375	562,208	560,532	568,479	537,113	556,049	435,904
18+ Percent	10.6	11.9	12	12	11.2	11.4	8.7

FIGURE 1: Rate of Uninsured Populations (2001-2014)



Reasons for Failure to Obtain Medical Insurance

The reported underlying reasons for a lack of insurance have changed little over the period since TennCare was implemented in 1994, though the percentages have shifted somewhat. The major reason that people continue to report being uninsured is their perception that they cannot afford insurance (Table 3). In 2014, 86 percent indicate that this is a major reason for not having insurance, a 3 percentage point increase from 2013. Though there is some variation from one year to the next, the difference among income groups has been consistently large, with those in the higher income groups considerably less likely to consider affordability as a major reason (Table 4). The group least likely to consider cost a major barrier to having insurance is the $50,000+ group, with only 59 percent claiming affordability as a major barrier for not having insurance.[4] Of those in the lowest income bracket, 94 percent of the respondents cite affordability as a major barrier to having insurance, which is a 6 percent increase from the previous year. A notable change from the previous several years is that 12 percent of

[4] While the $50,000+ bracket experienced a large percentage point change in the number of people claiming "cannot afford" as a major reason for no insurance, the sample size is small so its difference is not statistically significant. Therefore, the change may not reflect the shift in the underlying population.

respondents reported a major reason for not having insurance is that they do not need it, which is more than double the percentage from 2013 (Table 3). While financial pressures and lack of need limit people from obtaining coverage, 11 percent indicate that they just did not get around to securing it.

TABLE 3: Reasons for Not Having Insurance (1997–2014) (Percent)

Reason	Cannot Afford			Did Not Get to It			Do Not Need		
Year	Major Reason	Minor Reason	Not a Reason	Major Reason	Minor Reason	Not a Reason	Major Reason	Minor Reason	Not a Reason
1997	79	7	14	15	18	67	9	15	76
1998	73	10	17	12	17	72	13	13	74
1999	71	10	19	15	22	63	10	16	74
2000	76	8	16	6	21	73	7	12	81
2001	78	9	13	11	20	69	12	16	72
2002	74	10	17	11	16	74	8	14	78
2003	82	8	10	10	20	70	8	15	77
2004	82	7	11	8	19	73	8	16	76
2005	82	7	10	9	16	75	8	15	77
2006	87	4	9	12	14	74	12	14	74
2007	89	6	4	9	11	79	5	13	82
2008	93	4	4	7	11	82	5	8	87
2009	92	3	4	3	15	81	5	10	85
2010	91	5	4	5	13	82	6	15	80
2011	88	5	7	11	12	77	8	12	79
2012	88	5	7	9	13	78	7	13	80
2013	83	6	11	9	17	74	5	16	79
2014	86	6	8	11	15	75	12	14	74

TABLE 4: "Cannot Afford" Major Reason for No Insurance: By Income (2006–2014) (Percent)

Household Income	2006	2007	2008	2009	2010	2011	2012	2013	2014
Less than $10,000	92	93	97	96	96	89	87	88	94
$10,000 - $14,499	96	95	97	96	95	90	94	83	85
$15,000 - $19,999	87	93	88	93	88	90	91	87	86
$20,000 - $29,999	90	89	96	92	94	89	92	85	82
$30,000 - $39,999	76	90	88	90	87	83	85	79	82
$40,000 - $49,999	84	88	93	92	92	80	91	82	83
$50,000+	68	76	81	80	76	92	71	71	59

Evaluations of Medical Care and Insurance Coverage

Tennessee residents' perceptions about the quality of care received changed little and has remained fairly stable over the last decade. Overall, 78 percent of all heads of households and 70 percent of heads of households with TennCare rated the quality of care as "good" or "excellent" compared to 78 percent and 68 percent, respectively, in 2013.

Heads of households rate the quality of care received by children consistently high. In 2014, 89 percent of all heads of households rated their children's quality of care as "excellent" or "good," up from 86 percent in the prior year. Ratings from TennCare heads of households are also higher, with 87 percent rating the quality of care for their children as "excellent" or "good" compared to 80 percent the previous year. The share of TennCare heads of households rating their children's care "excellent" increased slightly from 35 percent in 2013 to 38 percent in 2014. Only 2 percent of all heads of household (3 percent for those on TennCare) rate the quality of care their children receive as "poor." (Table 6).

TABLE 5: Quality of Medical Care Received by Heads of Households (2004–2014) (Percent)

All Heads of Households	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Excellent	26	29	28	28	28	32	32	31	30	32	31
Good	50	48	48	47	46	46	46	46	46	46	47
Fair	18	17	18	18	18	16	16	15	17	16	16
Poor	6	6	7	7	8	6	6	7	7	6	6
Heads of Households w/ TennCare	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Excellent	23	28	21	23	24	29	24	30	24	24	25
Good	47	40	43	44	43	47	41	41	45	44	45
Fair	23	26	27	27	25	18	29	19	22	24	22
Poor	7	6	10	6	8	6	6	10	9	8	8

TABLE 6: Quality of Medical Care Received by Children of Heads of Households (2004–2014) (Percent)

All Heads of Households	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Excellent	36	38	39	35	34	39	46	44	42	43	41
Good	48	49	47	48	51	49	43	45	45	43	48
Fair	12	9	11	12	11	9	9	9	10	10	9
Poor	4	4	3	4	4	3	3	2	3	4	2
Heads of Households w/ TennCare[5]	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Excellent	31	34	39	30	32	41	43	48	38	35	38
Good	47	49	38	49	49	48	45	39	42	45	49
Fair	16	12	17	19	14	8	6	11	14	14	10
Poor	5	5	6	2	6	3	6	2	6	6	3

Satisfaction with Quality of Care Received from TennCare

TennCare recipients continue to show high levels of satisfaction with the quality of care received from TennCare (Table 7), with 93 percent responding "somewhat satisfied" or "very satisfied."[6] While the satisfaction rate is two percentage points lower than 2013, the rate appears to be in line with past reports.

TABLE 7: Percent Indicating Satisfaction with TennCare (2000–2014) (Percent)

2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
78	79	85	83	90	93	87	90	89	92	94	95	93	95	93

Behavior Relevant to Medical Care

Each respondent was asked a series of questions regarding his or her behavior when initially seeking medical care (Table 8). Among all heads of households, the choice between a doctor's office, clinic, hospital, and other in 2014 is very similar to that in 2013; however, the TennCare head of households' choice between these types of providers have changed. TennCare heads of households shifted their

[5] This subgroup includes all children who are on TennCare, regardless of the insurance status of the head of household.

[6] A three point scale was used, and respondents could indicate "very satisfied," "somewhat satisfied," or "not satisfied."

preferences from seeking initial care at doctor's offices (8 percent decrease) toward clinics (4 percent increase), hospitals (2 percent increase) and other (2 percent increase). When it comes to initial care choices for children, 99 percent of all households and 98 percent of TennCare households sought initial care at a doctor's office or a clinic, consistent with 2013. (Table 9).

TABLE 8: Head of Household: Medical Facilities Used When Medical Care Initially Sought (2004-2014) (Percent)

All Heads of Households	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Doctor's Office	85	83	83	83	83	83	82	83	82	81	81
Clinic	9	11	11	11	11	12	12	12	13	13	14
Hospital	5	5	5	4	4	4	4	4	4	4	3
Other	1	1	1	2	2	2	2	2	1	2	2
Heads of Households w/ TennCare	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Doctor's Office	77	78	76	79	80	83	77	80	75	80	72
Clinic	14	14	15	15	13	12	15	11	14	14	18
Hospital	8	7	7	4	6	4	7	8	10	6	8
Other	1	1	1	2	<1	1	<1	2	1	<1	2

TABLE 9: Children: Medical Facilities Used When Medical Care Initially Sought (2004-2014) (Percent)

All Heads of Households	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Doctor's Office	85	86	87	88	88	86	87	88	88	86	87
Clinic	11	10	10	9	10	10	11	9	10	12	12
Hospital	3	3	3	2	2	3	2	2	2	1	1
Other	1	1	<1	1	<1	<1	<1	<1	<1	1	<1
Heads of Households w/ TennCare	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Doctor's Office	78	79	82	83	83	85	82	84	86	84	84
Clinic	16	13	12	14	14	15	15	7	11	12	14
Hospital	6	8	6	3	3	0	3	9	3	3	1
Other	0	0	1	0	<1	0	0	0	0	<1	1

TennCare recipients continue to report seeing physicians on a more frequent basis than the average Tennessee household. TennCare heads of households see a physician at least monthly almost three times as much as all head of households (37 percent compared to 13 percent, respectively), and TennCare heads of households are about half as likely to see a physician yearly or rarely as all heads of households (19 percent compared to 40 percent, respectively) (Table 10). The same trend is observed among children with 19 percent of TennCare households taking their children to visit a doctor at least monthly compared to only 10 percent of all households. For households with children, 27 percent of those with TennCare reported taking their child to the doctor yearly or rarely compared with 43 percent of all households (Table 11).

TABLE 10: Frequency of Visits to Doctor for Head of Household (2004–2014) (Percent)

All Heads of Households	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Weekly	3	2	2	2	3	2	2	2	1	2	2
Monthly	11	11	12	13	12	12	11	11	11	11	11
Every Few Months	44	46	44	46	46	49	45	44	46	46	47
Yearly	26	26	25	23	22	22	24	25	25	24	25
Rarely	16	15	18	16	17	15	18	17	17	17	15
Heads of Households w/ TennCare	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Weekly	7	6	7	8	7	6	6	6	4	5	6
Monthly	28	30	30	33	33	30	29	26	31	34	31
Every Few Months	46	46	45	45	47	51	47	46	43	43	45
Yearly	9	11	8	6	8	7	7	10	8	8	11
Rarely	10	7	10	8	4	6	12	11	14	10	8

TABLE 11: Frequency of Visits to Doctor for Children (2004–2014) (Percent)

All Heads of Households	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Weekly	1	2	1	2	2	1	2	1	1	1	1
Monthly	10	11	10	11	9	9	9	10	8	9	9
Every Few Months	53	53	52	50	50	51	51	50	50	52	47
Yearly	26	23	28	27	29	31	29	31	35	30	35
Rarely	10	11	10	10	10	8	9	8	6	8	8
Heads of Households w/ TennCare[7]	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Weekly	3	2	2	4	1	1	3	1	0	1	2
Monthly	14	21	16	14	16	18	13	15	15	19	17
Every Few Months	53	49	51	54	55	50	51	55	58	53	53
Yearly	22	17	23	16	21	27	24	25	22	25	25
Rarely	9	11	8	11	7	4	10	4	5	2	2

Appointments

The reported time required to obtain an appointment is comparable to previous years' findings, and the distribution of appointment wait time is not very different from 2013. The percent of TennCare recipients reporting obtaining a doctor's appointment within a week is 68 percent in 2014 compared to 66 percent in 2013 (Table 12). The number of TennCare heads of households reporting having to wait three weeks or longer is 25 percent compared to 24 percent last year. TennCare recipients wait 53 minutes on average to see their physicians once they reach the office (Table 12), which is a slight increase from 2013 but still lower than most previous years. The average travel time to a physician's office (22 minutes) for TennCare households has held steady since 2011.

[7] This subgroup includes the children of heads of household enrolled in TennCare.

TABLE 12: Time between Attempt to Make Appointment and First Availability of Appointment: TennCare Heads of Household (2005–2014) (Percent)

When you last made an appointment to see a primary care physician for an illness in the last 12 months, how soon was the first appointment available?	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Same day	21	22	22	21	18	20	21	20	18	18
Next day	17	27	20	17	23	19	19	21	25	21
1 week	31	22	30	27	25	29	30	25	23	29
2 weeks	10	10	8	10	9	11	10	14	10	8
3 weeks	5	4	4	4	4	4	4	2	4	6
Over 3 weeks	16	16	15	22	20	17	16	18	20	19

TABLE 13: Wait for Appointments: TennCare Heads of Household (2004–2014) (Minutes)

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Number of minutes wait past scheduled appointment time?	63	57	80	57	50	52	65	58	58	51	53
Number of minutes to travel to physician's office?	27	32	30	21	25	24	31	23	22	22	22

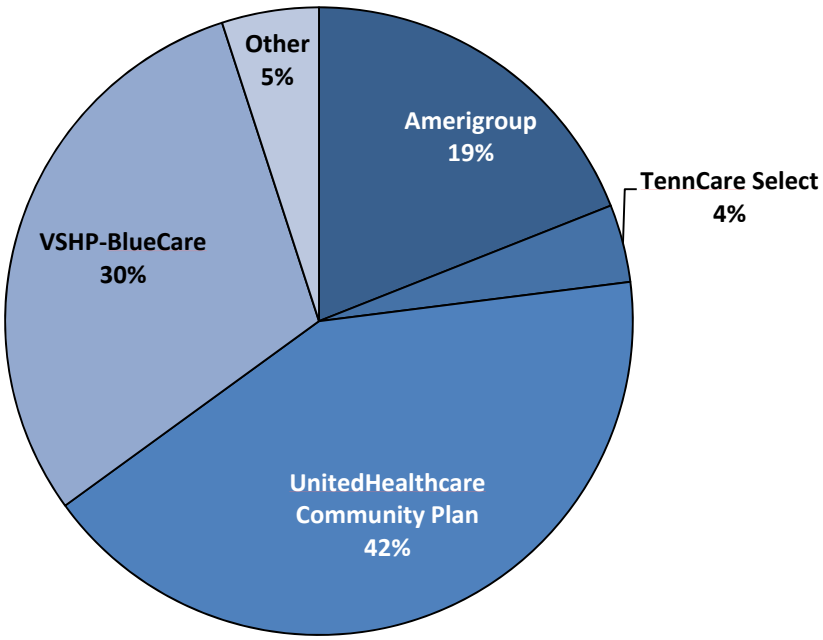
TennCare Plans

The largest number of TennCare survey respondents (42 percent) report being signed up with UnitedHealthcare Community Plan as their TennCare MCO. Volunteer State Health Plan (BlueCare) also accounts for a large percentage of the TennCare recipients (30 percent). Amerigroup accounts for another 19 percent, while 4 percent are represented by TennCare Select. Five percent report being represented by other plans, though there are no other active TennCare plans (Table 14).[8] These distributions are relatively unchanged from last year.

TABLE 14: Reported TennCare Plan (2010–2014) (Percent)

What company manages your TennCare plan?	2010	2011	2012	2013	2014
Amerigroup	10	16	20	17	19
TennCare Select	8	8	6	5	4
UnitedHealthcare Community Plan (formerly AmeriChoice)	37	41	37	41	42
VSHP – BlueCare	36	32	33	30	30
Other	7	4	4	7	5

FIGURE 2: Reported TennCare Plan (2014)



[8] UnitedHealthcare Community Plan serves all regions of the state, while BlueCare serves east and west Tennessee. Amerigroup serves only middle Tennessee. TennCare Select serves a specialized segment composed primarily of children in DCS custody.

In 2014, a decreased share of TennCare households reported receiving information from MCOs about an enrollment card (6 percent fewer), filing appeals (6 percent fewer), and a list of rights and responsibilities (4 percent fewer), but there was no change in the share that reported receiving information about the name of the MCO (Table 15).

The preferred method for receiving information about TennCare remains through the mail, with 75 percent reporting this is the best way they obtain TennCare information (Table 16).

TABLE 15: Households Receiving TennCare Information from Plans (2005–2014) (Percent)

Please indicate whether or not you or anyone in your household has received each of the following regarding TennCare	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
An enrollment card	70	73	78	78	77	74	61	62	69	63
Information on filing grievances	26	41	46	41	41	43	29			
Information on filing appeals[9]								73	76	70
A list of rights and responsibilities	71	78	77	73	75	74	68	80	82	78
Name of MCO to whom assigned	79	82	81	79	79	79	76	79	76	76

TABLE 16: Best Way to Get Information about TennCare (2005–2014) (Percent)

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Mail	75	75	72	73	71	72	78	80	74	75
Doctor	6	8	8	5	6	5	5	6	9	5
Phone	9	5	8	11	10	11	5	4	6	6
Handbook	4	3	6	6	7	5	6	5	4	4
Drug Store	1	2	1	1	1	<1	<1	<1	<1	<1
Friends	0	1	1	<1	1	1	2	<1	<1	<1
TV	1	1	0	1	<1	<1	<1	<1	<1	<1
Paper	0	0	0	<1	1	<1	0	<1	<1	<1
Other	4	5	4	3	3	4	4	4	6	8

[9] From 1993 through 2011, survey respondents were asked whether they had received "information on filing grievances." The term "appeals" is much more widely used in the TennCare program than the term "grievances." Therefore, the question was changed in 2012 to ask whether respondents had received "information on filing appeals."

Five percent of respondents indicated that either they or someone else in their family had changed plans within the preceding twelve months, a two percentage point decrease from 2013. Of that total, 36 percent requested the change (as opposed to being automatically reassigned from one plan to another). The most commonly cited reason for changing plans was limited choice of doctors and hospitals.

The 2014 survey added questions concerning the use of non-emergency care from providers who do not participate in the TennCare health care plan. In the past 12 months, 10 percent of TennCare families used a non-emergency care provider who did not participate in their plan, with over half (52 percent) using these providers 1-2 times (Figure 3). The most common type of non-participating provider used by TennCare families was a general medical care/family doctor followed by a non-surgical specialist (Table 17). The most common reason cited was that the service was not covered under TennCare (38 percent), and 20 percent mistakenly thought the provider participated in their TennCare plan (Table 18). Only one percent was motivated to find an out-of-network provider over dissatisfaction with providers in the TennCare plan. Almost one-third (32 percent) of respondents reported that TennCare helped them find a provider that participated in the TennCare plan.

FIGURE 3: Number of Times Sought Non-Emergency Care at a Non-Participating Provider in Past 12 Months (Percent)

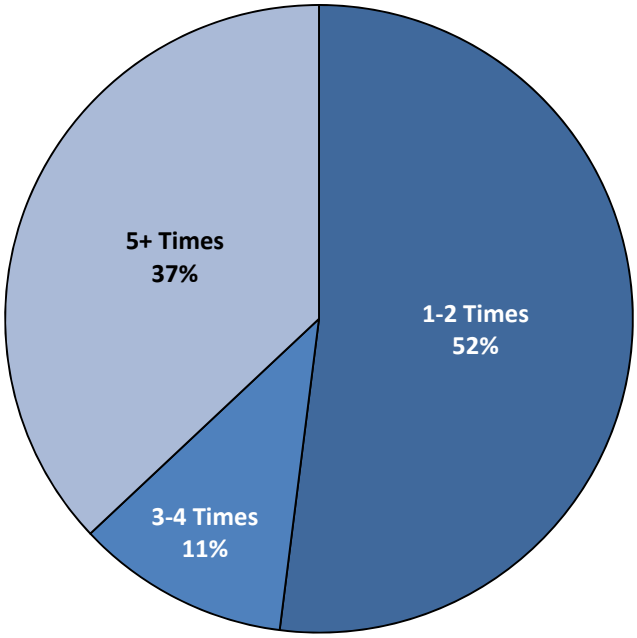


TABLE 17: Type of Non-Emergency Care Sought from a Non-TennCare Provider (Percent)

	2014
Eye Care	7
Dental Care	16
General Medical Care Specialist	59
Non-Surgical Specialist	20
Surgical Specialist	10
Not Sure	3

Total exceeds 100 percent because respondents could choose more than one type of non-emergency care.

TABLE 18: Reasons Sought Non-Emergency Care from a Non-TennCare Provider (Percent)

	2014
Dissatisfaction with quality of service from TennCare Provider	1
Service was not covered by TennCare	38
No TennCare provider in the area	18
Could not get timely appointment with TennCare Provider	6
When I made the appointment or received care, I mistakenly thought the provider participated in my TennCare health care plan	20
Other / Not sure	17

Conclusion

Tennessee's 7.2 percent rate of uninsured in 2014 is the lowest rate in a decade and is a 23 percent decrease from the previous survey in 2013 in the estimated number of Tennesseans without insurance. The total uninsured population is approximately 472,008. This decrease coincided with the late 2013 through early 2014 establishment of the Health Insurance Marketplace established as part of the Affordable Care Act. A higher percentage of those who do not have insurance, particularly among families who make less than $10,000 per year, cite affordability as a major reason for not having insurance. The number of respondents who do not see a need for health insurance increased 7 percent.

A higher share of TennCare enrollees (8 percent) versus all enrollees (3 percent) continue to seek initial care at hospitals instead of doctors' offices or clinics, but there was little change from 2013. Overall, TennCare continues to receive positive feedback from its recipients, with 93 percent reporting satisfaction with the program, indicating TennCare is providing medical care in a satisfactory manner and up to the expectations of those it serves.

ATTACHMENT E

2014 HEDIS/CAHPS REPORT: A COMPARATIVE ANALYSIS OF AUDITED RESULTS FROM TENNCARE MANAGED CARE ORGANIZATIONS

Comparative Analysis of Audited Results from TennCare MCOs

August 2014

2014 Annual

HEDIS/ CAHPS Report

State of Tennessee
Department of Finance & Administration
Bureau of TennCare

prepared by
Qsource
Memphis • Nashville • Knoxville • Little Rock

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Acronyms and Initialisms

AAB ..... Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

AAP ..... Adults' Access to Preventive/Ambulatory Health Services

ABA ..... Adult BMI Assessment

ABX ..... Antibiotic Utilization

ACE ..... Angiotensin Converting Enzyme

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

ADHD ..... Attention-Deficit/Hyperactivity Disorder

AHRQ ..... Agency for Healthcare Research and Quality

AMB ..... Ambulatory Care

AG ..... Amerigroup Community Care, Inc. d.b.a. Amerigroup in the Tennessee Middle Grand Region

AMI ..... Acute Myocardial Infarction

AMM ..... Antidepressant Medication Management

AMR ..... Asthma Medication Ratio

AOD ..... Alcohol or Other Drug

ARB ..... Angiotensin Receptor Blocker

ART ..... Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

ASM ..... Use of Appropriate Medications for People With Asthma

AWC ..... Adolescent Well-Care Visits

BCS ..... Breast Cancer Screening

BCE/BCW ..... Volunteer State Health Plan, Inc, d.b.a. BlueCare Tennessee, BlueCare-East in the Tennessee East Grand Region and BlueCare-West in the Tennessee West Grand Region

BMI ..... Body Mass Index

BP ..... Blood Pressure

CABG ..... Coronary Artery Bypass Graft

CAHPS ..... Consumer Assessment of Healthcare Providers and Systems

CAP ..... Children and Adolescents' Access to Primary Care Practitioners

CAT ..... Call Answer Timeliness

CBP ..... Controlling High Blood Pressure

CCC ..... Children With Chronic Conditions

CCS ..... Cervical Cancer Screening

CDC ..... Comprehensive Diabetes Care

CHL ..... Chlamydia Screening in Women

CIS ..... Childhood Immunization Status
CMC ..... Cholesterol Management for Patients With Cardiovascular Conditions
CPA ..... CAHPS Health Plan Survey 5.0H Adult Version
CPC ..... CAHPS Health Plan Survey 5.0H Child Version
COPD ..... Chronic Obstructive Pulmonary Disease
CT ..... Computed Tomography
CWP ..... Appropriate Testing for Children With Pharyngitis
CY ..... Calendar Year
d.b.a. ..... doing business as
DMARD ..... Disease-Modifying Anti-Rheumatic Drug
DTaP ..... Diphtheria, Tetanus and Acellular Pertussis Vaccination
ED ..... Emergency Department
Flu ..... Influenza
FPC ..... Frequency of Ongoing Prenatal Care
FSP ..... Frequency of Selected Procedure
FUH ..... Follow-Up After Hospitalization for Mental Illness
HbA1c ..... Hemoglobin A1c, also called Glycosylated Hemoglobin, Glycohemoglobin
HEDIS ..... Healthcare Effectiveness Data and Information Set
HepA ..... Hepatitis A
HepB ..... Hepatitis B
HiB ..... H Influenza Type B Vaccination
HPV ..... Human Papillomavirus Vaccine (also, HPV for Female Adolescents measure)
HTN ..... Hypertension
IAD ..... Identification of Alcohol and Other Drug Services
IET ..... Initiation and Engagement of AOD Dependence Treatment
IMA ..... Immunizations for Adolescents
IP; IPU ..... Inpatient; IP Utilization – General Hospital/Acute Care
IPV ..... Polio Vaccination
IVD ..... Ischemic Vascular Disease
LBP ..... Use of Imaging Studies for Low Back Pain
LDL-C ..... Low Density Lipoprotein-Cholesterol
LSC ..... Lead Screening in Children
MCO ..... Managed Care Organization
MMA ..... Medication Management for People With Asthma
MMR ..... Measles, Mumps and Rubella Vaccination
MPM ..... Annual Monitoring for Patients on Persistent Medications

MPT ..... Mental Health Utilization

MRI ..... Magnetic Resonance Imaging

MSC ..... Medical Assistance With Smoking and Tobacco Use Cessation

NA ..... Not Applicable

NCQA ..... National Committee for Quality Assurance

NCS ..... Non-Recommended Cervical Cancer Screening in Adolescent Females

OB/GYN ..... Obstetrician/Gynecologist

PBH ..... Persistence of Beta-Blocker Treatment After a Heart Attack

PCE ..... Pharmacotherapy Management of COPD Exacerbation

PCI ..... Percutaneous Coronary Interventions

PCP ..... Primary Care Practitioner

PCV ..... Pneumococcal Conjugate Vaccination

PMPY ..... Per Member Per Year

PPC ..... Prenatal and Postpartum Care

RV ..... Rotavirus

SAA ..... Adherence to Antipsychotic Medications for Individuals With Schizophrenia

SMC ..... Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia

SMD ..... Diabetes Monitoring for People With Diabetes and Schizophrenia

SPR ..... Use of Spirometry Testing in the Assessment and Diagnosis of COPD

SSD ..... Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Strep ..... Streptococcus

Td; Tdap ..... Tetanus, Diphtheria Toxoids Vaccine; Td and Acellular Pertussis Vaccine

TennCare ..... Tennessee Department of Finance and Administration, Bureau of TennCare

TCS ..... Volunteer State Health Plan, Inc. d.b.a. TennCare*Select* in all three of Tennessee's Grand Regions

UHCE/UHCM/UHCW ..... UnitedHealthcare Plan of the River Valley, Inc.
d.b.a. UnitedHealthcare-East in the Tennessee East Grand Region
d.b.a. UnitedHealthcare-Middle in the Tennessee Middle Grand Region
d.b.a. UnitedHealthcare-West in the Tennessee West Grand Region

URI ..... Appropriate Treatment for Children With Upper Respiratory Infection

VZV ..... Chicken Pox Vaccination

W15 ..... Well-Child Visits in the First 15 Months of Life

W34 ..... Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

WCC ..... Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Executive Summary

Medicaid managed care organizations (MCOs) are required to report a full Healthcare Effectiveness Data and Information Set (HEDIS) as a part of the accreditation mandates in Tennessee. The HEDIS requirement is an integral part of the accreditation process of the National Committee for Quality Assurance (NCQA). In 2006, Tennessee became the first state in the nation requiring all MCOs to become accredited by NCQA, an independent, nonprofit organization that assesses and scores MCO performance in the areas of quality improvement, utilization management, provider credentialing, and member rights and responsibilities.

HEDIS standardized measures of MCO performance allow comparisons to national averages/benchmarks and between Tennessee's MCOs, as well as tracking over time. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) set of standardized surveys is included in HEDIS to measure members' satisfaction with their care. This report summarizes the results of the HEDIS 2014 reporting year for HEDIS/CAHPS by the MCOs contracting with the Tennessee Department of Finance and Administration, Bureau of TennCare (TennCare). TennCare uses the information contained herein to help assess health plan performance and to reward, via pay-for-performance initiatives, those that are demonstrating significant improvement.

For an overview of the performance of Tennessee's MCOs, a calculated weighted average of the scores of all those reporting is provided alongside national averages in the **Statewide Performance** section. MCO-specific measures are presented in the **Individual Plan Performance** section for cross-comparison with color-coding for national and state benchmark comparison where available/applicable. The weighted average performances of Tennessee's MCOs on certain measures are presented in the **HEDIS Trending Since 2006** section. **Appendix A** contains a comprehensive table of plan-specific results for the HEDIS 2014 Utilization Measures and HEDIS 2013 national benchmarks. The table in **Appendix B** contains the HEDIS 2013 National Medicaid Means and Percentiles for reference to these benchmarks, and the table in **Appendix C** reveals MCO populations reported by health plans in member months by age and sex for 2014. **Appendix D** presents the reporting options for each measure, whether administrative, hybrid or both.

Background

HEDIS Measures—Domains of Care

The Healthcare Effectiveness Data and Information Set (HEDIS) is an important tool designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed healthcare plans. Standardized methodologies ensure the integrity of measure reporting and help purchasers make more reliable, relevant comparisons between health plans. HEDIS measures are subject to a National Committee for Quality Assurance (NCQA) HEDIS Compliance Audit that must be conducted by an NCQA-certified HEDIS Compliance Auditor under the auspices of an NCQA-licensed organization. This ensures the integrity of the HEDIS collection and calculation process at each managed care organization (MCO) through an overall information systems capabilities assessment, followed by an evaluation of the ability to comply with HEDIS specifications.

The HEDIS rates presented in this report refer to data collected during the review period of the previous calendar year (CY), from January 1 to December 31. For HEDIS 2014 results, CY2013 was the review period. Similarly, the comparative data presented in this report from the HEDIS 2013 Medicaid Means and Percentiles reflect data procured during CY2012.

For HEDIS 2014, there were a total of 81 measures (Commercial, Medicare and Medicaid) across five domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Utilization and Relative Resource Use
- Experience of Care [Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Results]
- Health Plan Descriptive Information

The following brief descriptions of selected HEDIS measures were extracted from NCQA's *HEDIS 2014 Volume 2: Technical Specifications*, which includes additional information related to each measure. The measures presented in this report reflect data submitted from the following domains of care: Effectiveness of Care, Access/Availability of Care, Utilization and Relative Resource Use, and Experience of Care (CAHPS Survey Results).

Effectiveness of Care Measures

The Effectiveness of Care domain contains measures that look at the clinical quality of care delivered within an MCO. Measures in this domain address four aspects of care:

1. How well the MCO delivers preventive services and keeps its members healthy
2. Whether the most up-to-date treatments are being offered to treat acute episodes of illness and help members get better

3. The process by which care is delivered to people with chronic diseases and how well the MCO's healthcare delivery system helps members cope with illness
4. Whether appropriate treatment and/or testing was provided to members

Starting with HEDIS 2008 reporting, Effectiveness of Care measures were grouped into more specific clinical categories: Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, Behavioral Health, Medication Management, and measures collected through the CAHPS Health Plan Survey. Only certain measures from these categories are presented in this report. Select Utilization Measures are included in **Appendix A**.

Prevention and Screening

Adult BMI Assessment (ABA)

The percentage of members 18 to 74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (WCC)

The percentage of members 3 to 17 years of age who had an outpatient visit with a primary care practitioner (PCP) or obstetrician/gynecologist (OB/GYN) and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year. *Note: Because BMI norms for youth vary with age and gender, this measure evaluated whether BMI percentile is assessed rather than an absolute BMI value.*

Childhood Immunization Status (CIS)

The percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (Flu) vaccines by the second birthday. The measure calculates a rate for each vaccine and nine separate combination rates. The following is the list of Combination vaccinations for CIS:

- Combination 2: DTaP, IPV, MMR, HiB, HepB and VZV
- Combination 3: DTaP, IPV, MMR, HiB, HepB, VZV and PCV
- Combination 4: DTaP, IPV, MMR, HiB, HepB, VZV, PCV and HepA
- Combination 5: DTaP, IPV, MMR, HiB, HepB, VZV, PCV and RV
- Combination 6: DTaP, IPV, MMR, HiB, HepB, VZV, PCV and Flu
- Combination 7: DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA and RV
- Combination 8: DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA and Flu
- Combination 9: DTaP, IPV, MMR, HiB, HepB, VZV, PCV, RV and Flu
- Combination 10: DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV and Flu

Immunizations for Adolescents (IMA)

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria

toxoids vaccine (Td) by the 13th birthday. The measure calculates a rate for each vaccine and one combination (Meningococcal, Tdap/Td) rate.

Human Papillomavirus Vaccine for Female Adolescents (HPV)

The percentage of female adolescents 13 years of age who had three doses of Human Papillomavirus Vaccine (HPV) by the 13th birthday.

Lead Screening in Children (LSC)

The percentage of children two years of age who had one or more capillary or venous lead blood tests for lead poisoning by the second birthday.

Breast Cancer Screening (BCS)

The percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer during the measurement year or the year prior to the measurement year.

Cervical Cancer Screening (CCS)

The percentage of women 21 to 64 years of age who received a screening test for cervical cancer meeting either of the following criteria:

- Women age 21–64 who had cervical cytology performed every three years
- Women age 30–64 who had cervical cytology/HPV co-testing performed every five years

Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)

The percentage of adolescent females 16 to 20 years of age who were screened unnecessarily for cervical cancer. A lower rate indicates better performance.

Chlamydia Screening in Women (CHL)

The percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. This measure calculates a total rate as well as two age stratifications: 16- to 20- and 21- to 24-year-old women.

Respiratory Conditions

Appropriate Testing for Children With Pharyngitis (CWP)

The percentage of children 2 to 18 years of age who were diagnosed with pharyngitis, were dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).

Appropriate Treatment for Children With Upper Respiratory Infection (URI)

The percentage of children three months to 18 years of age who were given a diagnosis of upper respiratory infection and were not dispensed an antibiotic prescription. This measure is reported as an inverted rate [1 - (numerator/eligible population)], with a higher rate indicating appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed).

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)

The percentage of adults 18 to 64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription; reported as an inverted rate [1 - (numerator/eligible population)], with a higher rate indicating appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were not prescribed).

Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

The percentage of members 40 years of age and older with a new diagnosis or newly active chronic obstructive pulmonary disease (COPD) who received appropriate spirometry testing to confirm the diagnosis.

Pharmacotherapy Management of COPD Exacerbation (PCE)

The percentage of COPD exacerbation for members 40 years of age and older who had an acute inpatient (IP) discharge or emergency department (ED) encounter between January 1 and November 30 of the measurement year and who were dispensed appropriate medication. Two rates are reported:

- Dispensed a systemic corticosteroid within 14 days of the event
- Dispensed a bronchodilator within 30 days of the event

Note: The eligible population for this measure is based on acute IP discharge and ED visits, not on members. The denominator may include multiple events for the same individual.

Use of Appropriate Medications for People With Asthma (ASM)

The percentage of members 5 to 64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year. This measure calculates a total rate as well as four age stratifications: 5- to 11-, 12- to 18-, 19- to 50- and 51- to 64-year-olds.

Medication Management for People With Asthma (MMA)

The percentage of members 5 to 64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:

- The percentage of members who remained on an asthma controller medication for at least 50 percent of their treatment period
- The percentage of members who remained on an asthma controller medication for at least 75 percent of their treatment period

Asthma Medication Ratio (AMR)

The percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. This measure calculates a total rate as well as four age stratifications: 5- to 11-, 12- to 18-, 19- to 50- and 51- to 64-year-olds.

Cardiovascular Conditions

Cholesterol Management for Patients With Cardiovascular Conditions (CMC)

The percentage of members 18 to 75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year, who had each of the following during the measurement year:

- Low density lipoprotein-cholesterol (LDL-C) screening
- LDL-C control (<100 mg/dL)

Controlling High Blood Pressure (CBP)

The percentage of members 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.

Diabetes

Comprehensive Diabetes Care (CDC)

The percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had each of the following during the measurement year:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0 percent) for the most recent HbA1c test[2]
- HbA1c control (<7.0 percent) for the most recent HbA1c test
- HbA1c control (<8.0 percent) for the most recent HbA1c test
- An eye exam (retinal or dilated) for diabetic retinal disease performed [or a negative retinal exam (no evidence of retinopathy) in the year prior to the measurement year]
- LDL-C screening performed
- LDL-C control (<100 mg/dL) for the most recent LDL-C screening
- Medical attention for nephropathy that includes a nephropathy screening test or evidence of nephropathy
- Blood pressure control (<140/80 mm Hg) for the most recent reading
- Blood pressure control (<140/90 mm Hg) for the most recent reading

Musculoskeletal Conditions

Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

The percentage of members who were diagnosed with rheumatoid arthritis and were dispensed at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD).

[2] *For this indicator, a lower rate indicates better performance (i.e., low rates of poor control indicate better care).*

Use of Imaging Studies for Low Back Pain (LBP)

The percentage of members with primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI [Magnetic Resonance Imaging], CT [Computed Tomography] scan) within 28 days of the diagnosis; reported as an inverted rate [1 - (numerator/eligible population)]. A higher rate indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

Behavioral Health

Antidepressant Medication Management (AMM)

The percentage of members 18 years of age and older with a diagnosis of major depression and treated with antidepressant medication, and remained on an antidepressant medication treatment. Two rates are reported:

- *Effective Acute Phase Treatment* (on medication for at least 84 days/12 weeks)
- *Effective Continuation Phase Treatment* (for at least 180 days/6 months)

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period (where members diagnosed with narcolepsy are excluded from the denominator if optional exclusions are applied). One of these visits must have been within 30 days of the earliest ambulatory prescription dispensed for ADHD medication, at which time the member must have been 6 to 12 years of age. Two rates are reported:

- *Initiation Phase*—The percentage of members who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase
- *Continuation and Maintenance Phase*—The percentage of members who remained on the medication at least 210 days and who, in addition to the Initiation Phase follow-up, had at least two follow-up visits with a practitioner within 270 days (nine months) of the end of the Initiation Phase

Follow-Up After Hospitalization for Mental Illness (FUH)

The percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental health disorders and had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported as the percentage of discharges for which the member received follow-up within:

- seven days of discharge
- 30 days of discharge

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

The percentage of members 18 to 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

The percentage of members 18 to 64 years of age with schizophrenia and diabetes, who had both an LDL-C test and an HbA1c test during the measurement year.

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

The percentage of members 18 to 64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.

Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)

The percentage of members 19 to 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

Medication Management

Annual Monitoring for Patients on Persistent Medications (MPM)

The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, four separate rates and a total are reported:

- Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blocker (ARB)
- Annual monitoring for members on digoxin
- Annual monitoring for members on diuretics
- Annual monitoring for members on anticonvulsants
- Total rate (the sum of the four numerators divided by the sum of the four denominators)

Measures Collected Through CAHPS Health Plan Survey

Medical Assistance With Smoking and Tobacco Use Cessation (MSC)

This measure is collected using the survey methodology to arrive at a rolling average that represents the percentage of members 18 years of age and older who are current smokers or tobacco users seen by the MCO during the measurement year. For these members, the following facets of providing medical assistance with cessation are assessed:

- *Advising Smokers and Tobacco Users to Quit*—Those who received advice to quit
- *Discussing Cessation Medications*—Those for whom cessation medications were recommended or discussed
- *Discussing Cessation Strategies*—Those for whom cessation methods or strategies were provided or discussed

Access/Availability of Care Measures

The measures in the Access/Availability of Care domain evaluate how members access important and basic services of their MCO. Included are measures of overall access, how many members are actually using basic MCO services, and the use and availability of specific services.

Adults' Access to Preventive/Ambulatory Health Services (AAP)

The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year. The MCO reports three age stratifications and a total rate. Rates for adults 65 years of age and older, however, are not included in this report as those services would be provided by Medicare. Because the total rate would include this age group, it has been excluded from this report as well.

- 20 to 44 years of age
- 45 to 64 years of age
- 65 years of age and older
- Total

Children and Adolescents' Access to Primary Care Practitioners (CAP)

The percentage of members 12 months to six years who had a visit with a PCP during the measurement year, and members 7–19 years who had a visit with a PCP during the measurement year or the year prior. The MCO reports four separate percentages:

- 12 to 24 months
- 25 months to 6 years
- 7 to 11 years
- 12 to 19 years

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

The percentage of adolescent and adult members age 13 and older who demonstrated a new episode of alcohol or other drug (AOD) dependence and received the following:

- *Initiation of AOD Treatment*—Percentage who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or patient hospitalization within 14 days of diagnosis
- *Engagement of AOD Treatment*—Percentage who, in addition to initiating treatment, had two or more services with an AOD diagnosis within 30 days of the initiation visit

The MCO reports three separate percentages: 13 to 17; ≥18; and a Total rate.

Prenatal and Postpartum Care (PPC)

The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care:

- *Timeliness of Prenatal Care*—The percentage of deliveries that received a prenatal care visit as a member of the MCO in the first trimester *or* within 42 days of enrollment in the MCO
- *Postpartum Care*—The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery

Call Answer Timeliness (CAT)

The percentage of calls received by the MCO's Member Services call centers (during operating hours) during the measurement year that were answered by a live voice within 30 seconds.

Utilization and Relative Resource Use

Utilization

Utilization measures are designed to capture the frequency of certain services provided by the organization.

Frequency of Ongoing Prenatal Care (FPC)

The percentage of members who delivered a child between November 6 of the year prior to the measurement year and November 5 of the measurement year and who received the expected number of prenatal care visits, adjusted for gestational age and the month of pregnancy that the member enrolled in the MCO. This measure uses the same denominator as the Prenatal and Postpartum Care measure. Rates are reported by the percentage of expected visits:

- < 21 percent
- 21 to 40 percent
- 41 to 60 percent
- 61 to 80 percent
- ≥ 81 percent

Well-Child Visits in the First 15 Months of Life (W15)

The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: zero, one, two, three, four, five, or six or more.

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)

The percentage of members who were three to six years of age who received one or more well-child visits with a PCP during the measurement year.

Adolescent Well-Care Visits (AWC)

The percentage of enrolled members who were 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Relative Resource Use

These measures are detailed in a separate annual *Relative Resource Use Report*.

Experience of Care

The CAHPS Health Plan Survey 5.0H Adult Version (CPA) and 5.0H Child Version (CPC) are tools for measuring consumer healthcare satisfaction with the quality of care and customer service provided by their health plans. Topics include the following:

- Getting Needed Care
- Customer Service
- Getting Care Quickly
- How Well Doctors Communicate
- Shared Decision Making
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often
- Rating of All Health Care[3]
- Rating of Health Plan

The CAHPS Consortium decided in 2002 to integrate a new set of items in the 3.0H version of the CAHPS Health Plan Survey child questionnaires (now 5.0H) to better address the needs of children with chronic conditions, who are commonly referred to as children with special healthcare needs. Known as the Children With Chronic Conditions (CCC) Survey set, these items include supplemental questions focused on topics with special relevance to children with chronic conditions. The CCC set is designed for children who have a chronic physical, developmental,

[3] *While* healthcare *is the standard usage adopted for this report,* health care *is used when it follows AHRQ measure names.*

behavioral or emotional condition and who also require health and related services of a type or amount beyond that generally required by children.

All CAHPS surveys must be administered by an NCQA-certified survey vendor using an NCQA-approved protocol of administration to ensure that results are collected in a standardized way and can be compared across plans. Standard NCQA protocols for administering CAHPS surveys include a mixed-model mail/telephone protocol and a mail-only protocol. The surveys contained within this domain are designed to provide standardized information about members' experiences with their MCOs. NCQA worked with the Agency for Healthcare Research and Quality (AHRQ) to develop these surveys.

For a plan's results to be considered reliable, the Medicaid MCO must follow one of the standard CAHPS protocols or an enhanced protocol approved by NCQA, or must achieve a 45-percent response rate using an alternative protocol. For more detail regarding this calculation methodology and the questions used in each composite, see *HEDIS 2014, Volume 3: Specifications for Survey Measures.* MCO results from the CPA, CPC and CCC surveys were evaluated for this report.

CAHPS Health Plan Survey 5.0H Adult Version (CPA)

The CPA includes five composite categories: Getting Needed Care, Customer Service, Getting Care Quickly, How Well Doctors Communicate and Shared Decision Making. Each composite category represents an overall aspect of plan quality and is comprised of similar questions. For each composite, an overall score is computed. Composites are comprised of two or more questions about a similar topic, measured on one of the two scales:

1. For Getting Needed Care, Customer Service, Getting Care Quickly and How Well Doctors Communicate
   - Never
   - Sometimes
   - Usually
   - Always
2. For Shared Decision Making
   - Different
   - Not at All
   - A Little
   - Some
   - A Lot

For any given question used in a composite, the percentage of respondents answering in a certain way is calculated for each plan. Summary rates represent the percentage of members who responded in the most positive way, as defined by NCQA. The following descriptions provide a brief explanation of the four composite categories and additional questions.

Getting Needed Care

The Getting Needed Care Composite measures the ease with which members were able to access care needed in the last six months. The summary rate represents the percentage of members who responded 'Always' or 'Usually' to specified questions.

Getting Care Quickly

The Getting Care Quickly Composite measures the ease with which members were able to access care quickly, including office waiting room experiences, in the last six months. The summary rate

represents the percentage of members who responded 'Always' or 'Usually' to specified questions.

How Well Doctors Communicate

The How Well Doctors Communicate Composite evaluates provider-patient communications for the last six months by asking members how often their personal doctor listens carefully, explain things in a way to easily understand, show respect for what they have to say and spend enough time with them. The summary rate represents the percentage of members who responded 'Always' or 'Usually' to specified questions.

Customer Service

The Customer Service Composite measures how often members were able to get information and help from a plan and how well they were treated by a plan's customer service in the last six months. The summary rate represents the percentage of members who responded 'Always' or 'Usually' to specified questions.

Shared Decision Making

The Shared Decision Making Composite measures how often doctors offered choices regarding healthcare, mentioned the good and bad things associated with each treatment option, the extent to which doctors requested input regarding healthcare preferences, and how often doctors involved members in the decision-making process, according to their preference. The summary rate represents the percentage of members who responded 'A Lot' to specified questions.

Additional Questions

There are four additional questions with responses scaled 0–10 in the CPA: *Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often* and *Rating of Health Plan*. For these, a response of 0 represents the 'worst possible' and 10 represents the 'best possible' healthcare received in the last six months. For each of these questions, the summary rate represents the percentage of members who responded with a 9 or 10.

CAHPS Health Plan Survey 5.0H Child Version: General Population (CPC)

The CPC set includes five composite categories. Each composite category represents an overall aspect of plan quality and is comprised of similar questions. For each composite, an overall score is computed. Composites are comprised of two or more questions about a similar topic, on one of the two scales:

1. For Getting Needed Care, Customer Service, Getting Care Quickly and How Well Doctors Communicate
   - Never
   - Sometimes
   - Usually
   - Always
2. For Shared Decision Making
   - Different
   - Not at All
   - A Little
   - Some
   - A Lot

For any given question used in a composite, the percentage of respondents answering in a certain way is calculated for each plan. Summary rates represent the percentage of members who responded in the most positive way, as defined by NCQA. The following provides a brief description of the four composite categories and additional questions, as well as the scoring methodology for each.

Getting Needed Care

The Getting Needed Care Composite measures the ease with which child members were able to access care needed in the last six months. The summary rate represents the percentage of child members' family/caregivers who responded 'Always' or 'Usually' to specified questions.

Getting Care Quickly

The Getting Care Quickly Composite measures the ease with which child members were able to access care quickly, including office waiting room experiences, in the last six months. The summary rate represents the percentage of child members' family/caregivers who responded 'Always' or 'Usually' to specified questions.

How Well Doctors Communicate

The How Well Doctors Communicate Composite evaluates provider-patient communication for the last six months by asking family/caregivers of child members how often their child's doctors listen carefully, explain things in a way to easily understand, show respect for what they have to say and spend enough time with them. The summary rate represents the percentage of child members' family/caregivers who responded 'Always' or 'Usually' to specified questions.

Customer Service

The Customer Service Composite measures how often child members' family/caregivers were able to get information and help from a plan and how well they were treated by a plan's customer service in the last six months. The summary rate represents the percentage of child members' family/caregivers who responded 'Always' or 'Usually' to specified questions.

Shared Decision Making

The Shared Decision Making Composite measures how often doctors offered choices regarding healthcare, mentioned the good and bad things associated with each treatment option, the extent to which doctors requested input regarding healthcare preferences, and how often doctors involved child members' family/caregivers in the decision-making process, according to their preference. The summary rate represents the percentage of child members' family/caregivers who responded 'A Lot' to specified questions.

Additional Questions

There are four additional questions with responses scaled 0–10 in the CPC: *Rating of All Health Care, Rating of Personal Doctor*, *Rating of Specialist Seen Most Often* and *Rating of Health Plan*. For these, a response of 0 represents the 'worst possible' and 10 represents the 'best possible.' The summary rate represents the percentage of members' family/caregivers who responded with a 9 or 10.

CAHPS Health Plan Survey 5.0H Child Version: Children With Chronic Conditions (CCC)

The CCC Survey set includes supplemental questions focused on topics with special relevance to children with chronic conditions. Results include the same ratings, composites and individual question summary rates as those reported for the CPC. Additionally, five CCC composites summarize satisfaction with basic components of care essential for successful treatment, management and support of children with chronic conditions. These topics are reflected in the following composite measures presented in this report:

1. Access to Specialized Services
2. Family-Centered Care: Personal Doctor Who Knows Child
3. Coordination of Care for Children With Chronic Conditions
4. Family-Centered Care: Getting Needed Information
5. Access to Prescription Medicines

The first three composites for CCC are responded to as:

- Never
- Sometimes
- Usually
- Always

The last two composites for CCC are responded to as:

- Yes
- No

Access to Specialized Services

This Composite measures how often in the last six months that child members were able to obtain special medical equipment or devices, therapy, and treatment or counseling, and assistance if they experienced an access problem. The summary rate represents the percentage of child members' family/caregivers who responded 'Always' or 'Usually.'

Family Centered Care: Personal Doctor Who Knows Child

This Composite measures whether or not in the last six months providers discussed the child member's feelings, growth and behavior; and if the provider understands how the child's medical or behavioral conditions affect both the child's and family's day-to-day life. The summary rate represents the percentage of child members' family/caregivers who responded 'Yes.'

Coordination of Care for Children With Chronic Conditions

This Composite measures whether or not in the last six months doctors or other health providers assisted family/ caregivers, if needed, in contacting a child member's school or daycare and if anyone from the health plan, doctor's office or clinic assisted in coordinating the child's care among different providers or services. The summary rate represents the percentage of child members' family/caregivers who responded 'Always' or 'Usually.'

Family Centered Care: Getting Needed Information

This Composite measures how often in the last six months that family/caregivers questions were answered by their children's doctors or health providers. The summary rate represents the percentage of child members' family/caregivers who responded 'Always' or 'Usually.'

Access to Prescription Medicines

This Composite measures how often in the last six months child members were easily able to obtain prescription medicines through their plans. The summary rate represents the percentage of child members' family/caregivers who responded 'Always' or 'Usually.'

Results

Statewide Performance

In conjunction with NCQA accreditation, MCOs are required to submit a full set of audited HEDIS measures to NCQA and TennCare each year. For HEDIS 2014, this included the health plans in all three Grand Regions: Amerigroup Community Care, Inc. (**AG**); Volunteer State Health Plan, Inc. (**BCE**, **BCW** and **TCS**); and UnitedHealthcare Plan of the River Valley, Inc. (**UHCE**, **UHCM** and **UHCW**).

Tables 1 (**a** and **b**), **2** and **3** summarize the weighted average TennCare score for each of the selected HEDIS 2013 and HEDIS 2014 measures as well as the HEDIS 2013 Medicaid National Average. The Medicaid National Average represents the sum of the reported rates divided by the total number of health plans reporting the rate. Weighted state rates are determined by applying the size of the eligible population within each plan to their overall results. Using this methodology, plan-specific findings contribute to the TennCare statewide estimate, proportionate to eligible population size. Where possible in **Tables 1** (**a** and **b**), **2** and **3**, the statewide changes for each measure reported during both HEDIS 2013 and HEDIS 2014 are presented. The column titled 'Change 2013 to 2014' indicates whether there was an improvement (⬆) or a decline (⬇) in statewide performance for the measure from HEDIS 2013 to HEDIS 2014.

Table 1a. HEDIS 2014 State to National Rates: Effectiveness of Care Measures

Measure	Weighted State Rate		HEDIS 2013 Medicaid National Avg.	Change 2013 to 2014
	2013	2014		
Prevention and Screening				
Adult BMI Assessment (ABA)	70.95%	78.50%	67.63%	⬆
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC):				
BMI Percentile: 3–11 years	49.42%	56.08%	51.48%	⬆
12–17 years	49.74%	58.27%	52.31%	⬆
Total	**49.52%**	**56.80%**	**51.78%**	⬆
Counseling for Nutrition: 3–11 years	59.90%	63.76%	56.68%	⬆
12–17 years	55.01%	54.24%	51.34%	⬇
Total	**58.28%**	**60.62%**	**55.01%**	⬆
Counseling for Physical Activity: 3–11 years	45.54%	52.77%	42.81%	⬆
12–17 years	48.02%	52.67%	47.30%	⬆
Total	**46.36%**	**52.70%**	**44.23%**	⬆
Childhood Immunization Status (CIS):				
DTaP/DT	80.17%	79.00%	80.95%	⬇
IPV	93.86%	93.07%	91.61%	⬇
MMR	91.44%	91.10%	91.60%	⬇
HiB	93.73%	92.62%	92.01%	⬇
HepB	93.33%	93.15%	89.51%	⬇
VZV	90.72%	91.47%	91.10%	⬆
PCV	82.42%	81.13%	80.07%	⬇

Table 1a. HEDIS 2014 State to National Rates: Effectiveness of Care Measures				
Measure	**Weighted State Rate**		**HEDIS 2013 Medicaid National Avg.**	**Change 2013 to 2014**
	2013	**2014**		
HepA	89.55%	89.93%	76.36%	↑
RV	68.43%	69.66%	66.00%	↑
Influenza	43.74%	43.73%	49.51%	↓
Combination 2	76.28%	75.24%	75.74%	↓
Combination 3	73.02%	72.12%	72.08%	↓
Combination 4	71.63%	71.18%	60.89%	↓
Combination 5	56.98%	57.66%	55.27%	↑
Combination 6	37.88%	38.24%	41.76%	↑
Combination 7	56.13%	56.88%	48.73%	↑
Combination 8	37.24%	38.07%	37.28%	↑
Combination 9	31.99%	33.02%	34.72%	↑
Combination 10	31.53%	32.89%	31.38%	↑
Immunizations for Adolescents (IMA):				
Meningococcal	65.69%	66.27%	69.37%	↑
Tdap/Td	83.31%	83.57%	81.33%	↑
Combination 1	64.40%	65.48%	67.19%	↑
Human Papillomavirus Vaccine for Female Adolescents (HPV)*	16.78%	17.47%		↑
Lead Screening in Children (LSC)	72.18%	73.44%	67.49%	↑
Breast Cancer Screening (BCS)**	44.27%	52.47%	51.82%	↑
Cervical Cancer Screening (CCS)***		66.25%		
Chlamydia Screening in Women (CHL):				
16–20 years	53.62%	51.54%	53.50%	↓
21–24 years	62.58%	62.56%	63.66%	↓
Total	**57.39%**	**56.03%**	**57.10%**	↓
Respiratory Conditions				
Appropriate Testing for Children With Pharyngitis (CWP)	76.03%	77.75%	68.03%	↑
Appropriate Treatment for Children With Upper Respiratory Infection (URI)	74.84%	75.05%	85.08%	↑
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)	24.39%	24.58%	24.22%	↑
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	34.40%	34.34%	31.52%	↓
Pharmacotherapy Management of COPD Exacerbation (PCE):				
Systemic Corticosteroid	47.81%	50.91%	65.30%	↑
Bronchodilator	73.48%	76.34%	81.48%	↑
Use of Appropriate Medications for People With Asthma (ASM):				
5–11 years	92.78%	93.11%	89.65%	↑
12–18 years	87.59%	88.30%	85.59%	↑
19–50 years	58.73%	62.36%	73.87%	↑
51–64 years	52.84%	49.48%	71.32%	↓
Total	**84.68%**	**84.91%**	**83.88%**	↑

Table 1a. HEDIS 2014 State to National Rates: Effectiveness of Care Measures				
Measure	Weighted State Rate		HEDIS 2013 Medicaid National Avg.	Change 2013 to 2014
	2013	2014		
Medication Management for People With Asthma (MMA):				
Medication Compliance 50%: 5-11 years*	54.30%	53.87%		↓
12–18 years*	51.55%	51.45%		↓
19–50 years*	48.18%	52.81%		↑
51–64 years*	59.02%	59.49%		↑
Total*	**52.85%**	**53.06%**		↑
Medication Compliance 75%: 5-11 years	30.45%	29.90%	25.35%	↓
12–18 years	29.09%	27.06%	25.11%	↓
19–50 years	27.46%	31.39%	34.14%	↑
51–64 years	36.10%	35.86%	50.16%	↓
Total	**29.79%**	**29.29%**	**28.70%**	↓
Asthma Medical Ratio (AMR): †				
5–11 years	74.99%	82.62%		↑
12–18 years	64.33%	70.68%		↑
19–50 years	30.97%	39.81%		↑
51–64 years	32.81%	33.05%		↑
Total	**63.66%**	**69.93%**		↑
Cardiovascular Conditions				
Cholesterol Management for Patients With Cardiovascular Conditions (CMC):				
LDL-C Screening	83.10%	80.29%	81.62%	↓
LDL-C Control (<100 mg/dL)	38.65%	40.16%	41.37%	↑
Controlling High Blood Pressure (CBP)	55.82%	56.98%	56.36%	↑
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	74.54%	83.10%	82.05%	↑
Diabetes				
Comprehensive Diabetes Care (CDC):				
HbA1c Testing	80.32%	79.76%	82.98%	↓
HbA1c Control (<7.0%)	38.54%	38.43%	34.03%	↓
HbA1c Control (<8.0%)	48.58%	49.22%	46.60%	↑
Retinal Eye Exam Performed	37.66%	38.69%	53.17%	↑
LDL-C Screening	76.44%	75.56%	75.56%	↓
LDL-C Control (<100 mg/dL)	31.36%	32.40%	33.93%	↑
Medical Attention for Nephropathy	76.22%	76.19%	78.38%	↓
Blood Pressure Control (<140/80 mm Hg)	36.97%	37.99%	37.91%	↑
Blood Pressure Control (<140/90 mm Hg)	59.03%	60.25%	59.02%	↑
Musculoskeletal Conditions				
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	58.91%	63.93%	69.96%	↑
Use of Imaging Studies for Low Back Pain (LBP)	66.91%	67.71%	75.55%	↑
Behavioral Health				
Antidepressant Medication Management (AMM):				
Effective Acute Phase Treatment	49.10%	46.48%	52.79%	↓
Effective Continuation Phase Treatment	30.78%	30.31%	36.65%	↓

Table 1a. HEDIS 2014 State to National Rates: Effectiveness of Care Measures				
Measure	Weighted State Rate		HEDIS 2013 Medicaid National Avg.	Change 2013 to 2014
	2013	2014		
Follow-Up Care for Children Prescribed ADHD Medication (ADD):				
Initiation Phase	46.02%	45.82%	39.05%	↓
Continuation and Maintenance Phase	57.54%	54.98%	45.29%	↓
Follow-Up After Hospitalization for Mental Illness (FUH):				
7-day follow-up	48.03%	54.70%	43.83%	↑
30-day follow-up	68.80%	71.85%	63.75%	↑
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)†	80.40%	79.85%		↓
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)†	67.69%	67.65%		↓
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)†	80.00%	78.69%		↓
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)†	61.91%	62.93%		↑
Medication Management				
Annual Monitoring for Patients on Persistent Medications (MPM):				
ACE Inhibitors or ARBs	90.61%	89.98%	86.30%	↓
Digoxin	92.31%	94.06%	90.15%	↑
Diuretics	91.00%	90.59%	85.96%	↓
Anticonvulsants	72.89%	72.75%	65.70%	↓
Total	**88.86%**	**88.48%**	**84.47%**	↓
Measures Collected Through CAHPS Health Plan Survey				
Medical Assistance With Smoking and Tobacco Use Cessation (MSC): ††				
Advising Smokers and Tobacco Users to Quit	74.87%	76.23%	75.56%	↑
Discussing Cessation Medications	42.11%	44.12%	45.81%	↑
Discussing Cessation Strategies	36.87%	37.01%	41.14%	↑

** Measure deemed first-year status again in 2013.*
*** The age group for this measure changed; NCQA has yet to determine if results are trendable with the previous year.*
**** The measure's specification changed and results cannot be trended with previous years.*
† Benchmarks are not reported by Quality Compass for 2013 first year measures.
†† The denominator was not available; hence, the average is not weighted.

For the Effectiveness of Care Measures presented in **Table 1b**, a lower rate (particularly one below the national average) is an indication of better performance (↑). A decrease in rates from the prior year also indicates improvement.

Table 1b. HEDIS 2014 State to National Rates: Effectiveness of Care Measures Where Lower Rates Indicate Better Performance				
Measure	Weighted State Rate		HEDIS 2013 Medicaid National Avg.	Change 2013 to 2014
	2013	2014		
Prevention and Screening				
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)‡		11.91%		
Diabetes				
Comprehensive Diabetes Care (CDC): HbA1c Poor Control (>9.0%)	43.22%	42.22%	44.63%	↑

‡Measure is first-year in 2014.

Table 2 summarizes results for the Access/Availability Domain of Care.

Table 2. HEDIS 2014 State to National Rates: Access/Availability of Care Measures				
Measure	**Weighted State Rate**		**HEDIS 2013 Medicaid National Avg.**	**Change 2013 to 2014**
	2013	**2014**		
Adults' Access to Preventive/Ambulatory Health Services (AAP):				
20–44 years	80.66%	82.21%	80.37%	↑
45–64 years	87.27%	89.28%	86.54%	↑
Children and Adolescents' Access to Primary Care Practitioners (CAP):				
12–24 months	96.94%	97.27%	95.97%	↑
25 months–6 years	90.51%	90.26%	88.32%	↓
7–11 years	93.47%	93.96%	89.88%	↑
12–19 years	90.38%	90.91%	88.38%	↑
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET):				
Initiation of AOD Treatment: 13–17 years	48.57%	51.05%	39.14%	↑
≥18 years	36.78%	35.69%	39.38%	↓
Total	37.62%	36.65%	39.35%	↓
Engagement of AOD Treatment: 13–17 years	27.90%	29.92%	16.53%	↑
≥18 years	9.82%	9.62%	10.18%	↓
Total	11.10%	10.88%	10.84%	↓
Prenatal and Postpartum Care (PPC):				
Timeliness of Prenatal Care	79.51%	80.70%	82.93%	↑
Postpartum Care	59.90%	58.77%	63.05%	↓
Call Answer Timeliness (CAT)	89.18%	89.86%	83.83%	↑

Table 3 summarizes results for the Utilization measures included in the Utilization and Relative Resource Domain of Care.

Table 3. HEDIS 2014 State to National Rates: Utilization Measures				
Measure	**Weighted State Rate**		**HEDIS 2013 Medicaid National Avg.**	**Change 2013 to 2014**
	2013	**2014**		
Frequency of Ongoing Prenatal Care (FPC): ≥ 81 %	61.60%	63.08%	60.45%	↑
Well-Child Visits in the First 15 Months of Life (W15): 6 or More Visits	62.32%	65.41%	63.65%	↑
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	71.68%	70.80%	72.00%	↓
Adolescent Well-Care Visits (AWC)	44.53%	50.27%	49.69%	↑

Individual Plan Performance

This section is intended to provide an overview of individual plan performance using appropriate and available comparison data. The results highlight those areas where each MCO is performing in relation to the HEDIS 2013 National Medicaid Means and Percentiles for select MCO-reported HEDIS measures. Qsource uses these data to determine overall TennCare plan performance in a distribution of statistical values that represent the lowest to highest percentiles achieved. For example, the 50th percentile represents the point at which half of the reported rates are below and half of the reported rates are above that value.

Tables 5 (**a** and **b**), **6** and **7** display the plan-specific performance rates for each measure selected from the Effectiveness of Care and Access/Availability of Care domains and Utilization measures. **Table 4** details the color-coding used in **Tables 5a** through **7** to indicate the rating of the MCO percentile achieved, and provides additional related comments. HEDIS measure results with an 'NA' indicate that there were fewer than 30 people in the denominator and hence results are not presented. While Medical Assistance With Smoking and Tobacco Use Cessation is an Effectiveness of Care measure, results are reported through the CPA as noted in **Tables 1a** and **5a**.

Table 4. MCO HEDIS 2014 Rating Determination

Color Designation	Percentile MCO Achieved	Additional Comments
	Greater than 75th	No additional comments
	25th to 75th	No additional comments
	Less than 25th	No additional comments
NA	Not Applicable	The measure was not applicable (NA) because there were fewer than 30 people in the denominator.
	No Rating Available	Benchmarking data were not available.

Table 5a. HEDIS 2014 Plan-Specific Rates: Effectiveness of Care Measures

Measure	AG	BCE	BCW	TCS	UHCE	UHCM	UHCW	HEDIS 2013 National Medicaid 50th Percentile
Prevention and Screening								
Adult BMI Assessment (ABA)	87.70%	71.54%	73.26%	65.43%	78.96%	82.62%	80.73%	72.09%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)								
BMI Percentile: 3-11 years (yrs)	71.04%	52.04%	58.87%	49.56%	49.65%	49.28%	58.04%	52.88%
12-17 yrs	57.78%	52.11%	63.57%	58.47%	51.18%	63.91%	61.60%	53.66%
Total	**66.90%**	**52.07%**	**60.34%**	**53.53%**	**50.12%**	**54.01%**	**59.12%**	**52.31%**
Counseling for Nutrition: 3-11 yrs	69.70%	57.62%	59.22%	56.14%	64.44%	65.47%	70.28%	60.19%
12-17 yrs	45.19%	45.77%	61.24%	51.37%	58.27%	59.40%	59.20%	55.29%
Total	**62.04%**	**53.53%**	**59.85%**	**54.01%**	**62.53%**	**63.50%**	**66.91%**	**59.11%**

Table 5a. HEDIS 2014 Plan-Specific Rates: Effectiveness of Care Measures								
Measure	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid 50th Percentile**
Counseling for Physical Activity: 3-11 yrs	57.91%	44.61%	43.97%	38.16%	55.99%	60.79%	60.14%	43.51%
12-17 yrs	42.22%	41.55%	54.26%	43.17%	60.63%	64.66%	61.60%	50.00%
Total	**53.01%**	**43.55%**	**47.20%**	**40.39%**	**57.42%**	**62.04%**	**60.58%**	**46.23%**
Childhood Immunization Status (CIS):								
DTaP/DT	81.94%	84.18%	74.45%	79.81%	80.05%	78.59%	74.21%	81.51%
IPV	93.98%	95.38%	91.97%	93.43%	94.89%	92.70%	89.29%	92.70%
MMR	91.44%	94.89%	89.29%	92.70%	92.70%	89.78%	88.08%	92.21%
HiB	93.52%	94.65%	91.24%	93.67%	93.92%	92.94%	89.05%	93.16%
HepB	93.75%	94.89%	92.46%	91.73%	95.62%	92.94%	89.54%	91.39%
VZV	93.06%	93.67%	88.56%	92.70%	93.19%	91.48%	88.56%	91.59%
PCV	85.19%	86.13%	76.89%	81.51%	80.29%	81.75%	75.67%	81.13%
HepA	91.44%	91.73%	88.56%	91.48%	91.48%	88.08%	88.08%	80.79%
RV	75.69%	74.70%	64.72%	50.36%	67.40%	73.48%	64.96%	66.67%
Flu	55.56%	49.39%	24.82%	54.01%	44.53%	53.77%	30.66%	50.00%
Combination 2	78.47%	81.51%	71.53%	76.89%	77.13%	72.99%	69.10%	76.89%
Combination 3	75.46%	79.08%	67.88%	73.72%	72.51%	71.29%	65.45%	72.88%
Combination 4	74.77%	76.89%	67.88%	72.51%	71.29%	70.32%	64.96%	63.02%
Combination 5	64.12%	63.02%	52.07%	45.01%	55.23%	61.80%	51.09%	55.41%
Combination 6	47.69%	43.55%	22.63%	44.28%	39.90%	46.72%	26.52%	41.89%
Combination 7	63.66%	61.07%	52.07%	44.28%	54.50%	60.83%	50.61%	50.33%
Combination 8	47.69%	43.31%	22.63%	43.55%	39.42%	46.47%	26.52%	38.66%
Combination 9	42.36%	37.47%	20.44%	27.74%	32.60%	42.09%	22.87%	34.38%
Combination 10	42.36%	37.23%	20.44%	27.25%	32.36%	41.85%	22.87%	31.39%
Immunization for Adolescents (IMA):								
Meningococcal	69.87%	65.50%	63.03%	61.27%	66.58%	72.78%	61.22%	71.07%
Tdap/Td	89.09%	82.16%	85.11%	77.72%	83.42%	85.28%	78.29%	85.19%
Combination 1	69.61%	63.74%	61.70%	60.76%	66.08%	72.78%	60.24%	68.59%
Human Papillomavirus Vaccine for Female Adolescents (HPV)*	16.47%	23.84%	16.06%	16.06%	19.95%	16.79%	10.95%	
Lead Screening in Children (LSC)	73.84%	75.18%	72.51%	76.89%	70.80%	75.18%	71.78%	72.26%
Breast Cancer Screening (BCS)**	49.07%	58.29%	55.33%	67.61%	52.43%	49.61%	46.37%	51.32%
Cervical Cancer Screening (CCS)***	68.24%	67.15%	70.32%	58.69%	60.64%	65.98%	64.84%	
Chlamydia Screening in Women (CHL):								
16-20 years old	54.27%	42.54%	58.92%	49.96%	46.45%	53.72%	55.02%	53.80%
21-24 years old	63.19%	56.18%	69.14%	35.29%	57.78%	63.17%	63.99%	64.58%
Total	**58.09%**	**47.93%**	**63.49%**	**49.74%**	**50.78%**	**57.77%**	**59.17%**	**57.30%**

Table 5a. HEDIS 2014 Plan-Specific Rates: Effectiveness of Care Measures								
Measure	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid 50th Percentile**
Respiratory Conditions								
Appropriate Testing for Children with Pharyngitis (CWP)	82.22%	75.83%	77.06%	74.20%	72.22%	82.84%	75.11%	70.30%
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	80.28%	71.14%	69.55%	73.11%	70.34%	81.14%	73.30%	85.86%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	24.62%	22.50%	25.76%	22.45%	20.58%	26.95%	28.48%	22.18%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	31.83%	35.13%	41.94%	NA	29.90%	32.32%	39.92%	31.31%
Pharmacotherapy Management of COPD Exacerbation (PCE):								
Systemic Corticosteroid	47.78%	44.76%	48.27%	NA	57.33%	50.82%	52.06%	67.00%
Bronchodilator	74.72%	76.41%	79.22%	NA	77.73%	73.58%	78.00%	83.24%
Use of Appropriate Medications for People with Asthma (ASM):								
5-11 years old	92.36%	95.81%	91.39%	95.36%	93.77%	91.97%	90.03%	90.31%
12-18 years old	86.57%	89.51%	88.31%	88.74%	89.58%	85.24%	89.14%	85.88%
19-50 years old	60.51%	60.88%	66.34%	81.18%	62.95%	58.62%	61.23%	74.76%
51-64 years old	44.30%	45.26%	48.89%	NA	54.79%	51.14%	54.72%	72.50%
Total	**82.84%**	**87.18%**	**84.51%**	**91.37%**	**85.34%**	**81.33%**	**82.76%**	**84.70%**
Medication Management for People With Asthma (MMA)								
Medication Compliance 50%: 5-11 years*	54.23%	57.78%	43.93%	61.57%	58.13%	55.43%	47.30%	
12-18 years*	50.19%	54.62%	42.57%	61.35%	56.29%	51.58%	41.38%	
19-50 years*	59.54%	55.91%	44.02%	59.42%	62.82%	52.60%	39.74%	
51-64 years*	65.71%	53.49%	63.64%	NA	77.50%	51.11%	NA	
Total*	**54.06%**	**56.50%**	**43.88%**	**61.37%**	**58.59%**	**53.77%**	**44.29%**	
Medication Compliance 75%: 5-11 years	28.15%	32.91%	19.89%	38.96%	36.90%	31.37%	23.77%	24.40%
12-18 years	26.63%	30.60%	17.57%	39.81%	29.25%	27.00%	16.78%	23.92%
19-50 years	33.59%	34.29%	24.49%	47.83%	38.27%	32.87%	19.65%	33.15%
51-64 years	40.00%	37.21%	36.36%	NA	45.00%	31.11%	NA	48.91%
Total	**28.72%**	**32.37%**	**20.13%**	**39.83%**	**34.78%**	**30.33%**	**21.10%**	**27.62%**
Asthma Medical Ratio (AMR):†								
5–11 years	80.09%	86.42%	78.07%	85.83%	85.26%	81.59%	80.44%	
12–18 years	66.56%	73.26%	70.28%	74.96%	70.70%	67.73%	68.93%	
19–50 years	39.24%	40.74%	39.29%	63.10%	43.55%	37.34%	33.15%	
51–64 years	29.11%	35.79%	28.89%	NA	39.73%	32.95%	30.77%	
Total	**66.67%**	**73.97%**	**67.04%**	**79.35%**	**71.30%**	**66.39%**	**66.10%**	
Cardiovascular Conditions								
Cholesterol Management for Patients with Cardiovascular Conditions (CMC):								
LDL-C Screening	79.58%	78.35%	77.86%	NA	80.78%	80.78%	84.91%	82.42%
LDL-C Control (<100 mg/dL)	39.21%	36.50%	35.77%	NA	43.55%	41.36%	43.07%	41.82%

Table 5a. HEDIS 2014 Plan-Specific Rates: Effectiveness of Care Measures								
Measure	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid 50th Percentile**
Controlling High Blood Pressure (CBP)	57.78%	59.35%	52.68%	68.73%	61.52%	53.83%	55.01%	56.20%
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)	76.60%	88.89%	75.93%	NA	86.36%	86.36%	80.00%	82.98%
Diabetes								
Comprehensive Diabetes Care (CDC):								
HbA1c Testing	81.20%	77.55%	76.28%	79.26%	81.03%	83.60%	78.80%	83.16%
HbA1c Control (<7.0%)	33.10%	41.44%	35.22%	45.22%	43.50%	38.24%	33.49%	34.76%
HbA1c Control (<8.0%)	44.49%	51.46%	42.70%	54.18%	52.31%	52.80%	47.73%	48.57%
Retinal Eye Exam Performed	40.97%	39.05%	39.05%	66.22%	38.46%	36.93%	36.67%	54.31%
LDL-C Screening	77.09%	77.19%	68.25%	68.90%	78.46%	77.87%	72.93%	76.28%
LDL-C Control (<100 mg/dL)	29.22%	34.49%	26.46%	37.46%	36.03%	34.13%	30.67%	34.89%
Medical Attention for Nephropathy	78.12%	75.36%	72.63%	57.19%	79.36%	74.93%	77.47%	79.23%
Blood Pressure Control (<140/80 mm Hg)	40.09%	38.32%	33.76%	51.84%	38.59%	41.07%	34.67%	38.89%
Blood Pressure Control (<140/90 mm Hg)	61.23%	61.13%	57.30%	73.58%	61.79%	62.53%	55.47%	61.03%
Musculoskeletal Conditions								
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	60.27%	64.41%	61.97%	NA	72.25%	58.98%	60.11%	69.46%
Use of Imaging Studies for Low Back Pain (LBP)	69.39%	65.23%	69.86%	75.00%	64.24%	68.22%	69.34%	75.14%
Behavioral Health								
Antidepressant Medication Management (AMM) Treatment:								
Effective Acute Phase	49.01%	45.96%	43.23%	48.81%	49.78%	44.57%	44.23%	51.47%
Effective Continuation Phase	34.92%	28.51%	27.30%	30.95%	33.52%	27.40%	29.09%	35.26%
Follow-Up Care for Children Prescribed ADHD Medication (ADD):								
Initiation Phase	60.59%	42.07%	35.61%	34.56%	52.26%	51.23%	42.51%	39.76%
Continuation and Maintenance Phase	69.92%	47.64%	50.70%	38.04%	59.81%	61.65%	54.09%	46.76%
Follow-Up After Hospitalization for Mental Illness (FUH):								
7-day follow-up	58.19%	46.90%	63.21%	50.32%	48.37%	51.67%	65.92%	44.66%
30-day follow-up	76.07%	68.27%	75.50%	67.22%	70.31%	69.38%	76.29%	65.85%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)†	82.01%	79.50%	76.89%	77.84%	81.41%	84.12%	74.67%	
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)†	75.76%	62.09%	58.05%	71.43%	67.30%	75.86%	67.35%	
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)†	87.50%	78.05%	64.58%	NA	82.86%	83.78%	82.22%	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)†	61.81%	68.48%	59.21%	71.09%	61.62%	63.80%	61.72%	

Table 5a. HEDIS 2014 Plan-Specific Rates: Effectiveness of Care Measures								
Measure	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid 50th Percentile**
Medication Management								
Annual Monitoring for Patients on Persistent Medications (MPM):								
ACE Inhibitors or ARBs	88.40%	85.51%	91.26%	89.01%	92.63%	90.31%	92.10%	86.98%
Digoxin	91.00%	93.10%	95.51%	NA	93.05%	97.41%	94.81%	90.91%
Diuretics	88.75%	86.95%	89.80%	96.43%	93.39%	91.87%	91.71%	86.68%
Anticonvulsants	72.52%	72.04%	69.78%	77.98%	75.55%	73.25%	69.21%	65.98%
Total	**87.28%**	**84.63%**	**88.59%**	**83.41%**	**91.35%**	**89.38%**	**89.55%**	**85.39%**
Measures Collected Through CAHPS Health Plan Survey								
Medical Assistance with Smoking and Tobacco Use Cessation (MSC):								
Advising Smokers and Tobacco Users to Quit	78.38%	80.04%	80.97%	61.32%	78.25%	78.04%	76.60%	76.20%
Discussing Cessation—Medications	41.98%	48.78%	52.59%	37.38%	45.17%	45.41%	37.50%	45.18%
Strategies	36.08%	42.28%	41.57%	32.38%	37.09%	34.94%	34.75%	40.25%

** Measure deemed first-year status again in 2013.*
*** The age group for this measure changed; NCQA has yet to determine if results are trendable with the previous year.*
**** The measure's specification changed and results cannot be trended with previous years.*
† Benchmarks are not reported by Quality Compass for 2013 first year measures.

For the Effectiveness of Care Measures presented in **Table 5b**, a lower rate (particularly one below the national 50th percentile) is an indication of better performance. For example, a rate in the 10th percentile is better than a rate in the 90th percentile.

Table 5b. HEDIS 2014 Plan-Specific Rates: Effectiveness of Care Measures Where Lower Rates Indicate Better Performance								
Measure	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid 50th Percentile**
Prevention and Screening								
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)‡	12.34%	11.84%	12.74%	9.28%	12.70%	12.75%	10.43%	
Diabetes								
Comprehensive Diabetes Care (CDC):								
HbA1c Poor Control (>9.0%)	48.02%	40.15%	47.99%	41.47%	38.97%	38.27%	43.73%	43.02%

‡Measure is first-year in 2014.

Table 6. HEDIS 2014 Plan-Specific Rates: Access/Availability of Care Measures								
Measure	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid 50th Percentile**
Adults' Access to Preventive/Ambulatory Health Services (AAP):								
20-44 year-olds	81.95%	84.29%	82.11%	73.68%	80.97%	86.16%	77.68%	82.39%
45-64 year-olds	87.31%	91.68%	88.41%	79.42%	89.14%	91.92%	86.14%	87.50%

Table 6. HEDIS 2014 Plan-Specific Rates: Access/Availability of Care Measures								
Measure	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid 50th Percentile**
Children and Adolescents' Access to Primary Care Practitioners (CAP):								
12-24 months	97.45%	98.36%	96.84%	97.98%	97.12%	97.34%	96.23%	96.89%
25 months-6 years	90.61%	91.38%	89.14%	93.26%	88.59%	91.44%	89.27%	89.39%
7-11 years	93.88%	94.75%	94.69%	95.13%	91.85%	94.06%	93.68%	90.88%
12-19 years	91.59%	92.17%	91.26%	90.48%	89.08%	91.96%	89.00%	89.58%
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET):								
Initiation of Treatment: 13-17 years	55.70%	46.31%	43.28%	57.24%	43.05%	52.24%	54.26%	40.00%
18 + years	39.71%	31.76%	35.33%	48.31%	37.05%	32.42%	40.03%	39.14%
Total	**40.66%**	**32.46%**	**35.76%**	**52.95%**	**37.29%**	**33.33%**	**40.72%**	**39.16%**
Engagement of Treatment: 13-17 years	39.47%	34.23%	16.42%	35.86%	21.08%	35.07%	14.89%	16.61%
18 + years	13.31%	8.78%	8.72%	16.91%	7.77%	9.93%	9.58%	8.90%
Total	**14.86%**	**9.99%**	**9.14%**	**26.77%**	**8.31%**	**11.09%**	**9.83%**	**10.19%**
Prenatal and Postpartum Care (PPC):								
Timeliness of Prenatal Care	87.96%	89.17%	70.24%	72.90%	84.90%	80.68%	67.40%	85.88%
Postpartum Care	65.74%	63.61%	51.95%	45.04%	59.90%	57.95%	51.58%	63.99%
Call Answer Timeliness (CAT)	94.53%	89.78%	89.84%	89.95%	88.79%	88.79%	88.79%	86.16%

Table 7. HEDIS 2014 Plan-Specific Rates: Use of Services Measures								
Measure	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid 50th Percentile**
Frequency of Ongoing Prenatal Care (FPC): ≥ 81 %	70.14%	75.28%	51.71%	41.60%	68.23%	61.37%	47.45%	64.70%
Well-Child Visits in the First 15 Months of Life (W15)								
6 or More Visits	66.20%	69.77%	51.82%	45.50%	73.98%	75.47%	57.32%	65.16%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	73.84%	71.19%	67.99%	71.65%	69.17%	72.60%	69.25%	72.26%
Adolescent Well-Care Visits (AWC)	54.29%	49.64%	49.88%	49.39%	49.88%	52.80%	45.50%	48.18%

Tables 9 through **11** display the plan-specific performance rates for the CAHPS survey results. **Table 8** details the color-coding and the MCO rating scale, as well as any additional comments, used in **Tables 9** through **11** to indicate the rating achieved. CAHPS measure results with an 'NA' indicate that there were fewer than 100 valid responses and, hence, results are not presented. For all CAHPS survey results, performance is measured against the calculated statewide average. The 2013 National Medicaid CAHPS Benchmarking data were obtained from Quality Compass.

Table 8. MCO 2013 CAHPS Rating Determination

Color Designation	Rating Scale	Additional Comments
	Greater than one standard deviation above the statewide average	No additional comments
	Within one standard deviation above or below the statewide average	No additional comments
	Greater than one standard deviation below the statewide average	No additional comments
NA	Not Applicable	The survey question was not applicable (NA) because there were less than 100 valid responses.
	No Rating Available	Benchmarking data were not available.

Table 9. 2014 CAHPS 5.0H Adult Medicaid Survey Results

AG	BCE	BCW	TCS	UHCE	UHCM	UHCW	Statewide Average	2013 National Medicaid CAHPS Benchmarking
1. Getting Needed Care (Always + Usually)								
84.11%	81.78%	86.22%	86.45%	83.78%	84.89%	80.41%	83.95%	80.62%
2. Getting Care Quickly (Always + Usually)								
83.75%	87.28%	87.15%	81.54%	80.74%	84.33%	79.86%	83.52%	81.16%
3. How Well Doctors Communicate (Always + Usually)								
87.55%	85.08%	87.82%	89.77%	86.17%	88.40%	89.76%	87.79%	89.27%
4. Customer Service (Always + Usually)								
91.67%	85.66%	NA	NA	90.00%	88.43%	84.34%	88.02%	86.16%
5. Shared Decision Making (A lot/Yes)								
46.96%	42.45%	47.99%	NA	45.12%	50.40%	43.67%	46.10%	
6. Rating of All Health Care (9+10)								
50.92%	44.51%	49.06%	51.72%	51.66%	53.15%	53.70%	50.67%	50.91%
7. Rating of Personal Doctor (9+10)								
60.87%	58.63%	65.15%	64.81%	63.09%	59.18%	61.18%	61.84%	63.14%
8. Rating of Specialist Seen Most Often (9+10)								
68.75%	64.53%	62.99%	71.07%	72.69%	61.57%	64.24%	66.55%	64.38%
9. Rating of Health Plan (9+10)								
58.82%	55.47%	60.14%	56.81%	58.41%	57.66%	59.12%	58.06%	56.29%

In **Tables 10** and **11**, the National Medicaid CAHPS Benchmarking data for the 5.0H Child Medicaid Survey aggregate results from the surveys for General Population (CPC) and Children With Chronic Conditions (CCC) and are acceptable as benchmarks for both. There are no benchmarking data specific to the supplemental questions in the CCC Survey set.

Table 10. 2014 CAHPS 5.0H Child Medicaid Survey Results (General Population)

AG	BCE	BCW	TCS	UHCE	UHCM	UHCW	Statewide Average	2013 National Medicaid CAHPS Benchmarking
1. Getting Needed Care (Always + Usually)								
87.49%	92.48%	86.79%	91.69%	90.71%	85.42%	87.41%	88.86%	84.38%
2. Getting Care Quickly (Always + Usually)								
90.05%	93.81%	92.64%	93.65%	91.52%	92.31%	90.92%	92.13%	89.18%
3. How Well Doctors Communicate (Always + Usually)								
93.38%	95.57%	95.61%	92.50%	94.67%	93.62%	93.02%	94.05%	92.61%
4. Customer Service (Always + Usually)								
87.40%	NA	NA	91.59%	91.11%	87.98%	89.69%	89.55%	87.61%
5.Shared Decision Making (A lot/Yes)								
54.86%	NA	NA	60.48%	54.50%	52.76%	58.30%	56.18%	
6. Rating of All Health Care (9+10)								
71.74%	67.19%	70.88%	69.60%	70.38%	69.30%	66.83%	69.42%	64.33%
7. Rating of Personal Doctor (9+10)								
79.86%	72.63%	74.37%	77.16%	73.68%	73.75%	70.99%	74.63%	72.92%
8. Rating of Specialist Seen Most Often (9+10)								
NA	NA	NA	77.27%	63.24%	69.90%	NA	70.14%	69.72%
9. Rating of Health Plan (9+10)								
79.13%	75.48%	76.96%	73.65%	68.90%	73.35%	68.75%	73.75%	66.79%

Table 11. 2014 CAHPS 5.0H Child Medicaid Survey Results (Children with Chronic Conditions)

AG	BCE	BCW	TCS	UHCE	UHCM	UHCW	Statewide Average	2013 National Medicaid CAHPS Benchmarking
1. Getting Needed Care (Always + Usually)								
86.32%	90.41%	90.34%	90.78%	89.39%	85.97%	86.33%	88.51%	86.43%
2. Getting Care Quickly (Always + Usually)								
93.59%	95.13%	93.81%	94.78%	94.17%	93.87%	93.07%	94.06%	91.81%
3. How Well Doctors Communicate (Always + Usually)								
93.01%	92.51%	96.90%	93.19%	93.96%	94.48%	91.46%	93.64%	93.06%
4. Customer Service (Always + Usually)								
NA	NA	NA	91.37%	86.71%	87.26%	86.69%	88.01%	88.74%
5.Shared Decision Making (A lot/Yes)								
64.34%	56.84%	60.79%	62.80%	60.90%	59.75%	63.84%	61.32%	
6. Rating of All Health Care (9+10)								
68.17%	64.65%	74.44%	66.15%	64.27%	66.33%	64.47%	66.93%	63.22%
7. Rating of Personal Doctor (9+10)								
75.57%	73.08%	78.38%	74.63%	71.62%	74.02%	69.40%	73.81%	73.35%

Table 11. 2014 CAHPS 5.0H Child Medicaid Survey Results (Children with Chronic Conditions)								
AG	BCE	BCW	TCS	UHCE	UHCM	UHCW	Statewide Average	2013 National Medicaid CAHPS Benchmarking
8.Rating of Specialist Seen Most Often (9+10)								
69.35%	69.81%	NA	74.05%	69.96%	67.34%	63.64%	69.03%	69.18%
9. Rating of Health Plan (9+10)								
70.46%	70.14%	76.11%	70.89%	65.66%	70.22%	65.71%	69.88%	64.69%
10. Access to Specialized Services (Always + Usually)								
NA	NA	NA	81.09%	79.87%	82.43%	74.85%	79.56%	76.70%
11. Family-Centered Care: Personal Doctor or Nurse Who Knows Child (Yes)								
91.17%	91.04%	92.33%	91.29%	91.35%	90.40%	89.18%	90.97%	89.26%
12. Coordination of Care With Chronic Conditions (Yes)								
NA	NA	NA	80.49%	78.14%	78.14%	80.54%	79.33%	77.19%
13. Family-Centered Care: Getting Needed Information (Always + Usually)								
89.31%	90.51%	90.99%	90.93%	93.08%	93.08%	89.37%	91.04%	90.26%
14. Access to Prescription Medicines (Always + Usually)								
90.37%	93.83%	93.16%	92.53%	91.86%	92.59%	93.25%	92.51%	90.55%

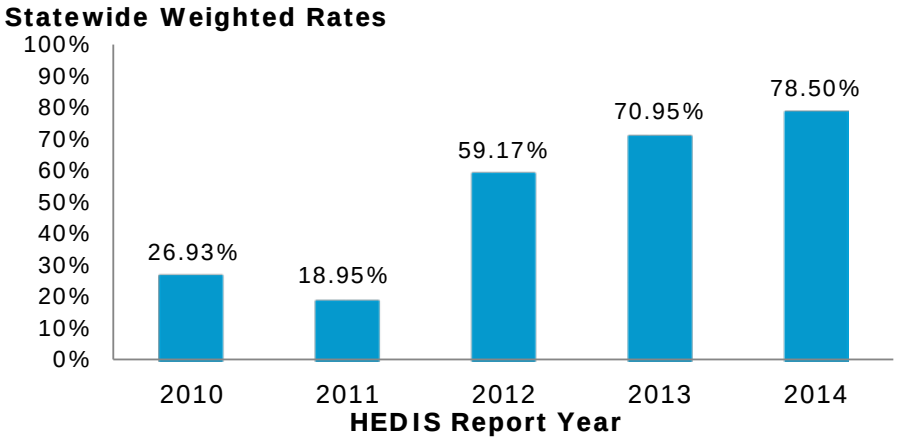
HEDIS Trending Since 2006—Statewide Weighted Rates

Each year of HEDIS reporting, Qsource has calculated statewide weighted averages for each measure by applying the size of the eligible population for each measure within a health plan to its reported rate. Using this methodology, plan-specific findings can be estimated from an overall TennCare statewide level, with each reporting health plan contributing to the statewide estimate proportionate to its eligible population size.

Trending for first-time measures—those reported for the first time in this year's HEDIS/CAHPS report—is not possible and, therefore, not presented in this section. Remaining measures are plotted to reflect the statewide performance of TennCare MCOs since reporting began in 2006, except where measures were not reported for a particular year as stated in footnotes. In 2008 new health plans were implemented in the Middle Grand Region that were not required to be NCQA accredited until December 2009. Similarly, new health plans were implemented in 2009 in the West Grand Region that were not required to be accredited until December 2010. The data would not have been reported by these MCOs for 2008 or 2009, respectively; hence, no 2008 or 2009 statewide weighted rates are presented.

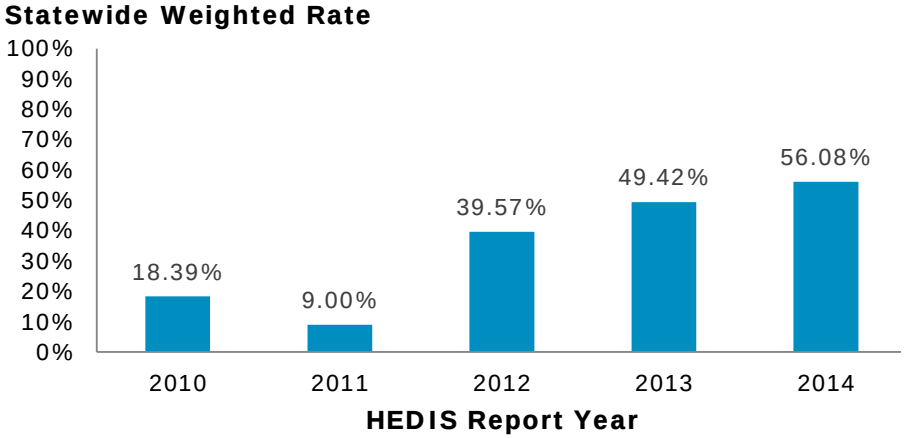
Effectiveness of Care Measures—Prevention and Screening

Fig. 1. Adult BMI Assessment (ABA)



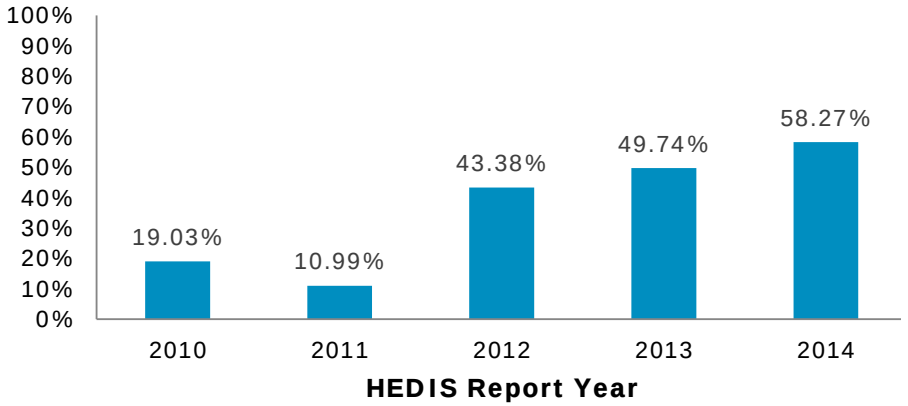
Footnote: First year data collection implemented in 2009.

Fig. 2. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile: 3–11 years



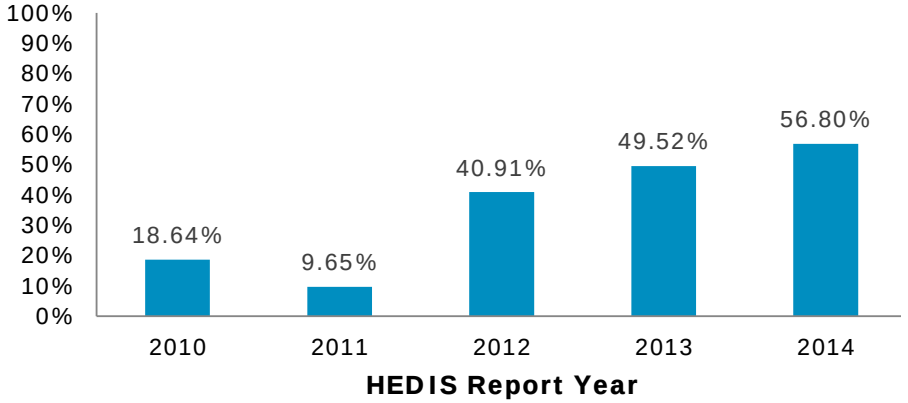
Footnote: First year data collection implemented in 2009.

Fig. 3. WCC—BMI Percentile: 12–17 years



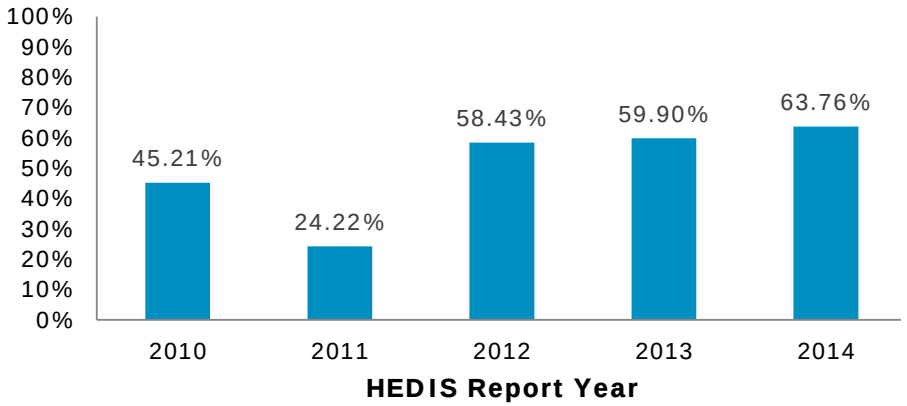
Footnote: First year data collection implemented in 2009.

Fig. 4. WCC—BMI Percentile: Total



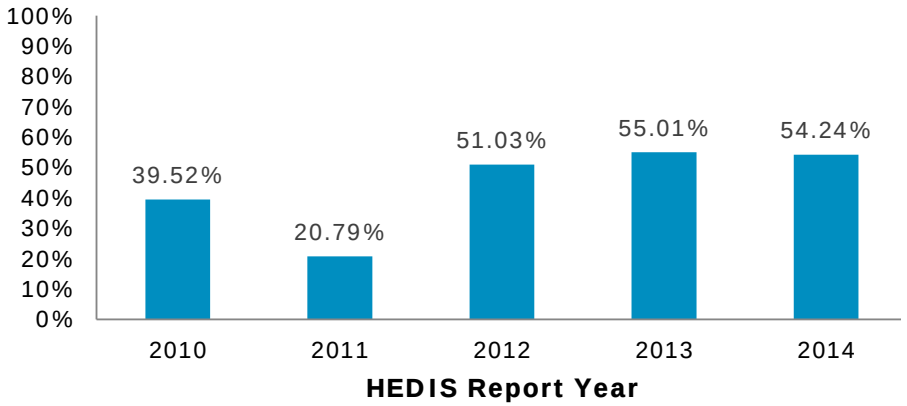
Footnote: First year data collection implemented in 2009.

Fig. 5. WCC—Counseling for Nutrition: 3–11 years



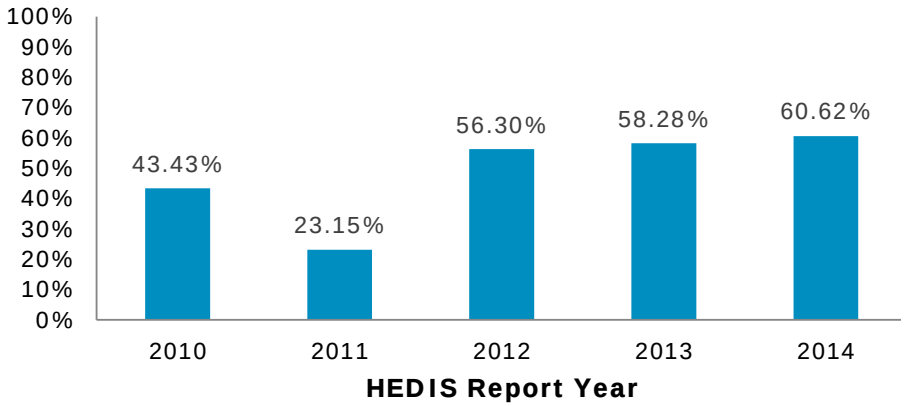
Footnote: First year data collection implemented in 2009.

Fig. 6. WCC—Counseling for Nutrition: 12–17 years



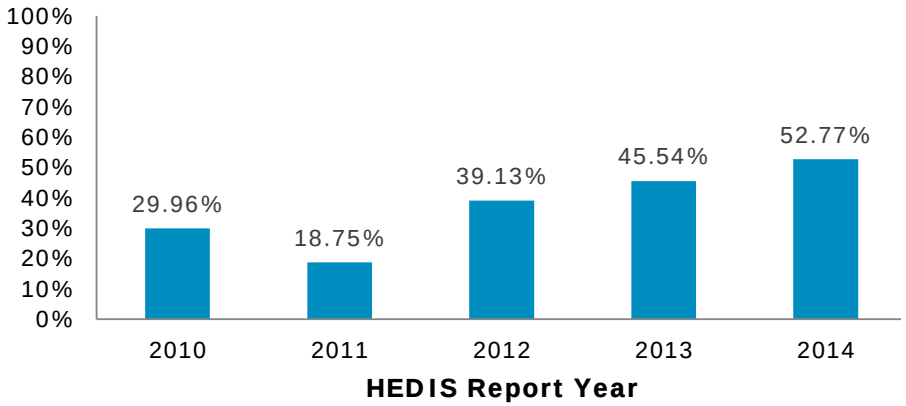
Footnote: First year data collection implemented in 2009.

Fig. 7. WCC—Counseling for Nutrition: Total



Footnote: First year data collection implemented in 2009.

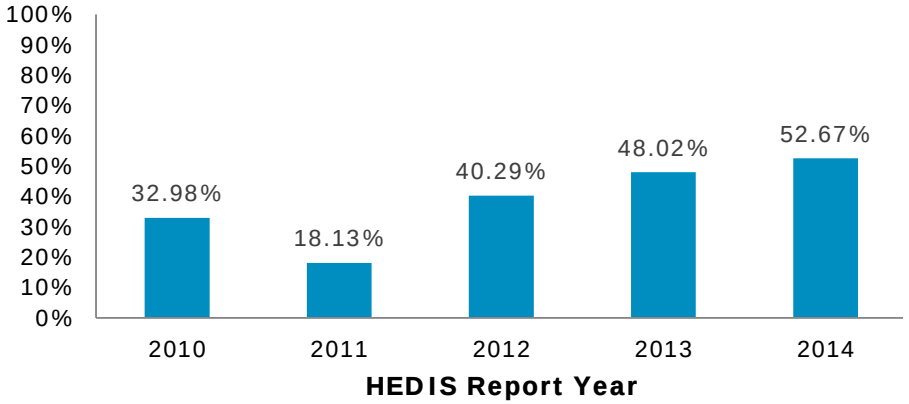
Fig. 8. WCC—Counseling for Physical Activity: 3–11 years



Footnote: First year data collection implemented in 2009.

Fig. 9. WCC—Counseling for Physical Activity: 12–17 years

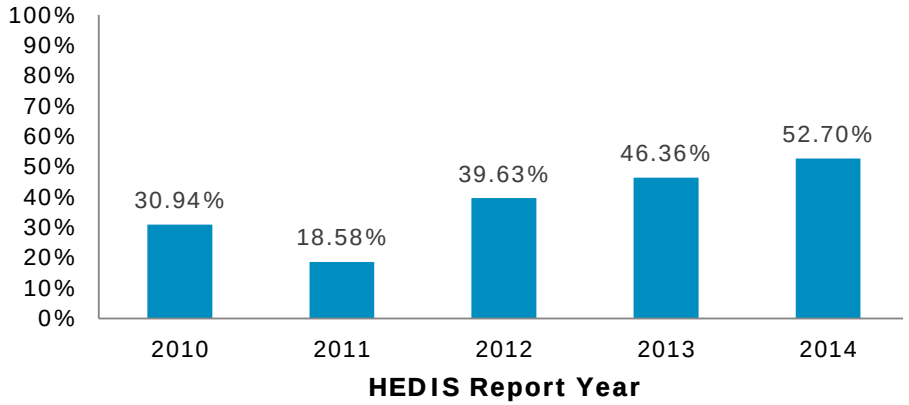
Statewide Weighted Rates



Footnote: First year data collection implemented in 2009.

Fig. 10. WCC—Counseling for Physical Activity: Total

Statewide Weighted Rates



Footnote: First year data collection implemented in 2009.

Fig. 11. Childhood Immunization Status (CIS)—DTaP

Statewide Weighted Rates

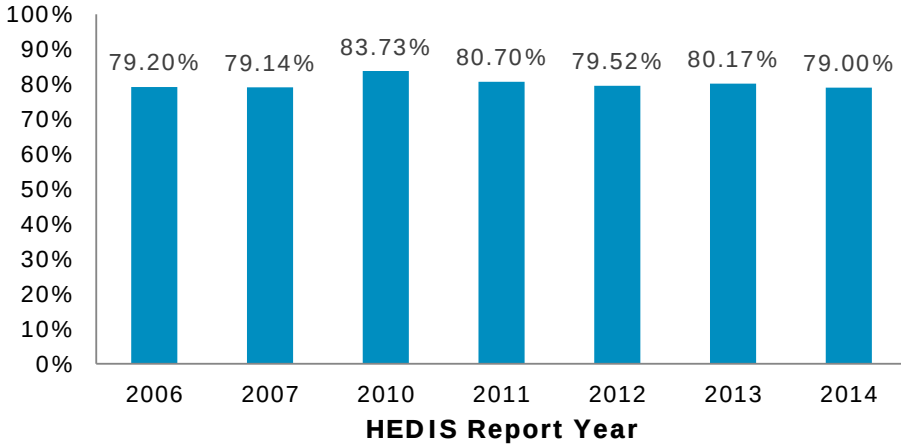


Fig. 12. CIS—IPV

Statewide Weighted Rates

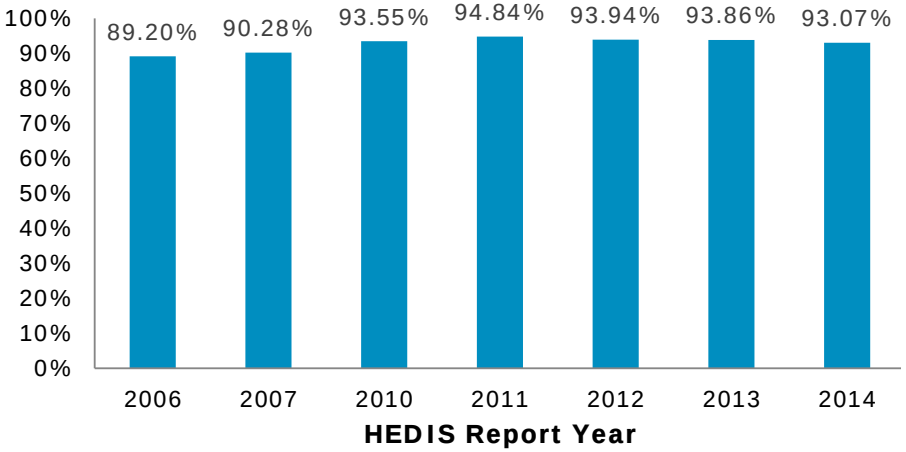


Fig. 13. CIS—MMR

Statewide Weighted Rates

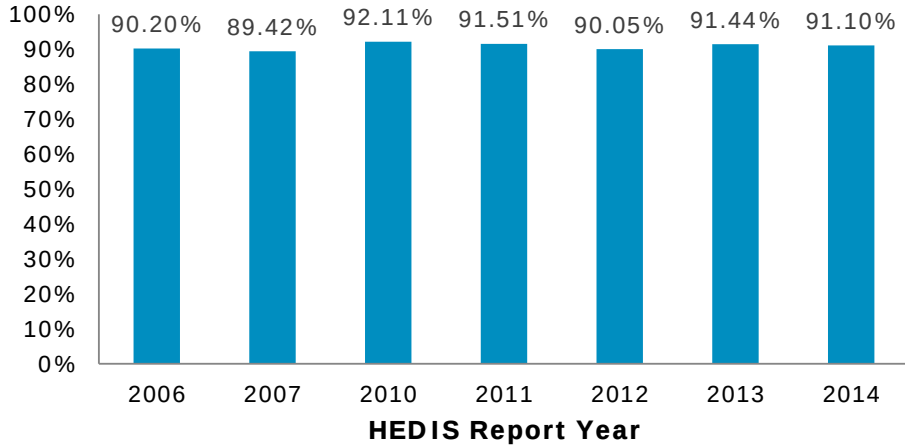


Fig. 14. CIS—HiB

Statewide Weighted Rates

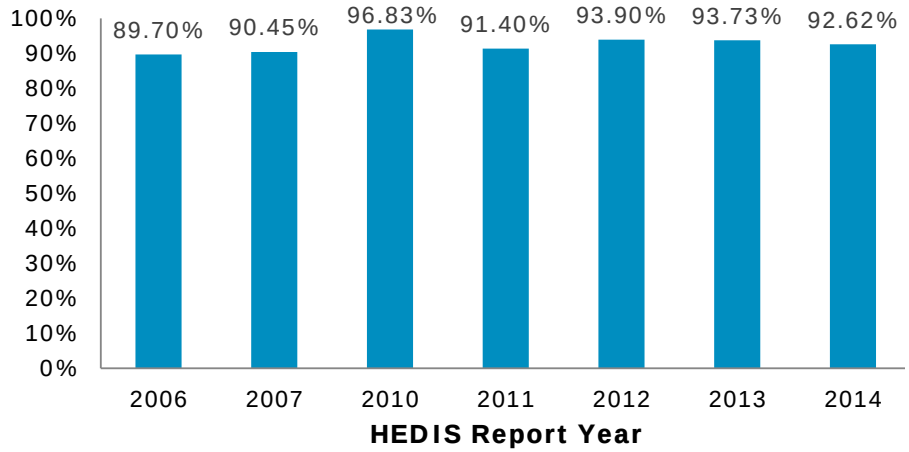


Fig. 15. CIS—HepB

Statewide Weighted Rates

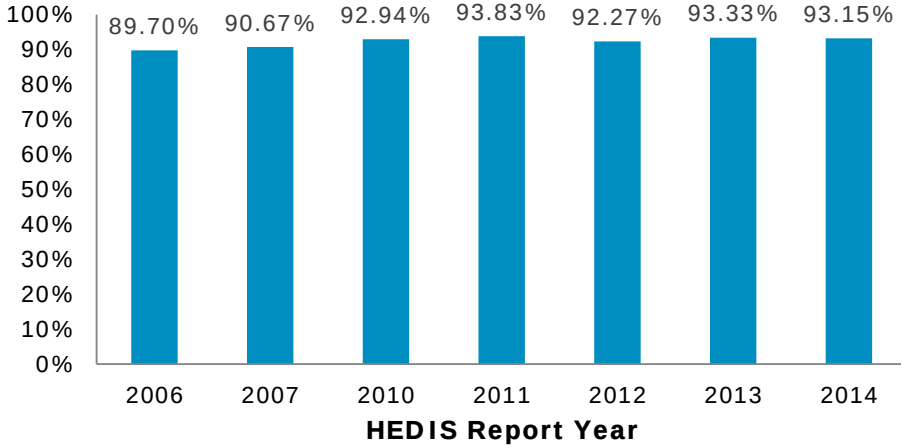


Fig. 16. CIS—VZV

Statewide Weighted Rates

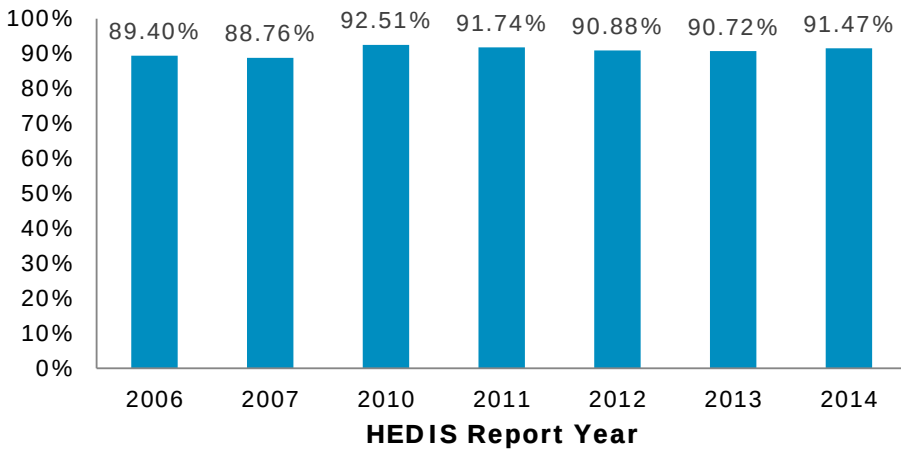


Fig. 17. CIS—PCV

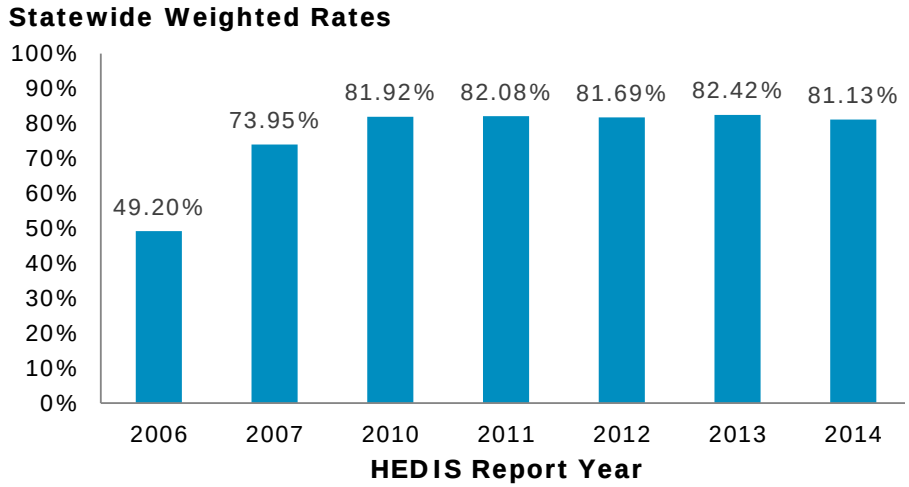
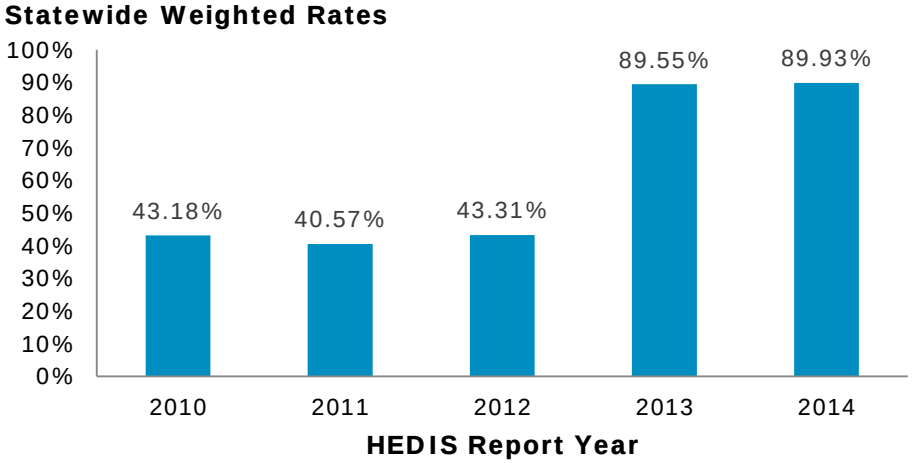
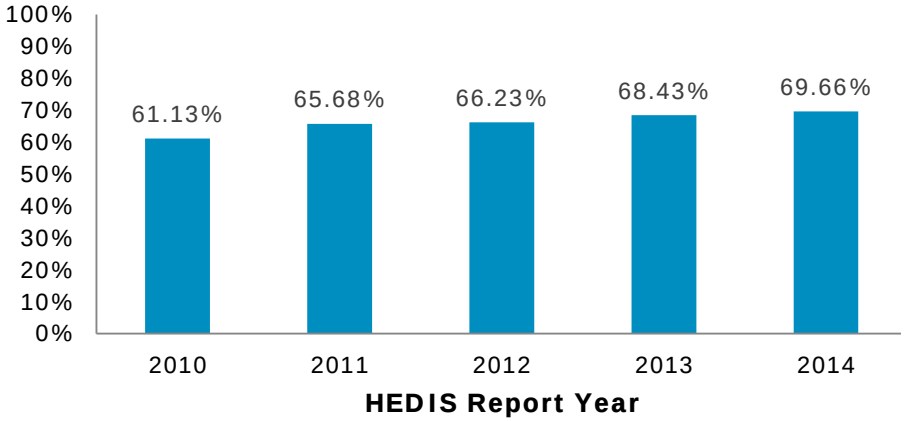


Fig. 18. CIS—HepA



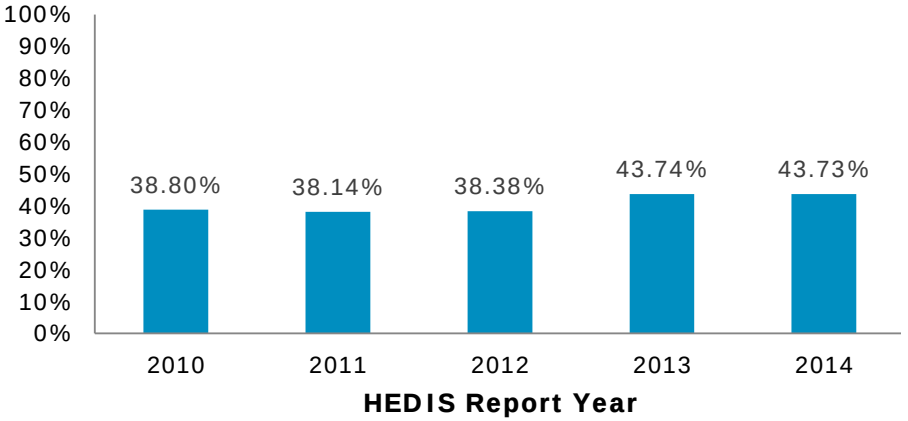
Footnote: First year measurement data collection implemented in 2009. Hep A dose requirements changed in 2013 from two doses to at least one dose; hence, trend with caution.

Fig. 19. CIS—RV



Footnote: First year data collection implemented in 2010.

Fig. 20. CIS—Influenza



Footnote: First year data collection implemented in 2010.

Fig. 21. CIS—Combination 2

Statewide Weighted Rates

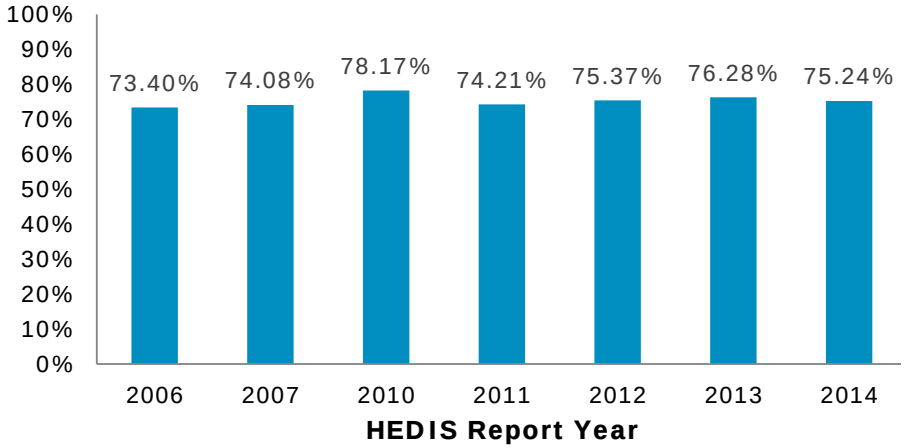


Fig. 22. CIS—Combination 3

Statewide Weighted Rates

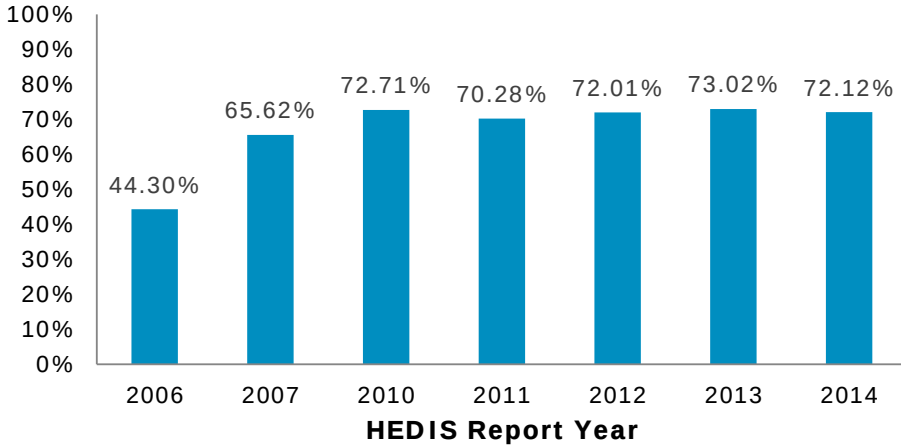
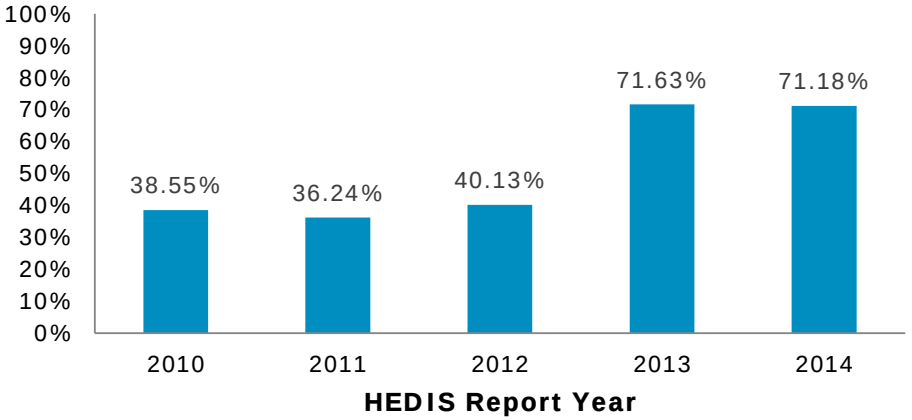


Fig. 23. CIS—Combination 4

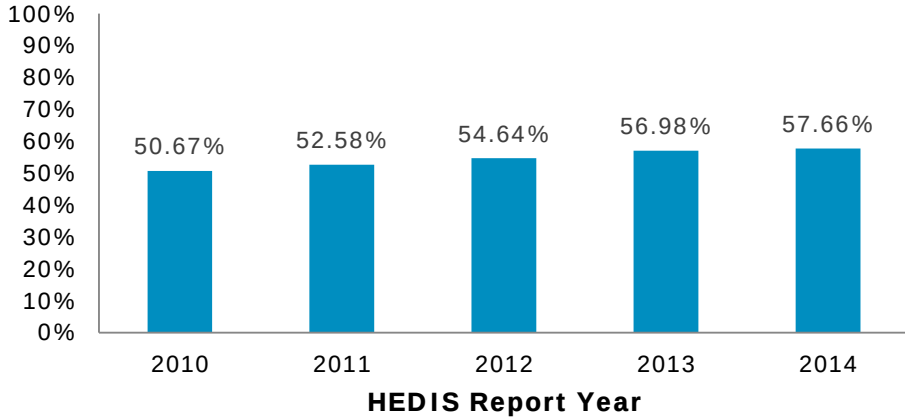
Statewide Weighted Rates



Footnote: First year data collection implemented in 2009. HepA dose requirements changed in 2013 from two doses to at least one dose; hence, trend with caution.

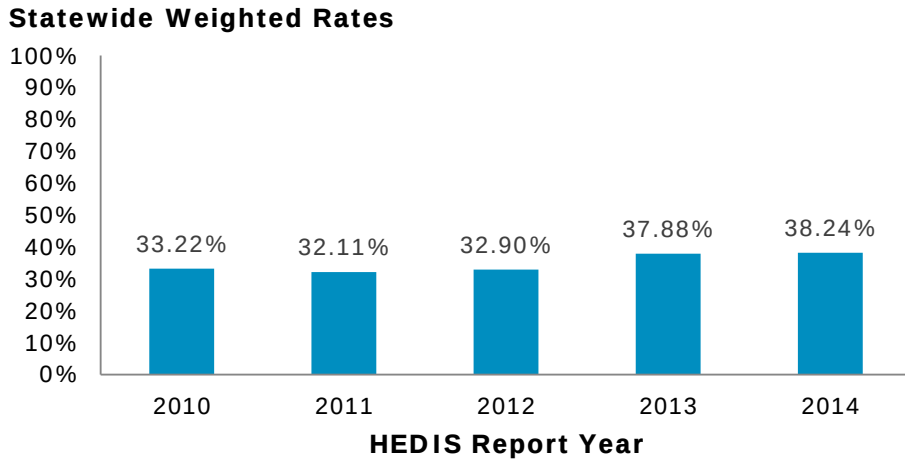
Fig. 24. CIS—Combination 5

Statewide Weighted Rates



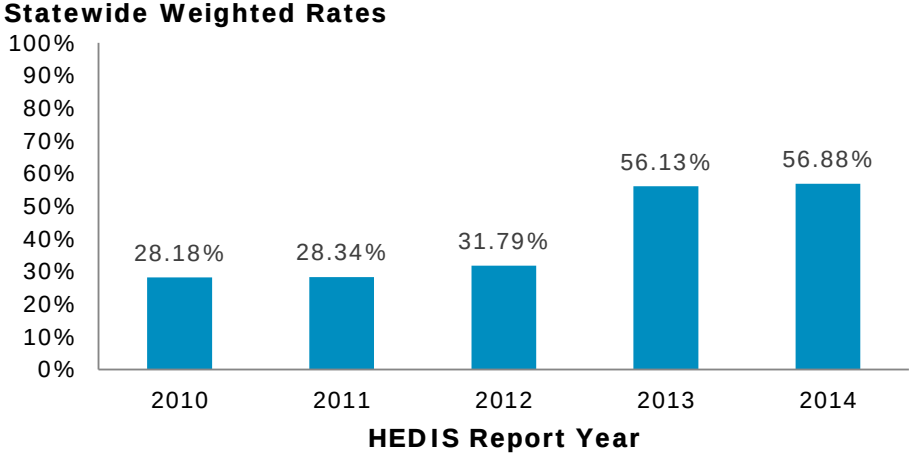
Footnote: First year data collection implemented in 2010.

Fig. 25. CIS—Combination 6



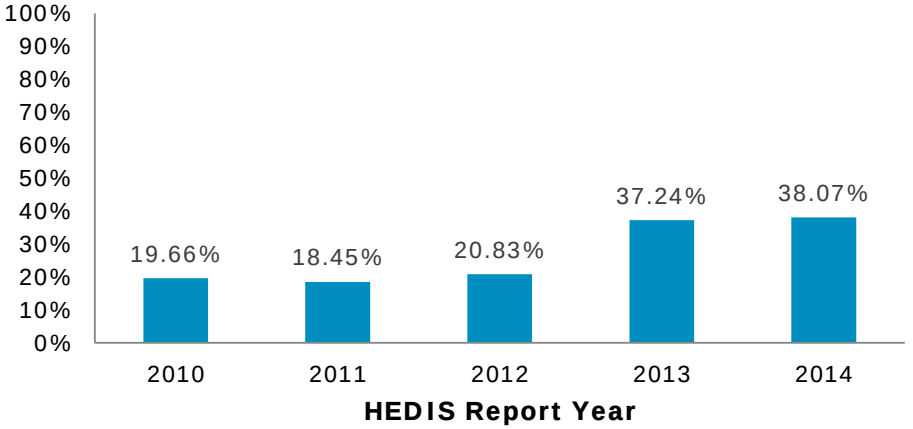
Footnote: First year data collection implemented in 2010.

Fig. 26. CIS—Combination 7



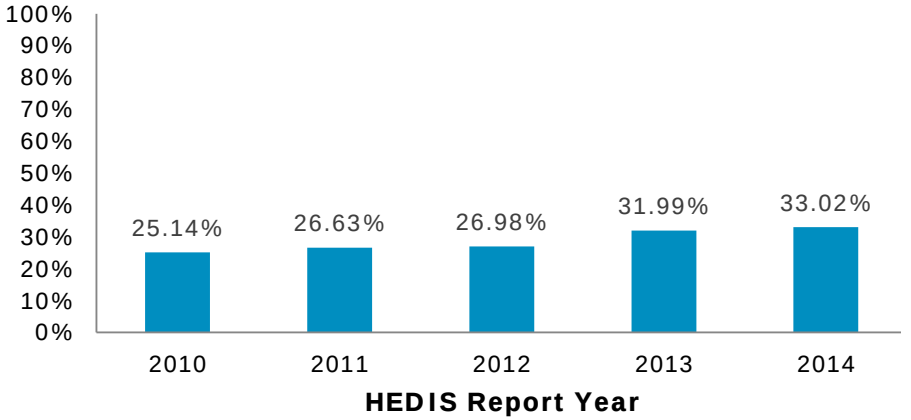
Footnote: First year data collection implemented in 2009. HepA dose requirements changed in 2013 from two doses to at least one dose; hence, trend with caution.

Fig. 27. CIS—Combination 8



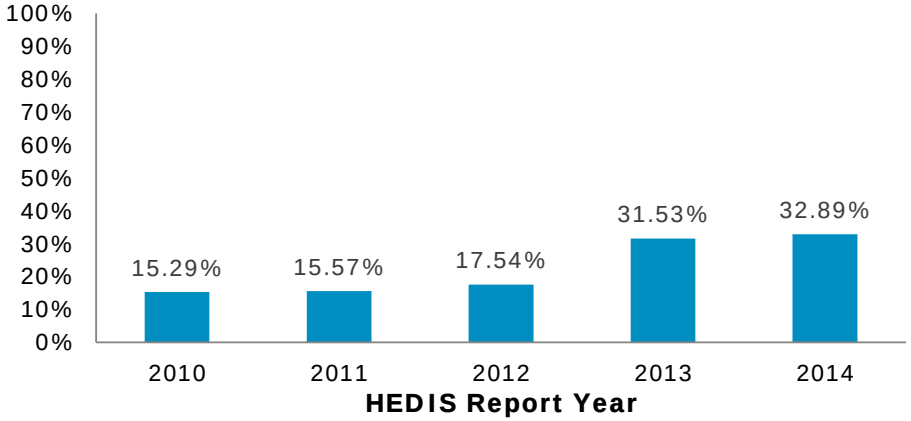
Footnote: First year data collection implemented in 2009. HepA dose requirements changed in 2013 from two doses to at least one dose; hence, trend with caution.

Fig. 28. CIS—Combination 9



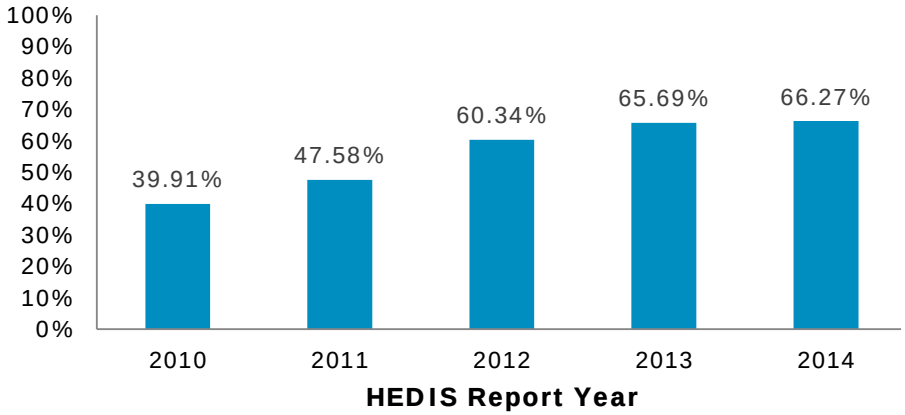
Footnote: First year data collection implemented in 2010.

Fig. 29. CIS—Combination 10
Statewide Weighted Rates



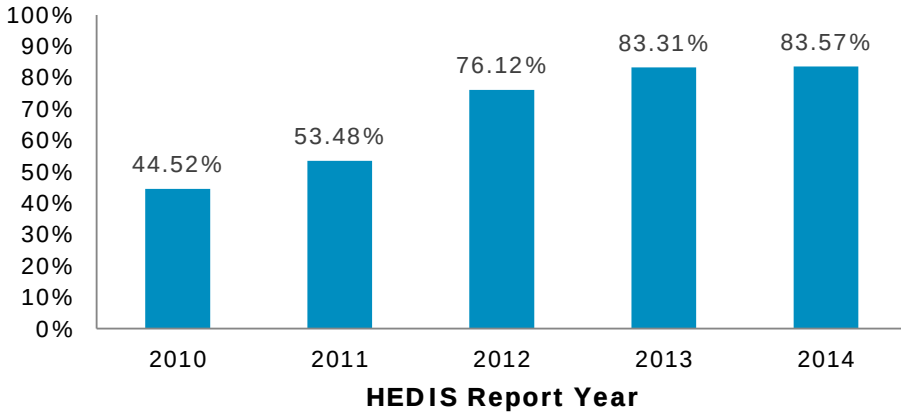
Footnote: First year data collection implemented in 2009. HepA dose requirements changed in 2013 from two doses to at least one dose; hence, trend with caution.

Fig. 30. Immunizations for Adolescents (IMA)—Meningococcal
Statewide Weighted Rates



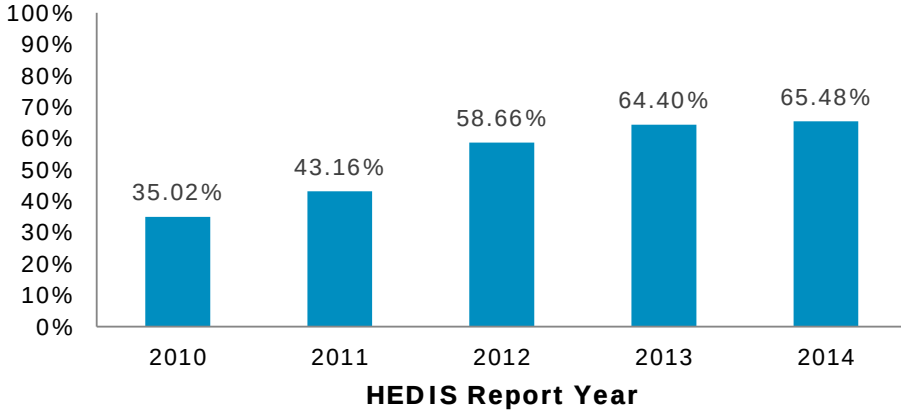
Footnote: First year data collection implemented in 2010.

Fig. 31. IMA—Tdap/Td
Statewide Weighted Rates



Footnote: First year data collection implemented in 2010.

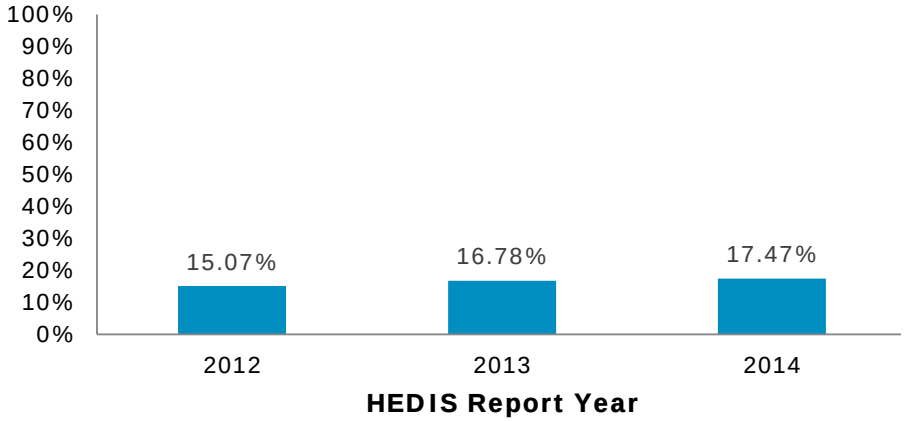
Fig. 32. IMA—Combination 1
Statewide Weighted Rates



Footnote: First year data collection implemented in 2010.

Fig. 33. Human Papillomavirus Vaccine for Female Adolescents (HPV)

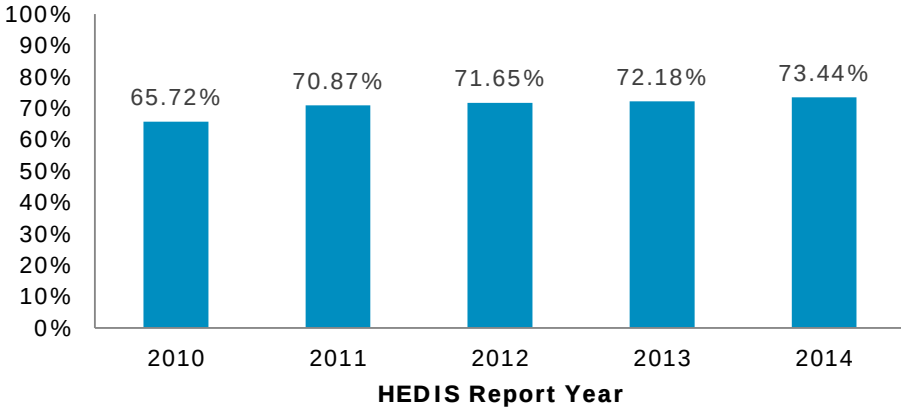
Statewide Weighted Rates



Footnote: First year data collection implemented in 2012.

Fig. 34. Lead Screening in Children (LSC)

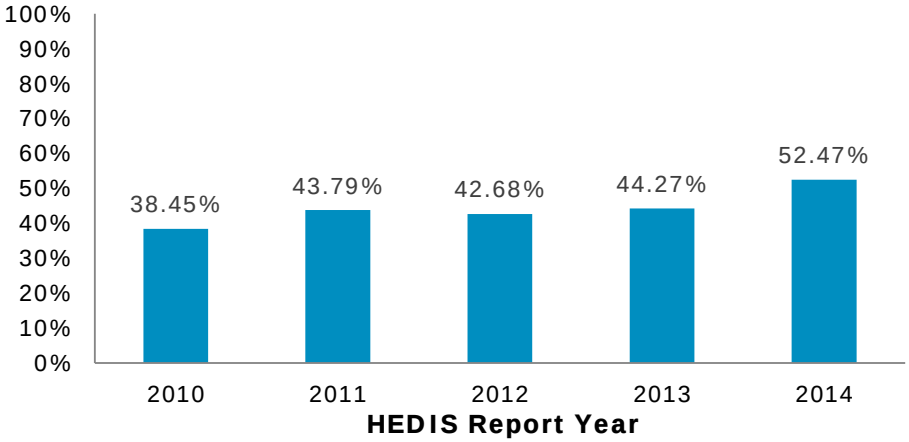
Statewide Weighted Rates



Footnote: First year data collection implemented in 2008.

Fig. 35. Breast Cancer Screening (BCS)

Statewide Weighted Rates



Footnote: Age stratification changed in 2009; as such, no comparative data are available from previous years. Age stratification changed again in 2014; however trending determinations were not finalized by NCQA before HEDIS 2014 reporting.

Fig. 36. Chlamydia Screening in Women (CHL)—16–20 years

Statewide Weighted Rates

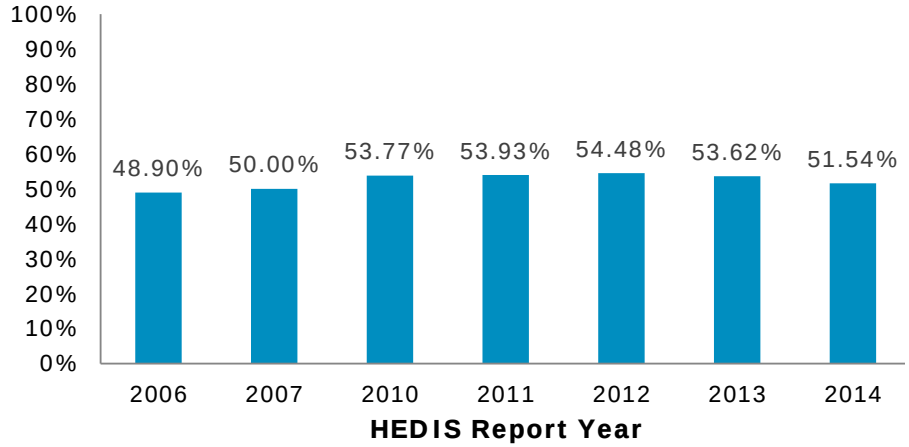
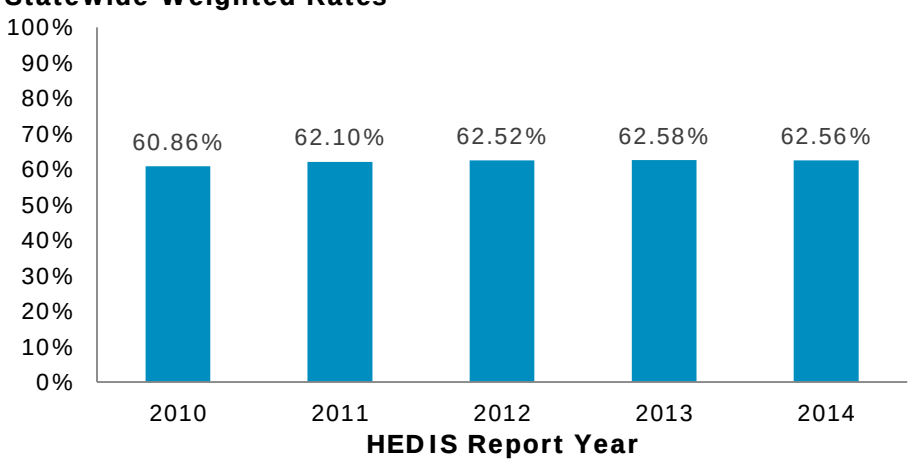
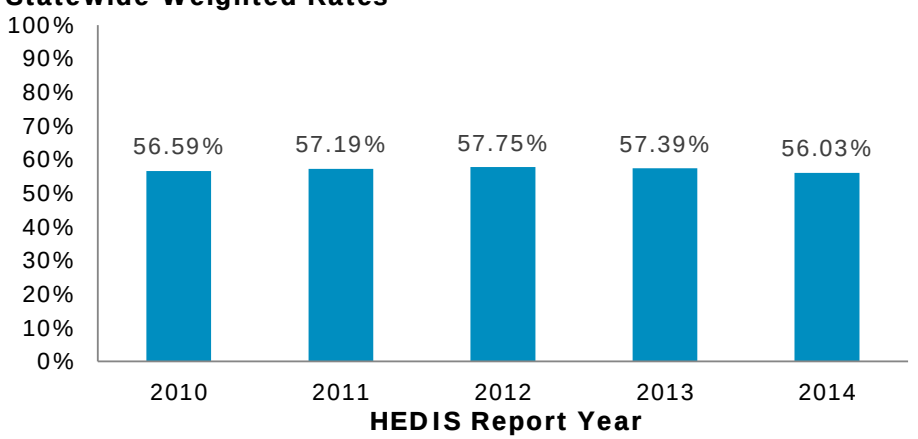


Fig. 37. CHL—21–24 years



Footnote: Age stratification changed in 2009; as such, no comparative data are available from previous years.

Fig. 38. CHL—Total



Footnote: Age stratification changed in 2009; as such, no comparative data are available from previous years.

Effectiveness of Care Measures—Respiratory Conditions

Fig. 39. Appropriate Testing for Children With Pharyngitis (CWP)

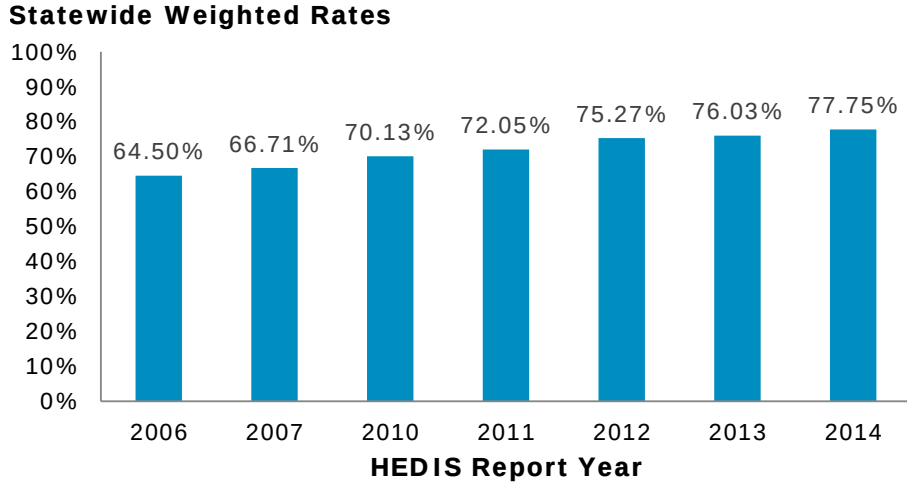


Fig. 40. Appropriate Treatment for Children With Upper Respiratory Infection (URI)

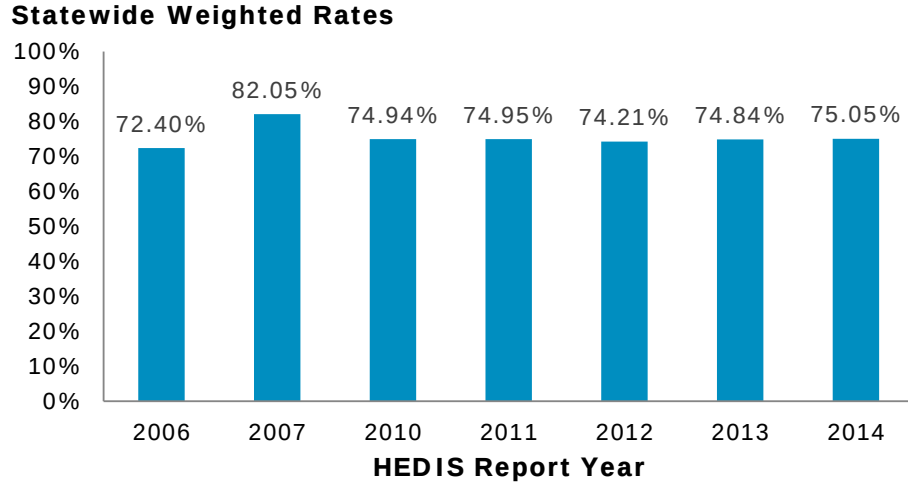
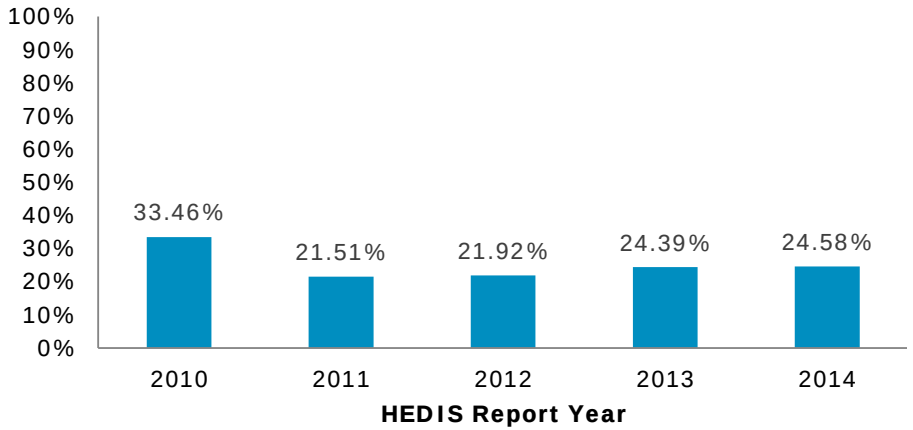


Fig. 41. Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)

Statewide Weighted Rates



Footnote: The measure rate was inverted in 2008; as such, no comparative data are available from previous years.

Fig. 42. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

Statewide Weighted Rates

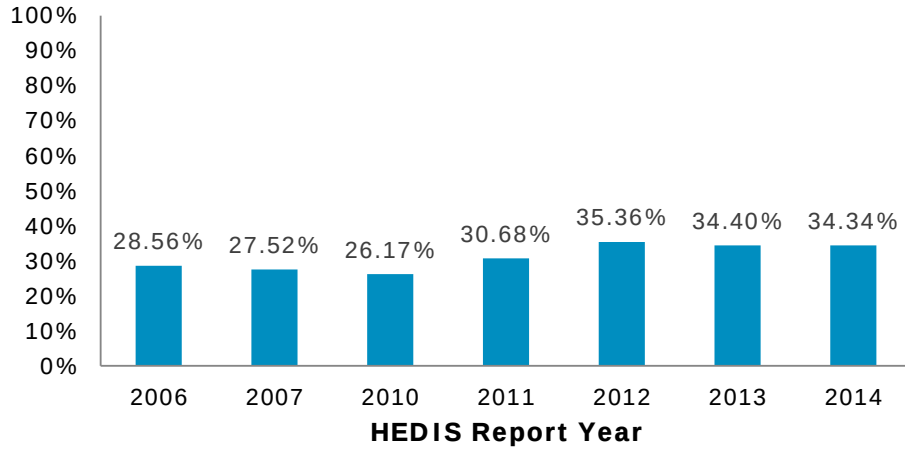
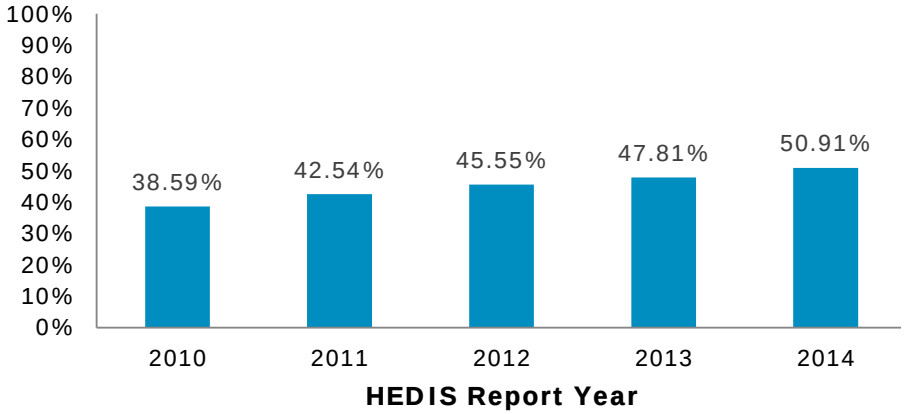


Fig. 43. Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid

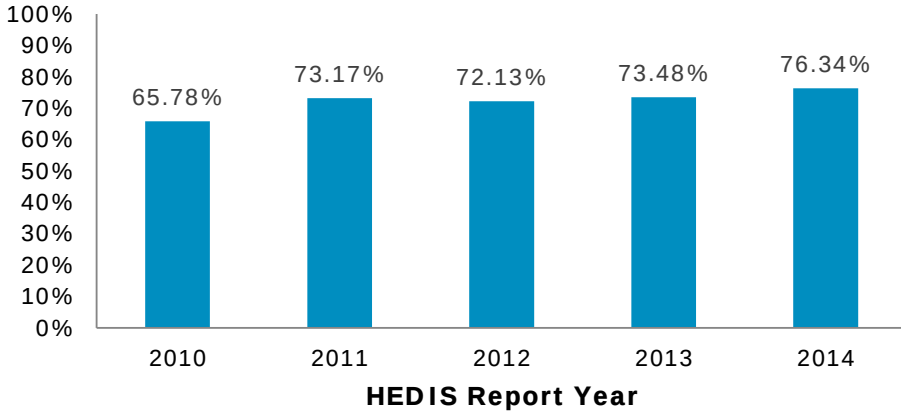
Statewide Weighted Rates



Footnote: First year data collection implemented in 2008.

Fig. 44. PCE—Bronchodilator

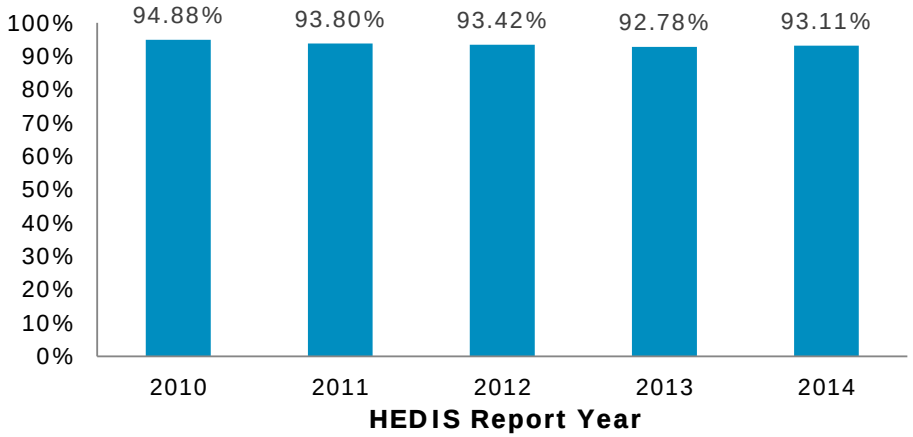
Statewide Weighted Rates



Footnote: First year data collection implemented in 2008.

Fig. 45. Use of Appropriate Medications for People With Asthma (ASM)—5–11 years

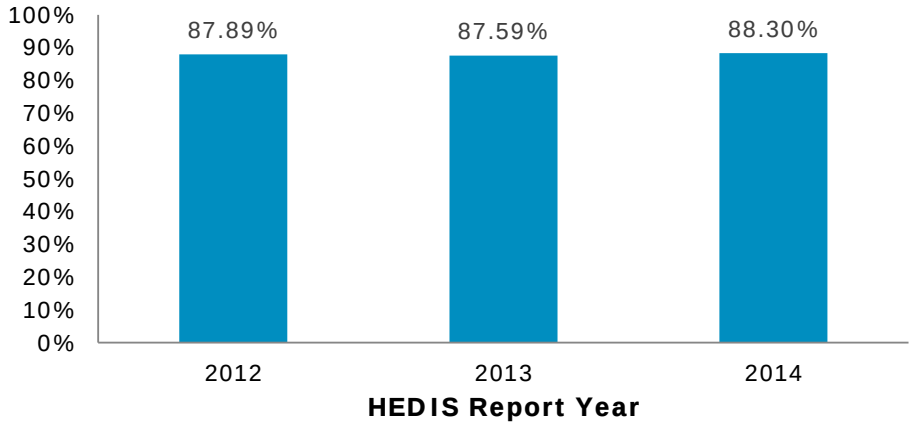
Statewide Weighted Rates



Footnote: Measure specification changed in 2010; as such, no comparative data are available from previous years.

Fig. 46. ASM—12–18 years

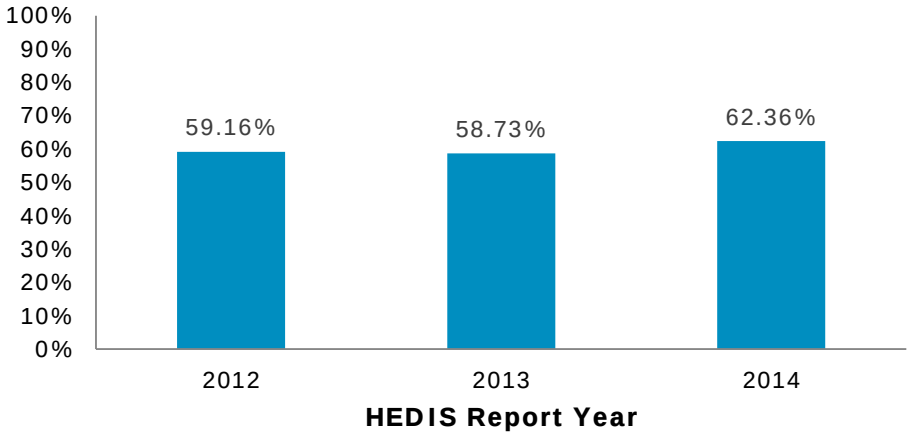
Statewide Weighted Rates



Footnote: Age stratification changed in 2012; as such, no comparative data are available from previous years.

Fig. 47. ASM—19–50 years

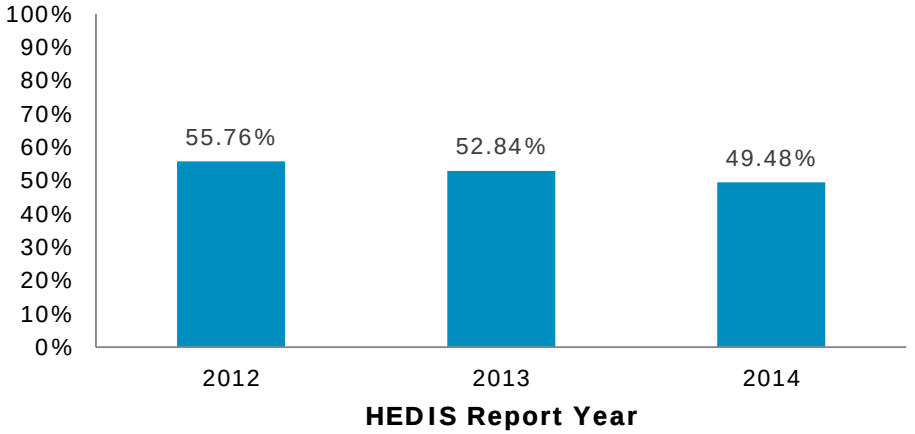
Statewide Weighted Rates



Footnote: Age stratification changed in 2012; as such, no comparative data are available from previous years.

Fig. 48. ASM—51–64 years

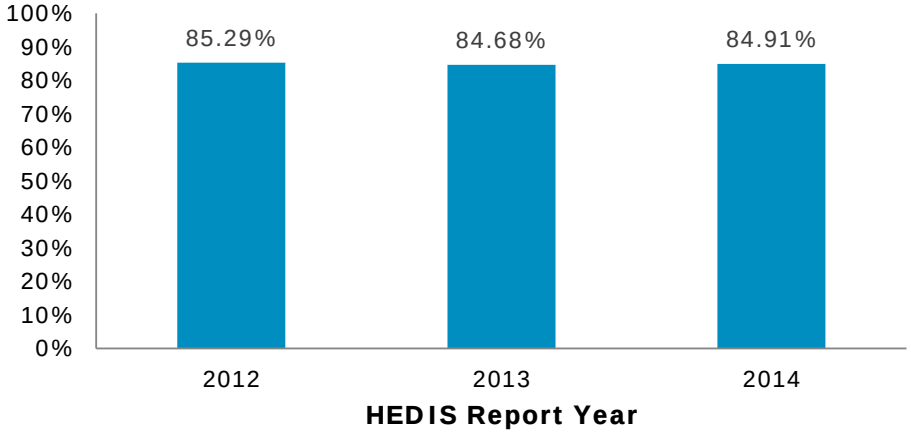
Statewide Weighted Rates



Footnote: Age stratification changed in 2012; as such, no comparative data are available from previous years.

Fig. 49. ASM—Total years

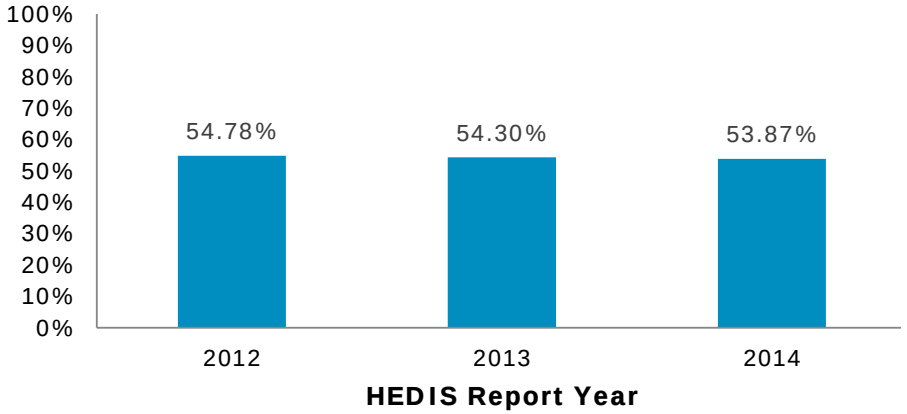
Statewide Weighted Rates



Footnote: Age stratification changed in 2012; as such, no comparative data are available from previous years.

Fig. 50. Medication Management for People With Asthma (MMA)—Medication Compliance 50%: 5–11 years

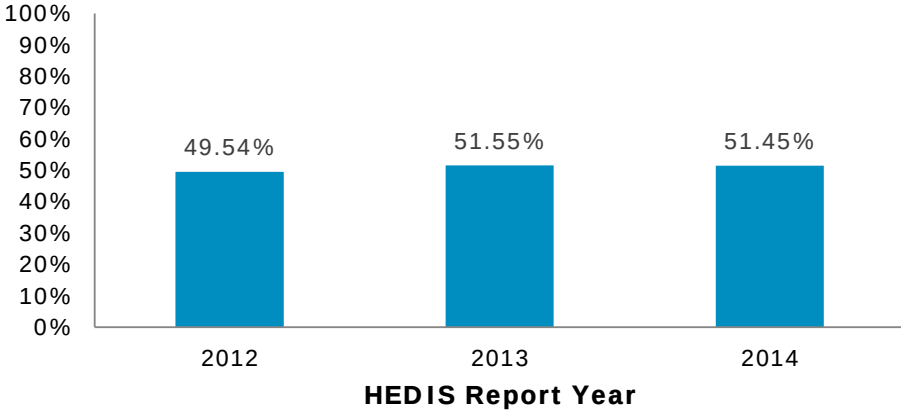
Statewide Weighted Rates



Footnote: First year data collection implemented in 2012.

Fig. 51. MMA—Medication Compliance 50%: 12–18 years

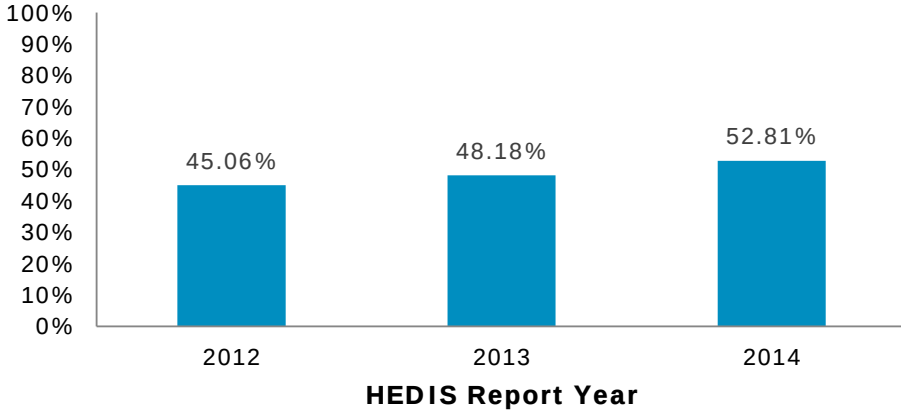
Statewide Weighted Rates



Footnote: First year data collection implemented in 2012.

Fig. 52. MMA—Medication Compliance 50%: 19–50 years

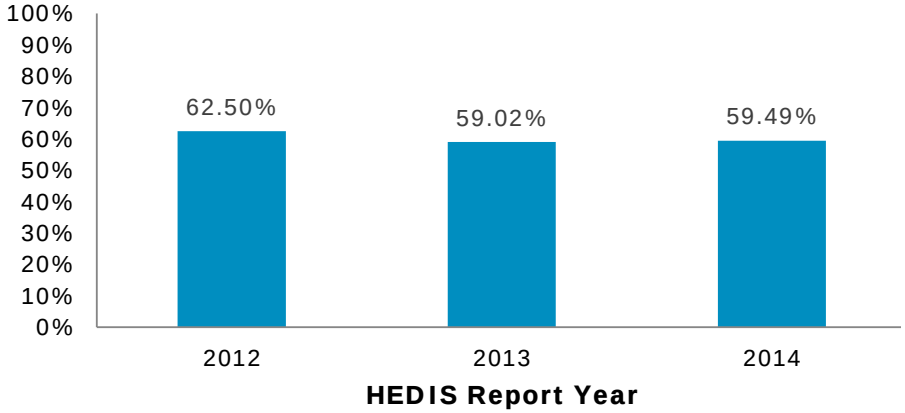
Statewide Weighted Rates



Footnote: First year data collection implemented in 2012.

Fig. 53. MMA—Medication Compliance 50%: 51–64 years

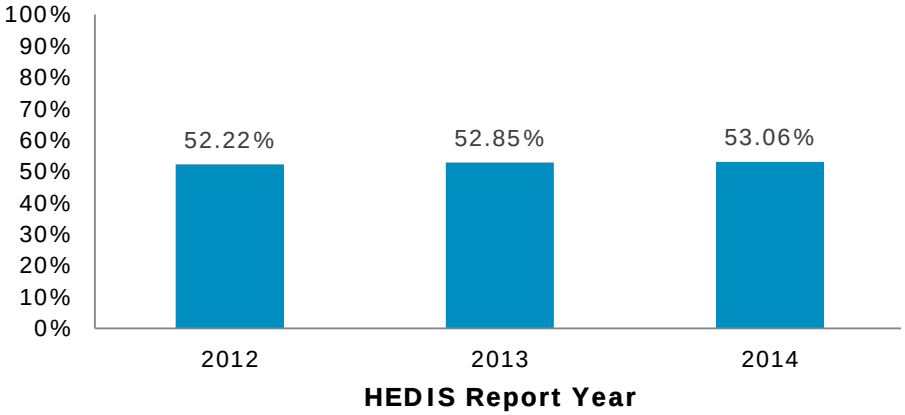
Statewide Weighted Rates



Footnote: First year data collection implemented in 2012.

Fig. 54. MMA—Medication Compliance 50%: Total

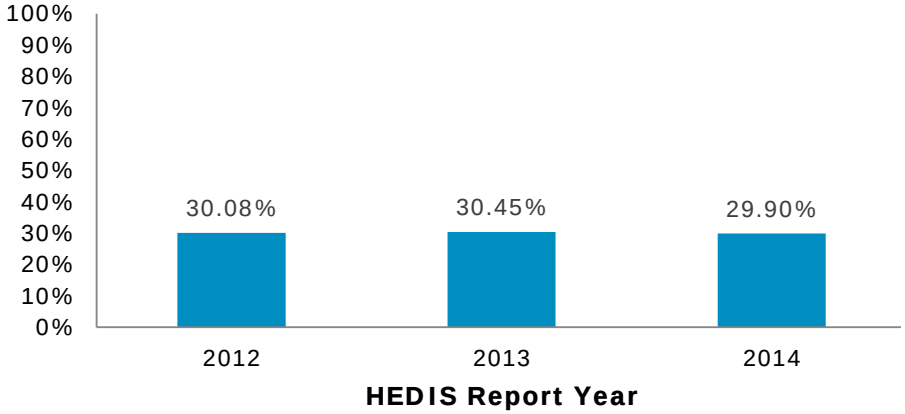
Statewide Weighted Rates



Footnote: First year data collection implemented in 2012.

Fig. 55. MMA—Medication Compliance 75%: 5–11 years

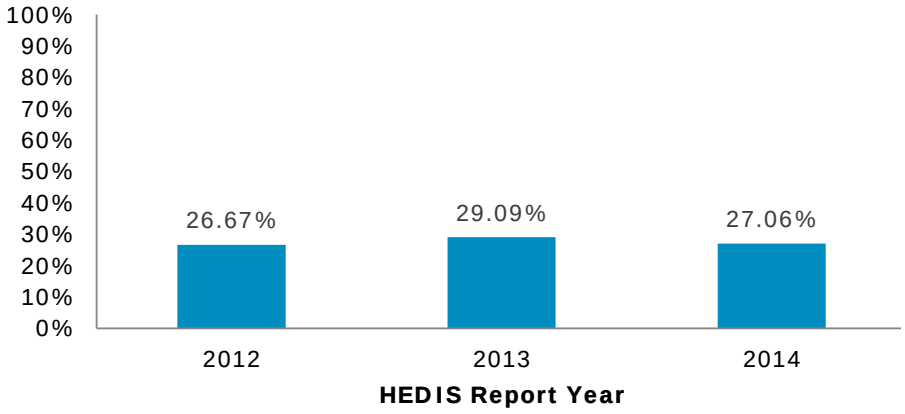
Statewide Weighted Rates



Footnote: First year data collection implemented in 2012.

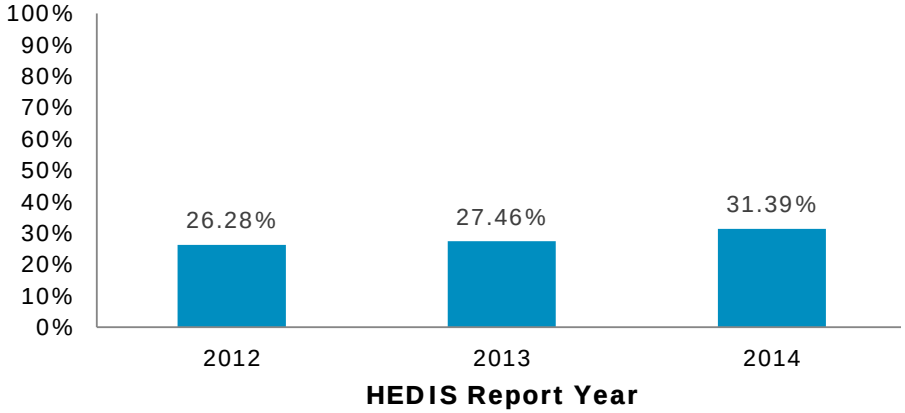
Fig. 56. MMA—Medication Compliance 75%: 12–18 years

Statewide Weighted Rates



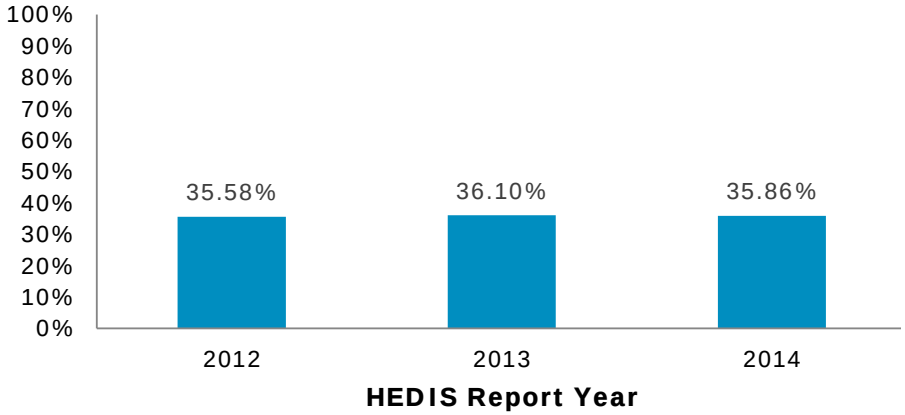
Footnote: First year data collection implemented in 2012.

Fig. 57. MMA—Medication Compliance 75%: 19–50 years
Statewide Weighted Rates



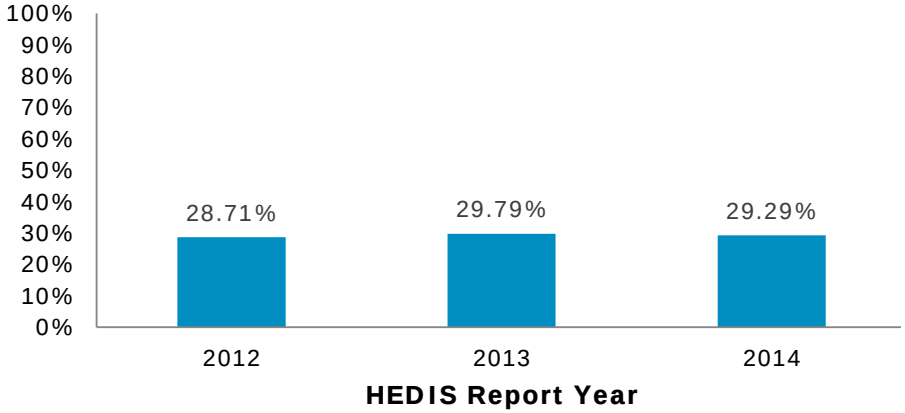
Footnote: First year data collection implemented in 2012.

Fig. 58. MMA—Medication Compliance 75%: 51–64 years
Statewide Weighted Rates



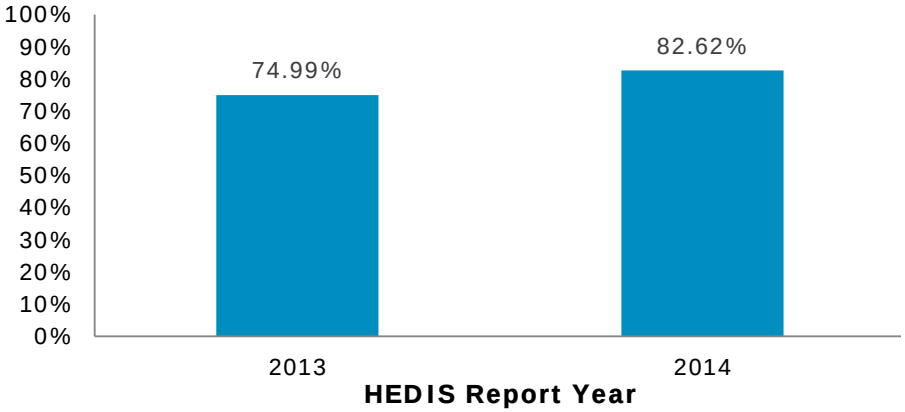
Footnote: First year data collection implemented in 2012.

Fig. 59. MMA—Medication Compliance 75%: Total
Statewide Weighted Rates



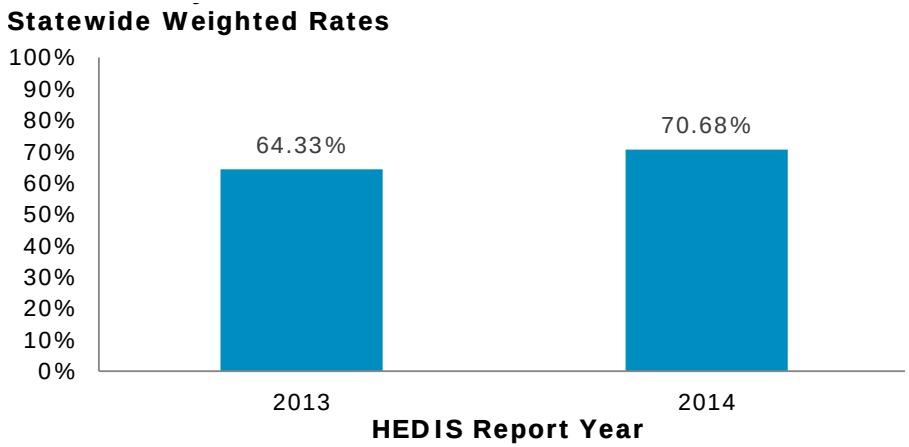
Footnote: First year data collection implemented in 2012.

Fig. 60. Asthma Medical Ratio (AMR): 5–11 years
Statewide Weighted Rates



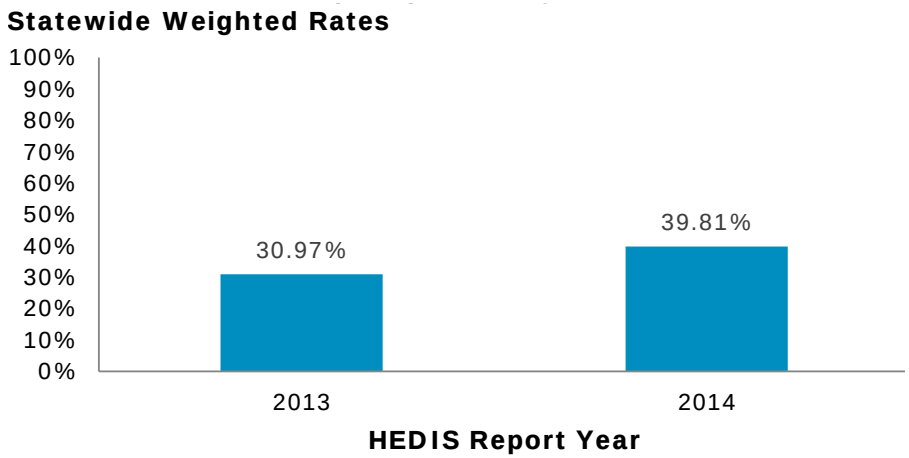
Footnote: First year data collection implemented in 2013.

Fig. 61. AMR: 12–18 years



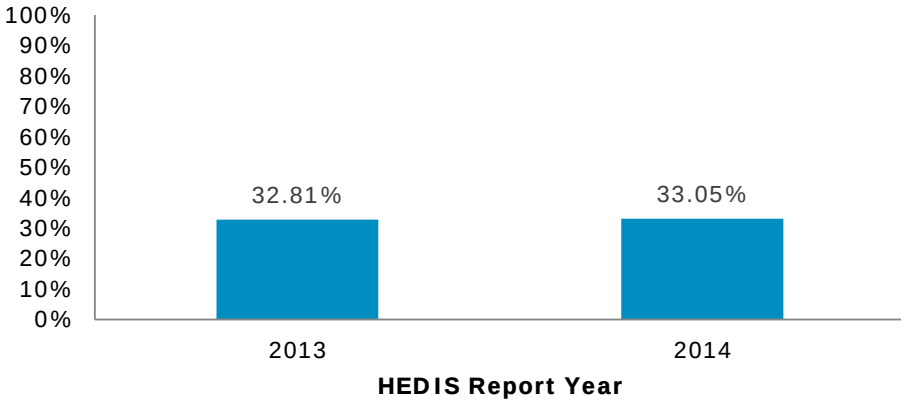
Footnote: First year data collection implemented in 2013.

Fig. 62. AMR: 19–50 years



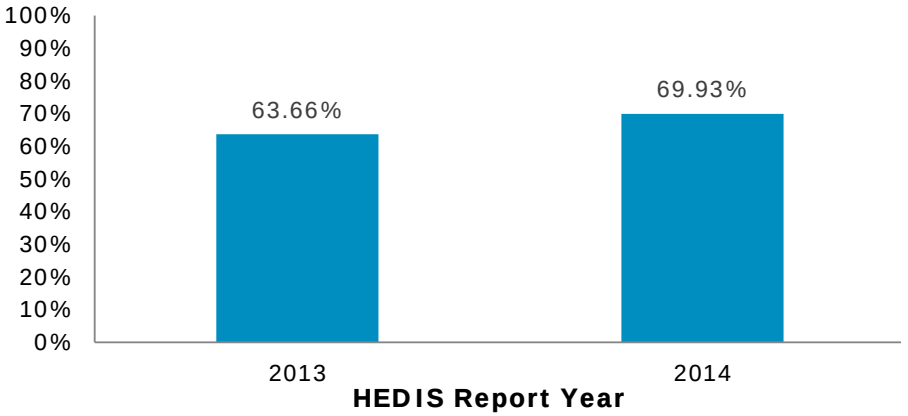
Footnote: First year data collection implemented in 2013.

Fig. 63. AMR: 51–64 years



Footnote: First year data collection implemented in 2013.

Fig. 64. AMR: Total



Footnote: First year data collection implemented in 2013.

Effectiveness of Care Measures—Cardiovascular Conditions

Fig. 65. Cholesterol Management for Patients With Cardiovascular Conditions (CMC)—LDL-C Screening
Statewide Weighted Rates

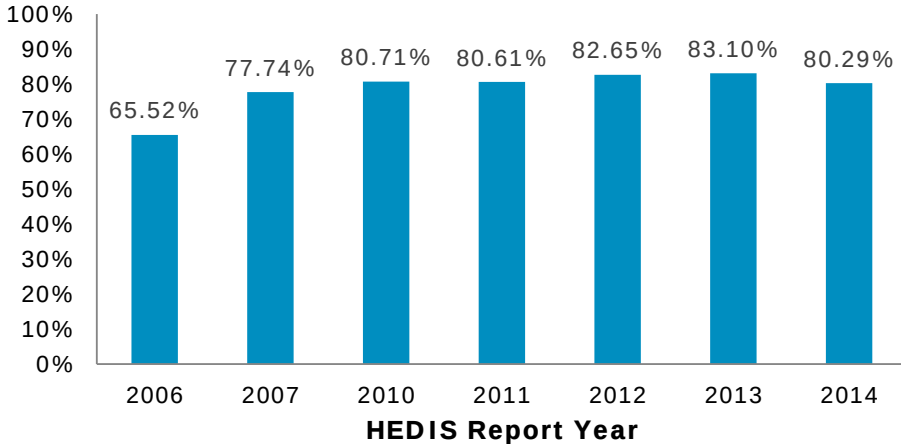


Fig. 66. CMC—LDL-C Control (<100 mg/dL)
Statewide Weighted Rates

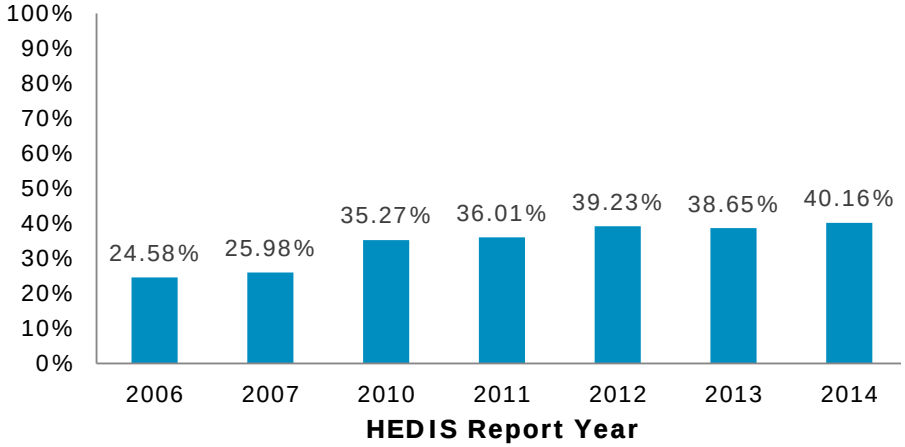


Fig. 67. Controlling High Blood Pressure (CBP)
Statewide Weighted Rates

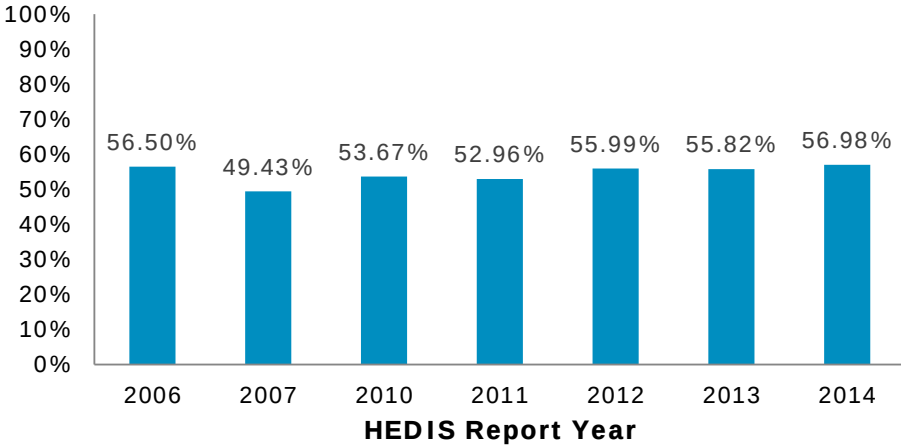
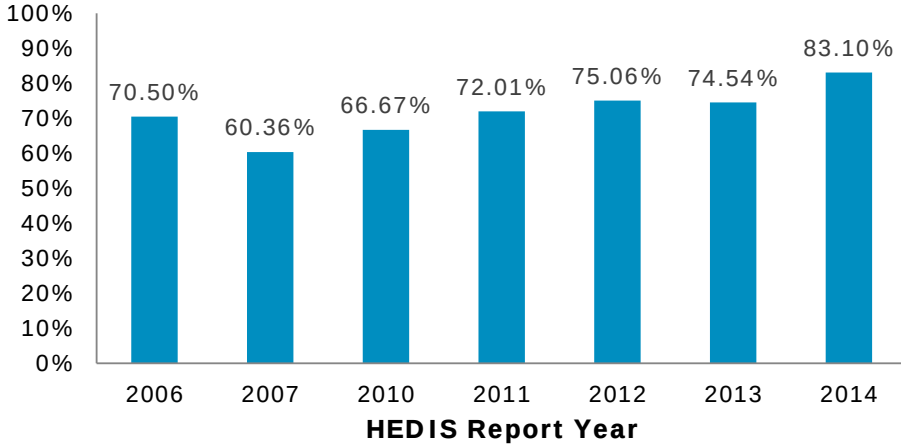


Fig. 68. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)
Statewide Weighted Rates



Effectiveness of Care Measures—Diabetes

Fig. 69. Comprehensive Diabetes Care (CDC)—HbA1c Testing

Statewide Weighted Rates

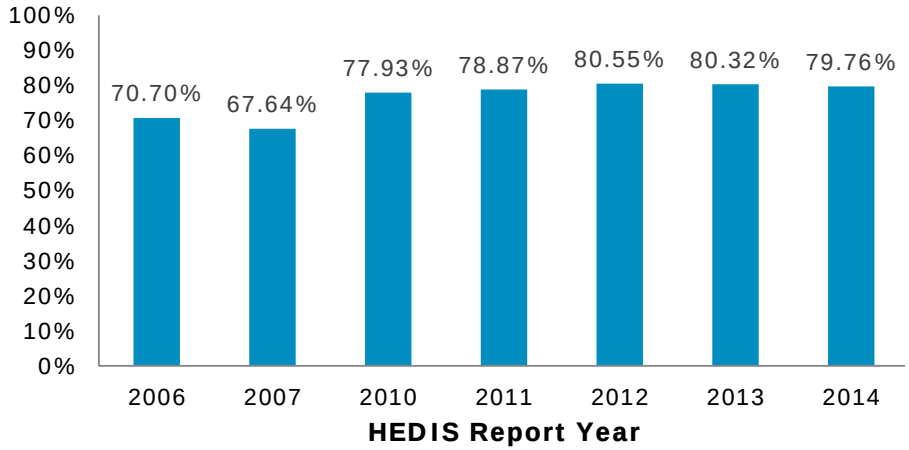
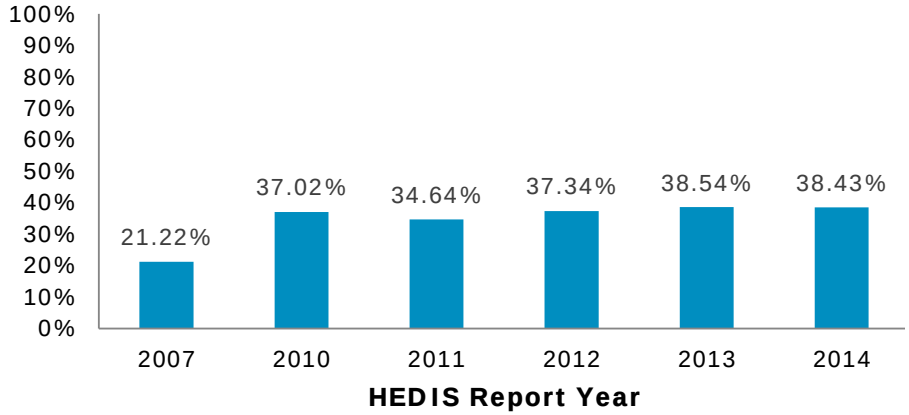


Fig. 70. CDC—HbA1c Control (<7.0%)

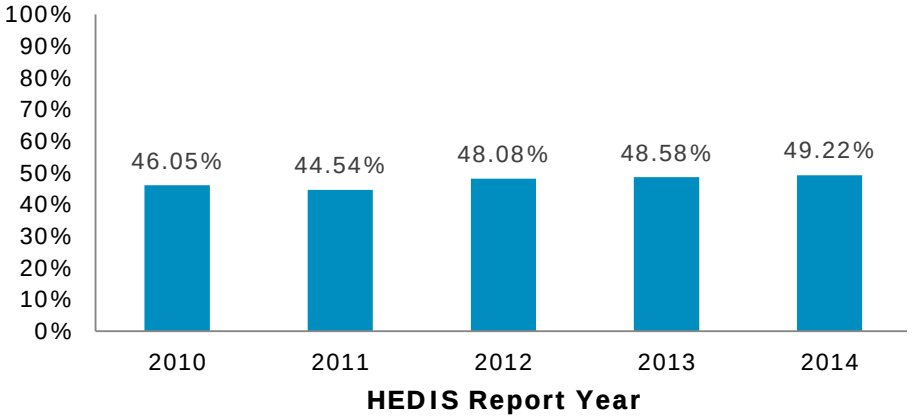
Statewide Weighted Rates



Footnote: First year data collection implemented in 2007.

Fig. 71. CDC—HbA1c Control (<8.0%)

Statewide Weighted Rates



Footnote: First year data collection implemented in 2009.

Fig. 72. CDC—Retinal Eye Exam Performed

Statewide Weighted Rates

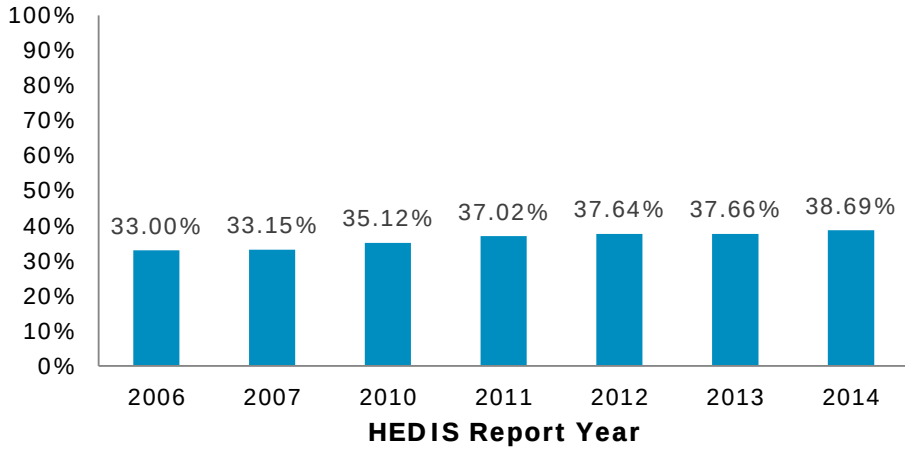


Fig. 73. CDC—LDL-C Screening
Statewide Weighted Rates

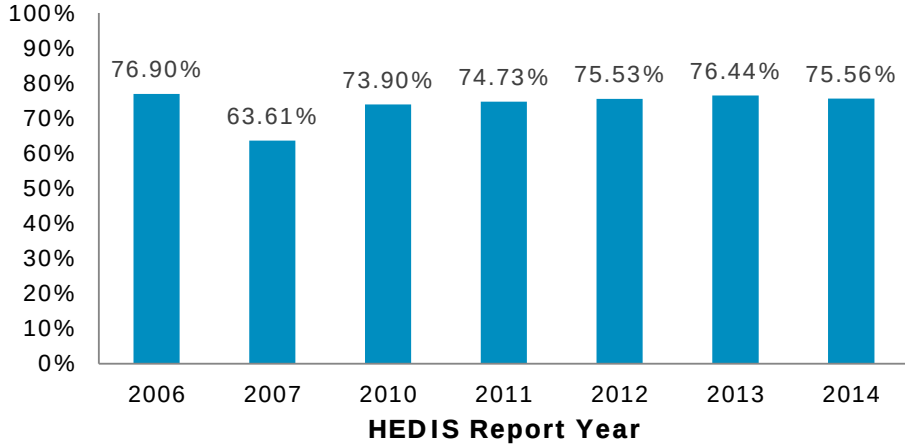


Fig. 74. CDC—LDL-C Control (<100 mg/dL)
Statewide Weighted Rates

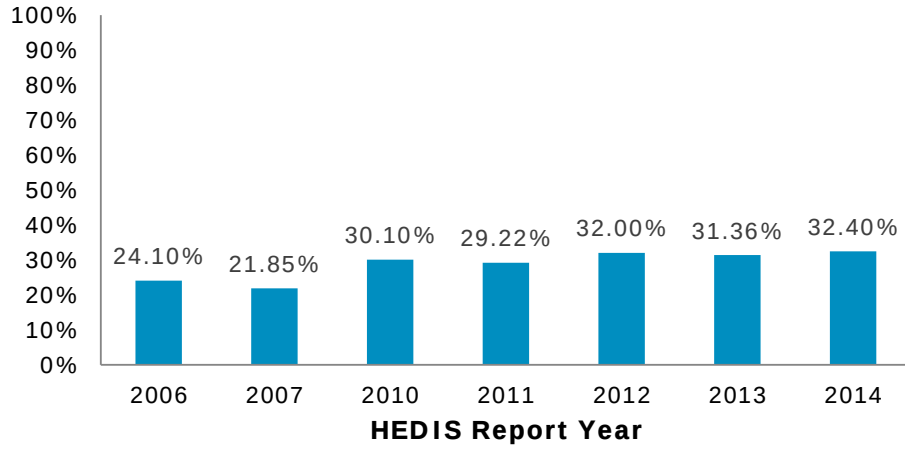


Fig. 75. CDC—Medical Attention for Nephropathy
Statewide Weighted Rates

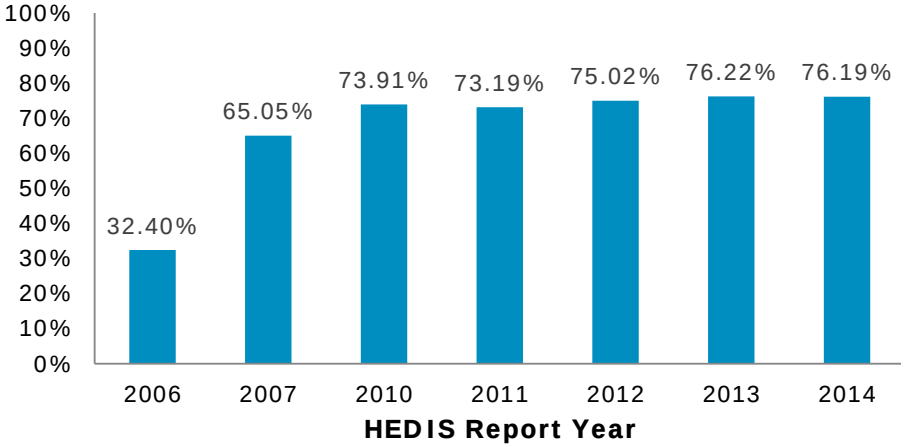
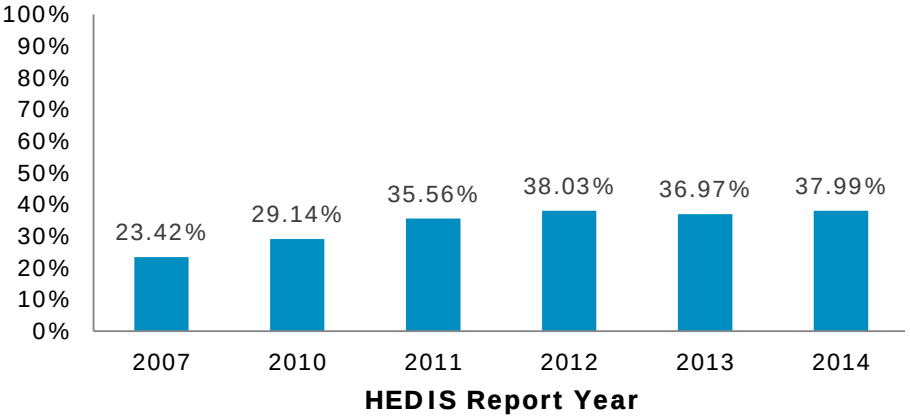


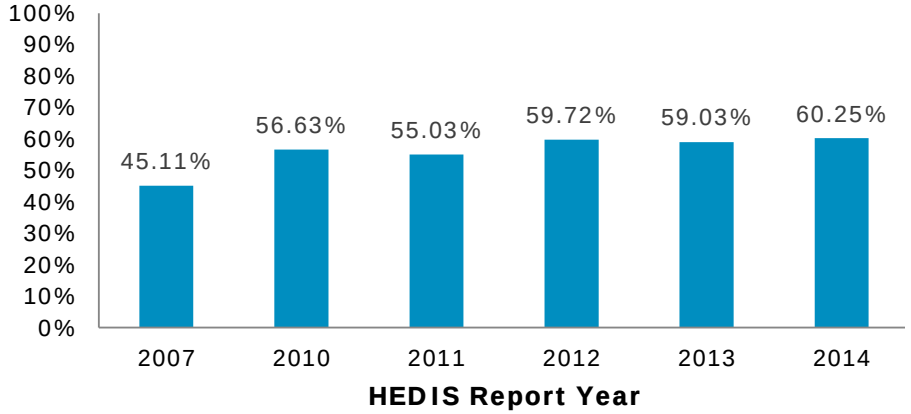
Fig. 76. CDC—Blood Pressure Control (<140/80 mm Hg)
Statewide Weighted Rates



Footnote: First year data collection implemented in 2007.

Fig. 77. CDC: Blood Pressure Control (<140/90 mm Hg)

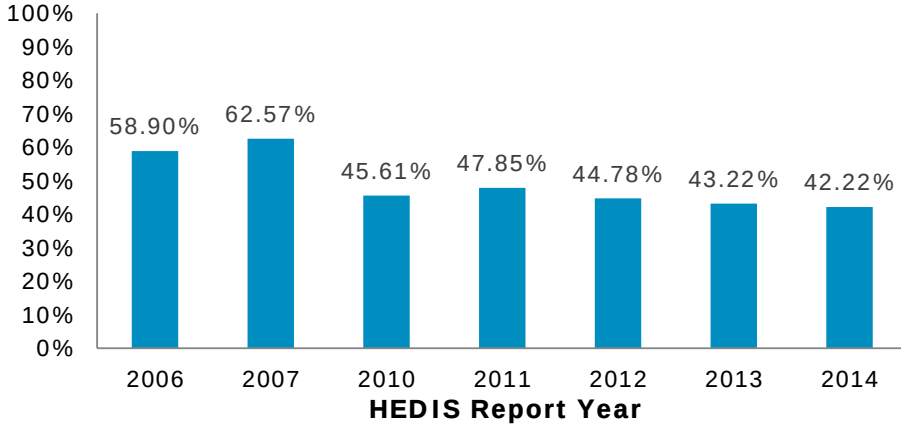
Statewide Weighted Rates



Footnote: First year data collection implemented in 2007.

Fig. 78. CDC—HbA1c Poor Control (>9.0%)*

Statewide Weighted Rates*



**Lower rates for this measure indicate better performance.*

Effectiveness of Care Measures—Musculoskeletal Conditions

Fig. 79. Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

Statewide Weighted Rates

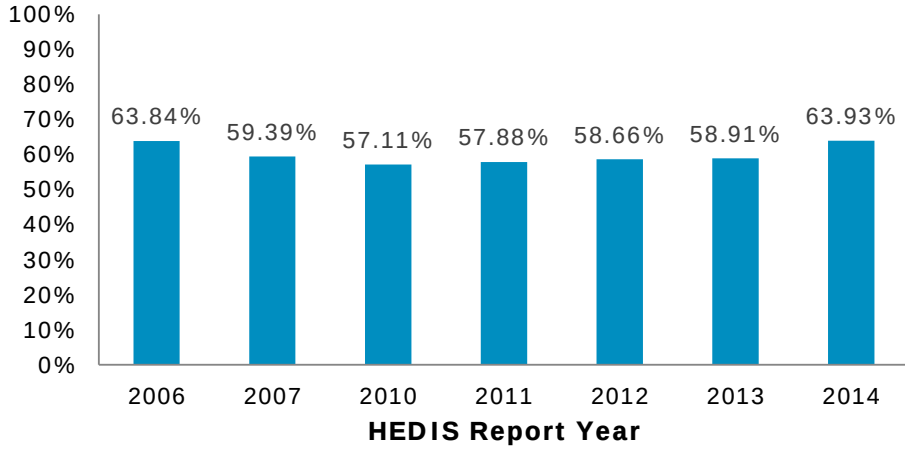
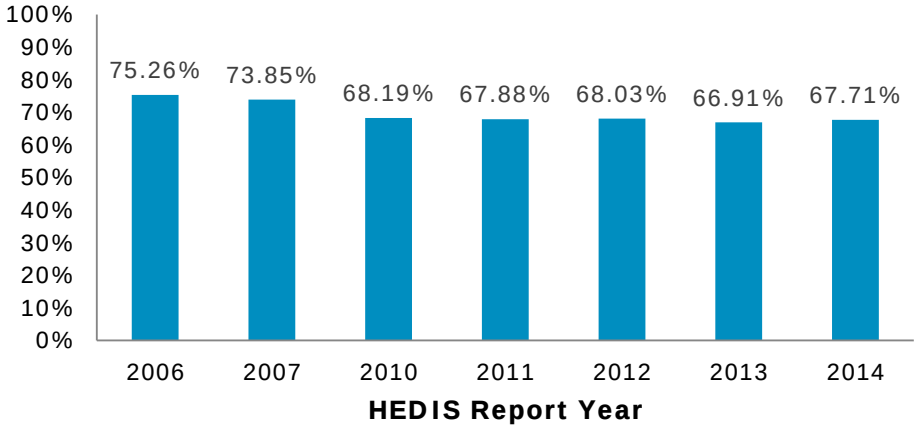


Fig. 80. Use of Imaging Studies for Low Back Pain (LBP)

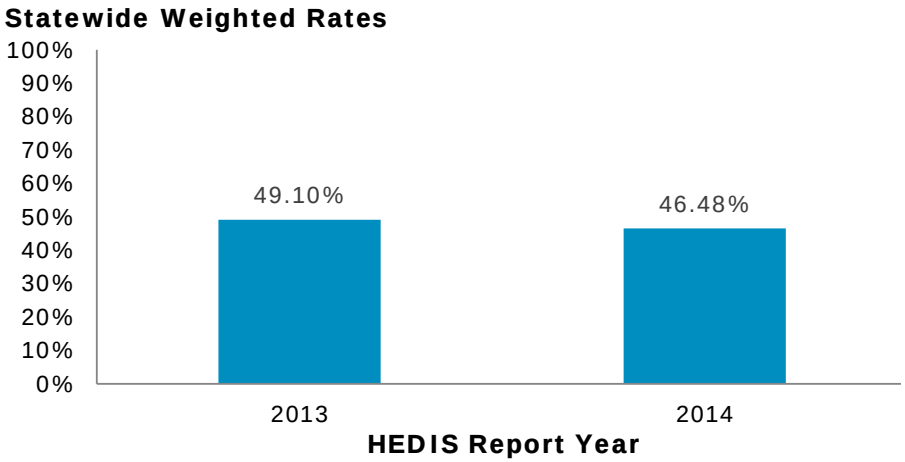
Statewide Weighted Rates



Footnote: United American Healthcare Corporation did not report this measure in 2007; hence, it was excluded from the statewide weighted average calculation for that report year.

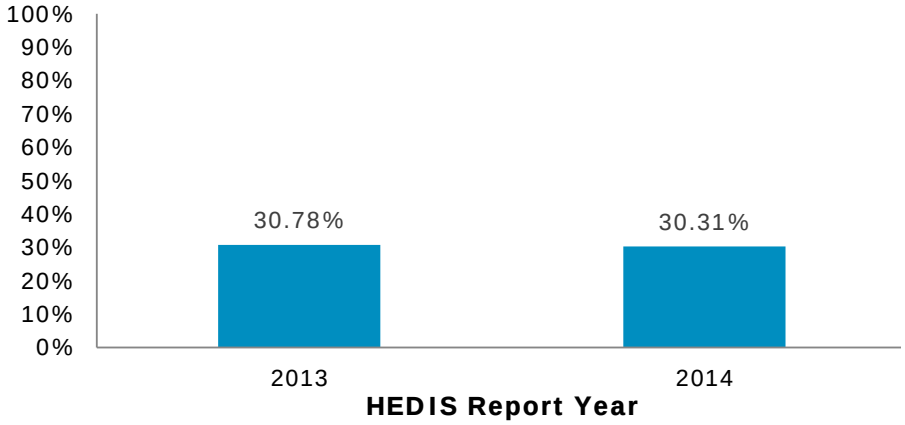
Effectiveness of Care Measures—Behavioral Health

Fig. 81. Antidepressant Medication Management (AMM)—Effective Acute Phase Treatment



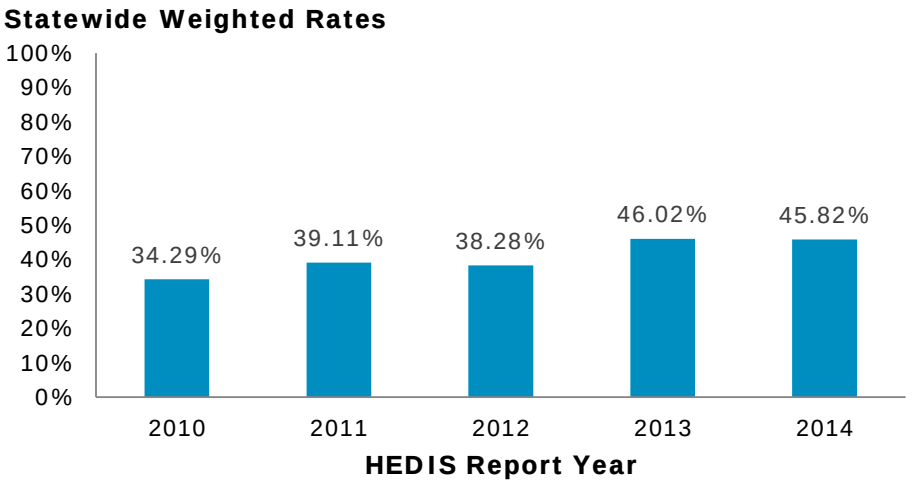
Footnote: Measure specification changed in 2013; as such, no comparative data are available from previous years.

Fig. 82. AMM—Effective Continuation Phase Treatment



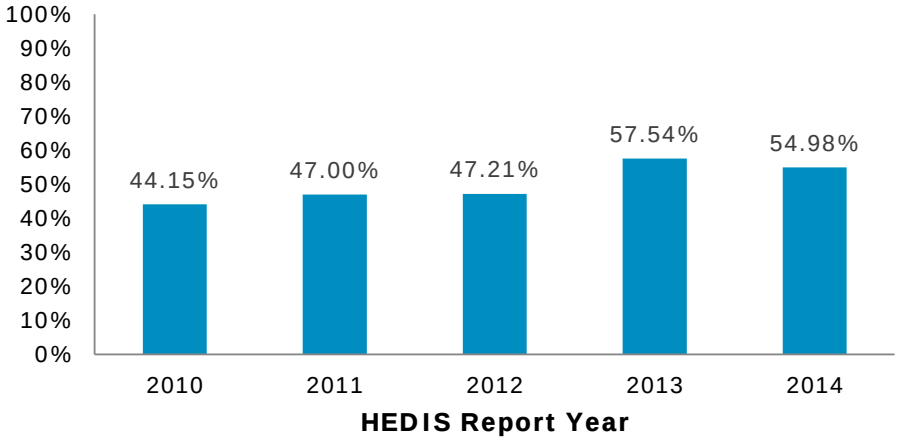
Footnote: Measure specification changed in 2013; as such, no comparative data are available from previous years.

Fig. 83. Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase



Footnote: Behavioral Health was carved out prior to HEDIS 2009; as such, no comparative data are available from previous years.

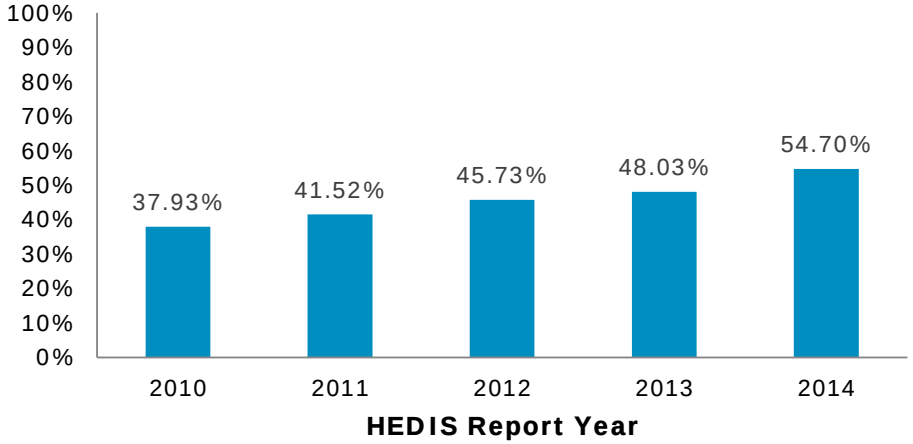
Fig. 84. ADD—Continuation and Maintenance Phase



Footnote: Behavioral Health was carved out prior to HEDIS 2009; as such, no comparative data are available from previous years.

Fig. 85. Follow-Up After Hospitalization for Mental Illness (FUH)—7-day follow-up

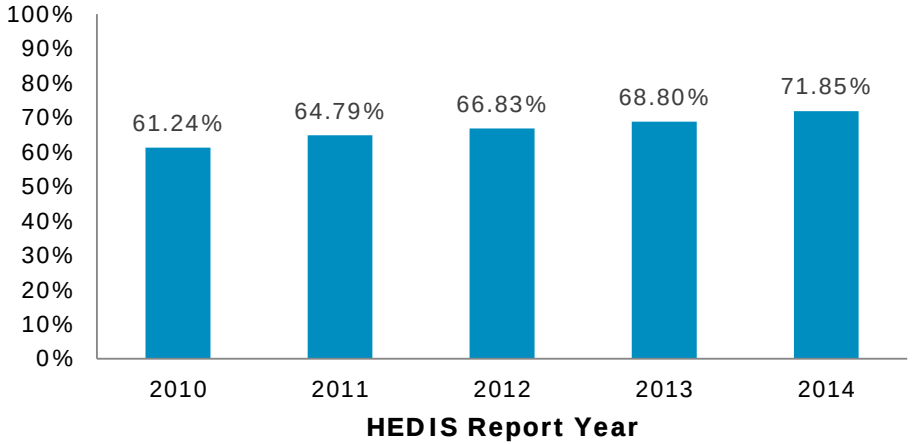
Statewide Weighted Rates



Footnote: Behavioral Health was carved out prior to HEDIS 2009; as such, no comparative data are available from previous years.

Fig. 86. FUH—30-day follow-up

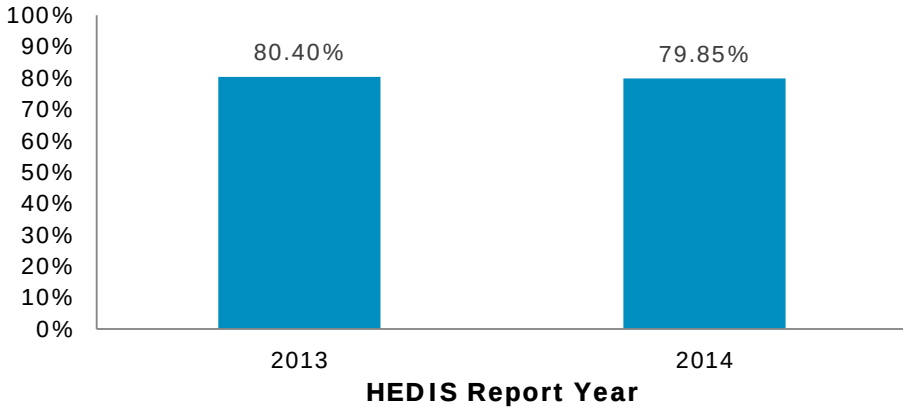
Statewide Weighted Rates



Footnote: Behavioral Health was carved out prior to HEDIS 2009; as such, no comparative data are available from previous years.

Fig. 87. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)

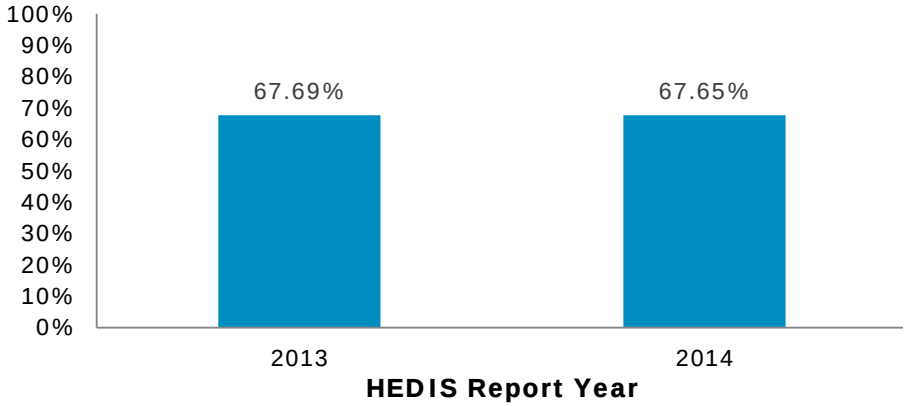
Statewide Weighted Rates



Footnote: First year data collection implemented in 2013.

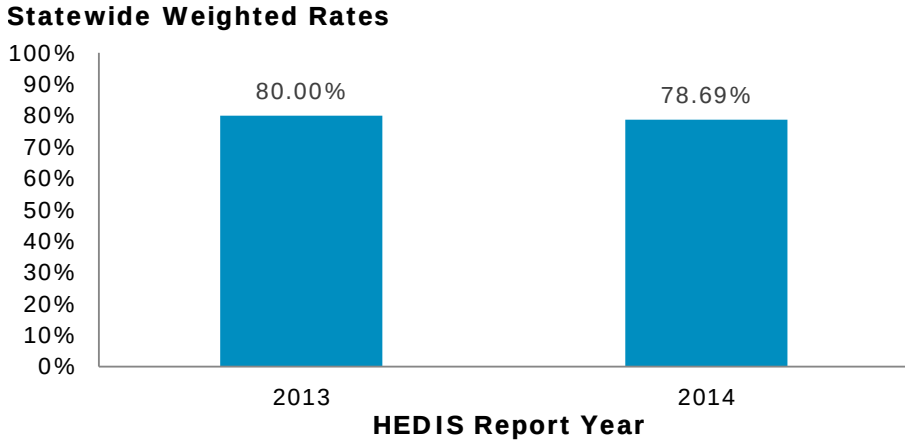
Fig. 88. Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

Statewide Weighted Rates



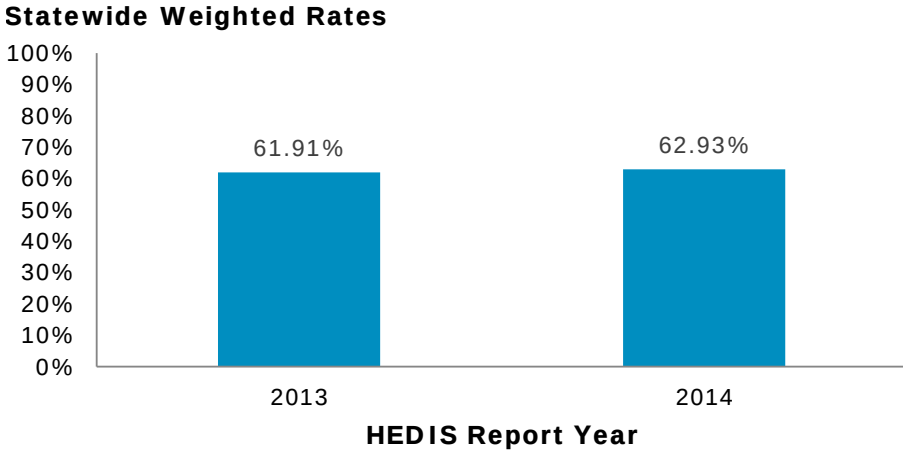
Footnote: First year data collection implemented in 2013.

Fig. 89. Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)



Footnote: First year data collection implemented in 2013.

Fig. 90. Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)



Footnote: First year data collection implemented in 2013.

Effectiveness of Care Measures—Medication Management

Fig. 91. Annual Monitoring for Patients on Persistent Medications (MPM)—ACE Inhibitors or ARBs

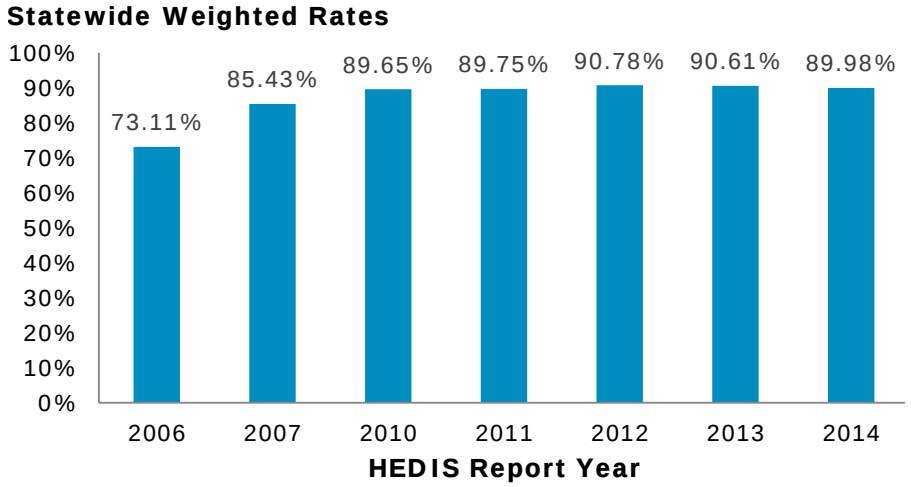


Fig. 92. MPM—Digoxin

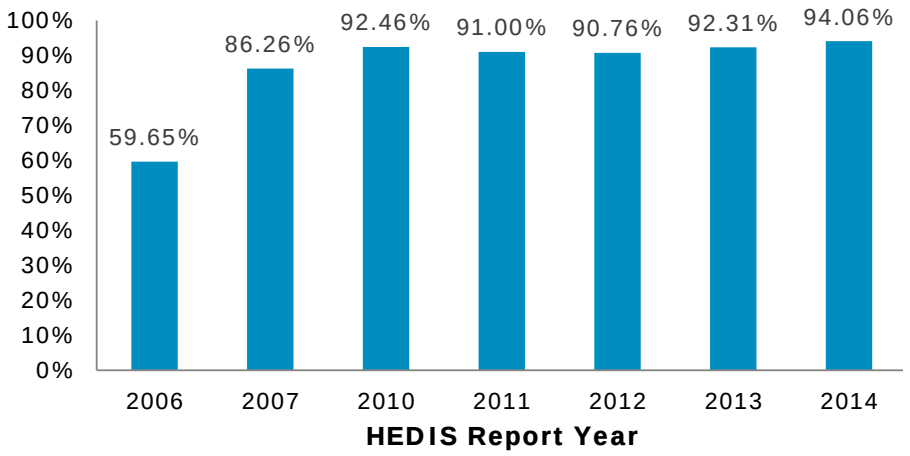


Fig. 93. MPM—Diuretics

Statewide Weighted Rates

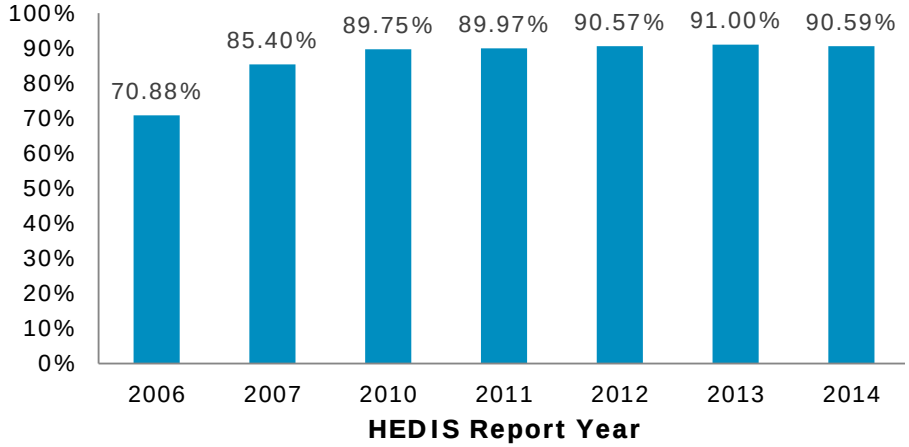


Fig. 94. MPM—Anticonvulsants

Statewide Weighted Rates

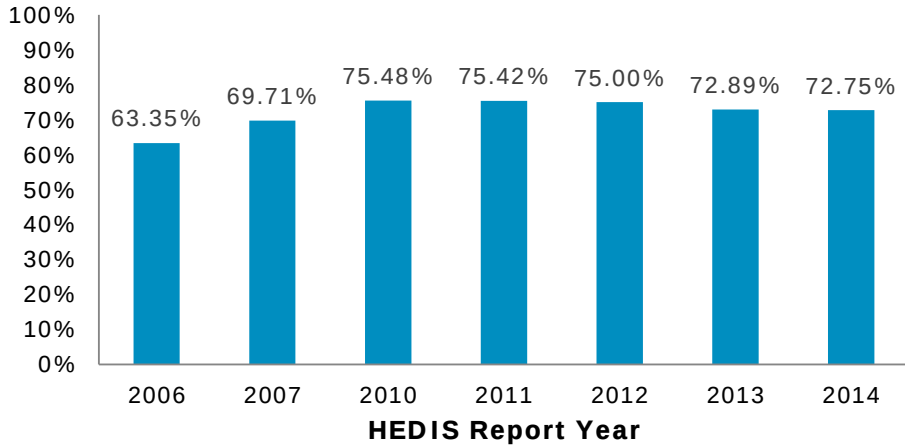
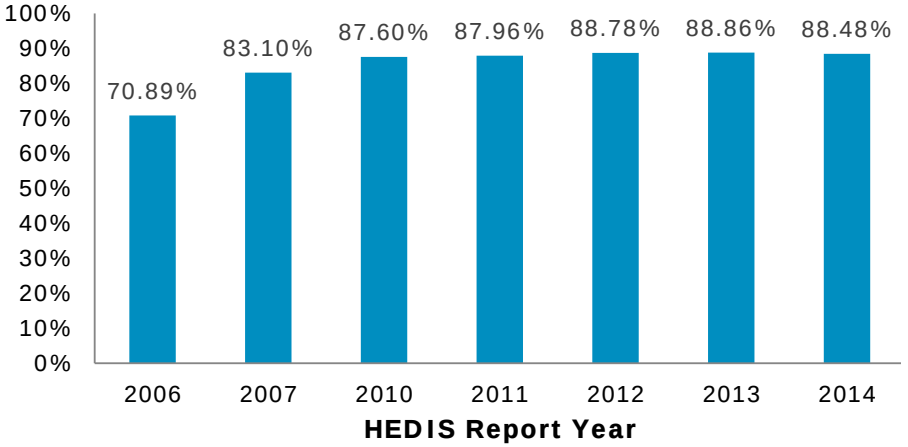


Fig. 95. MPM—Total

Statewide Weighted Rates



Access / Availability of Care Measures

Fig. 96. Adults' Access to Preventive / Ambulatory Health Services (AAP)—20–44 years

Statewide Weighted Rates

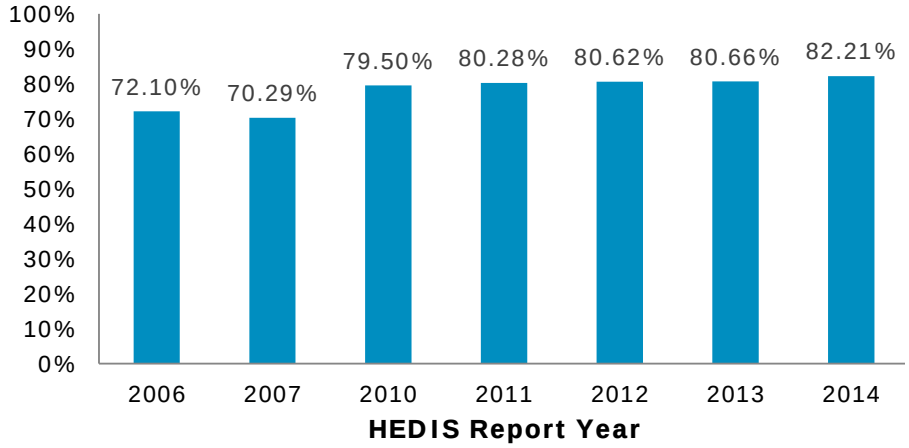


Fig. 97. AAP—45–64 years

Statewide Weighted Rates

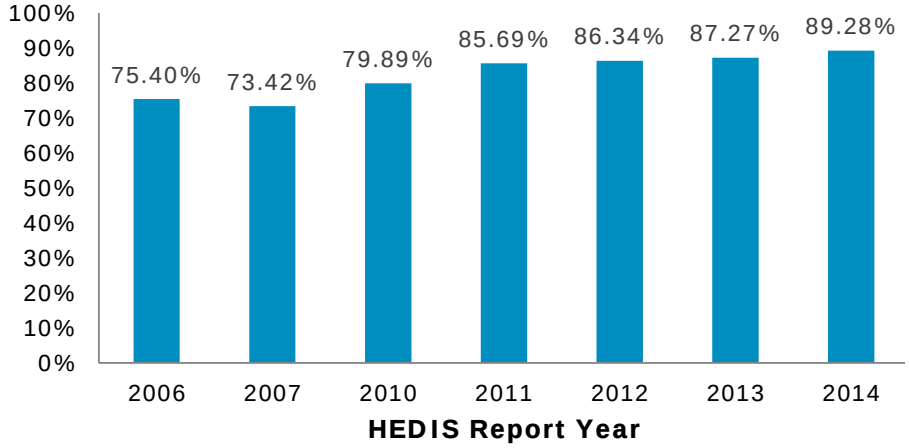


Fig. 98. Children and Adolescents' Access to Primary Care Practitioners (CAP)—12–24 months

Statewide Weighted Rates

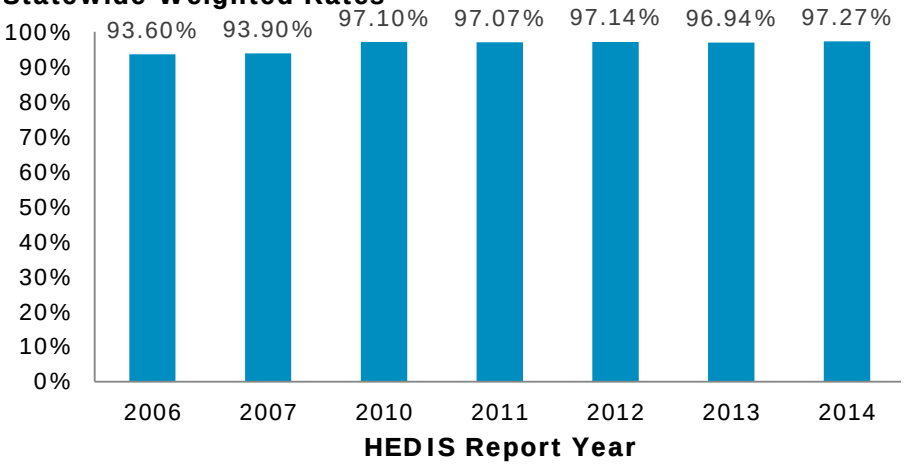


Fig. 99. CAP—25 months–6 years

Statewide Weighted Rates

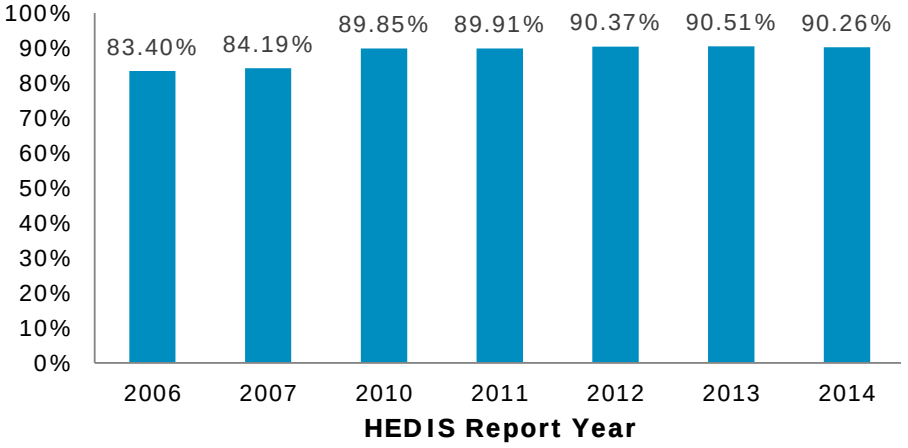


Fig. 100. CAP—7–11 years

Statewide Weighted Rates

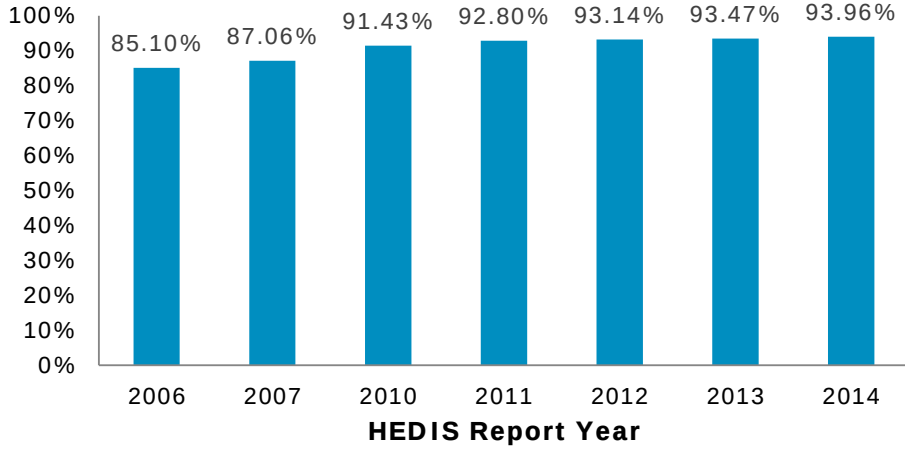


Fig. 101. CAP—12–19 years

Statewide Weighted Rates

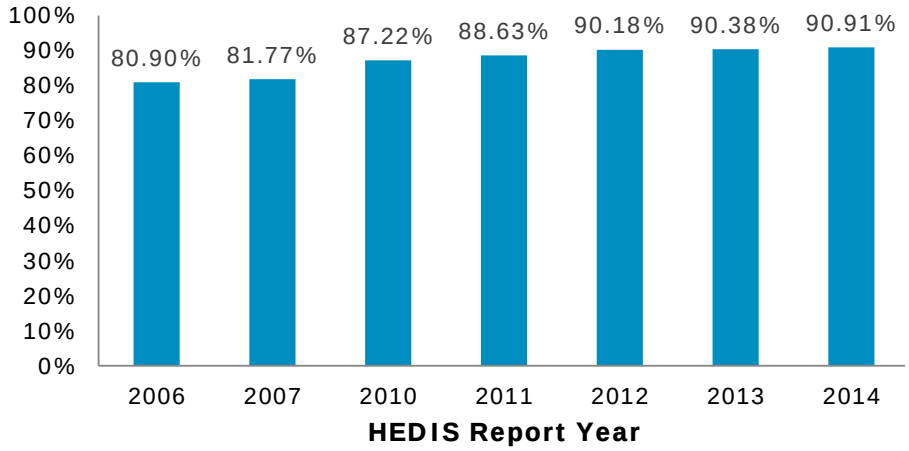
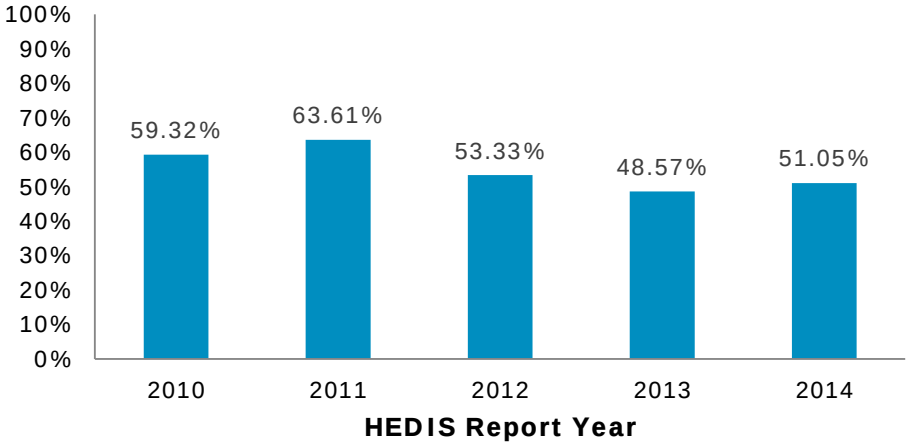


Fig. 102. Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)—Initiation of AOD Treatment: 13–17 years

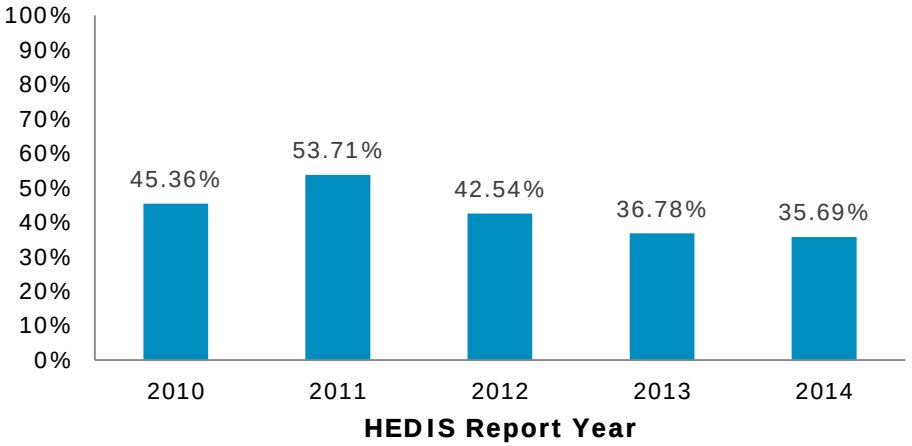
Statewide Weighted Rates



Footnote: Behavioral Health was carved out prior to HEDIS 2009; as such, no comparative data are available from previous years.

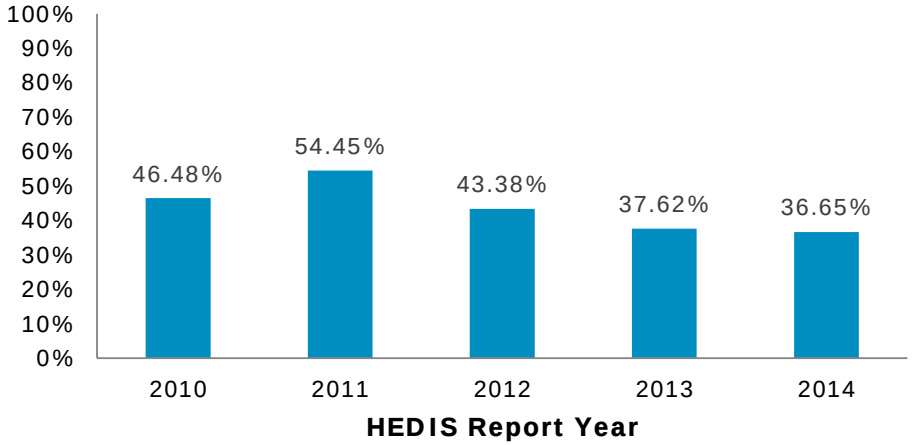
Fig. 103. IET—Initiation of AOD Treatment: ≥18 years

Statewide Weighted Rates



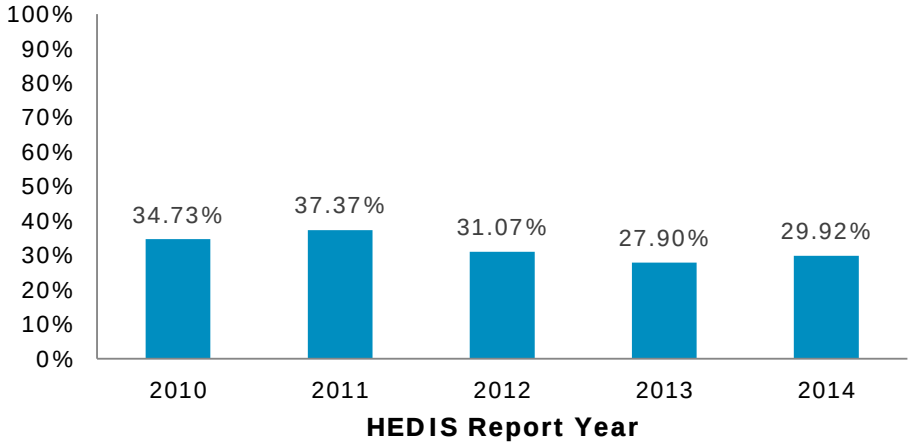
Footnote: Behavioral Health was carved out prior to HEDIS 2009; as such, no comparative data are available from previous years.

Fig. 104. IET—Initiation of AOD Treatment: Total
Statewide Weighted Rates



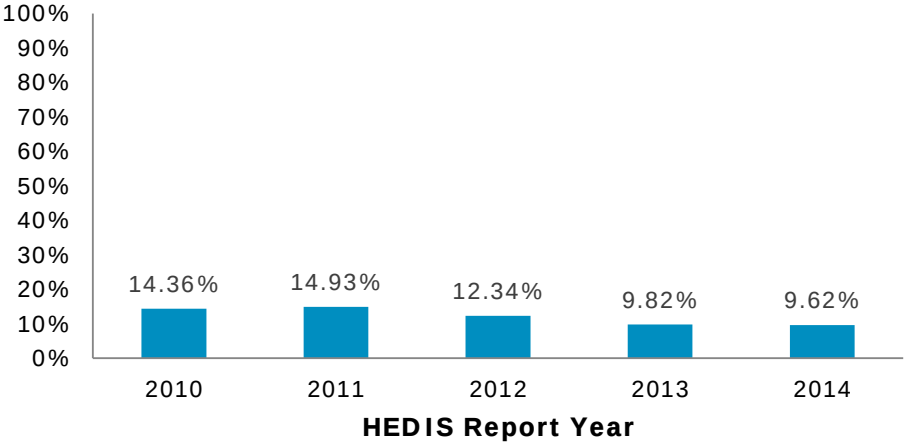
Footnote: Behavioral Health was carved out prior to HEDIS 2009; as such, no comparative data are available from previous years.

Fig. 105. IET—Engagement of AOD Treatment: 13–17 years
Statewide Weighted Rates



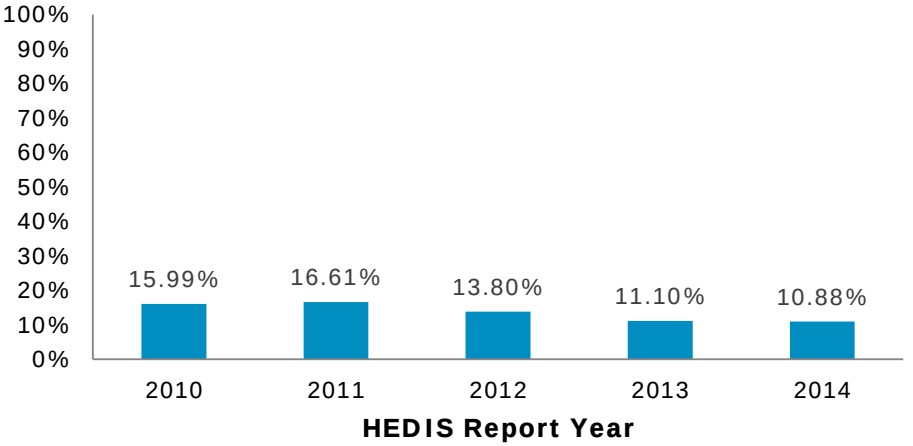
Footnote: Behavioral Health was carved out prior to HEDIS 2009; as such, no comparative data are available from previous years.

Fig. 106. IET—Engagement of AOD Treatment: ≥18 years
Statewide Weighted Rates



Footnote: Behavioral Health was carved out prior to HEDIS 2009; as such, no comparative data are available from previous years.

Fig. 107. IET—Engagement of AOD Treatment: Total
Statewide Weighted Rates



Footnote: Behavioral Health was carved out prior to HEDIS 2009; as such, no comparative data are available from previous years.

Fig. 108. Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care

Statewide Weighted Rates

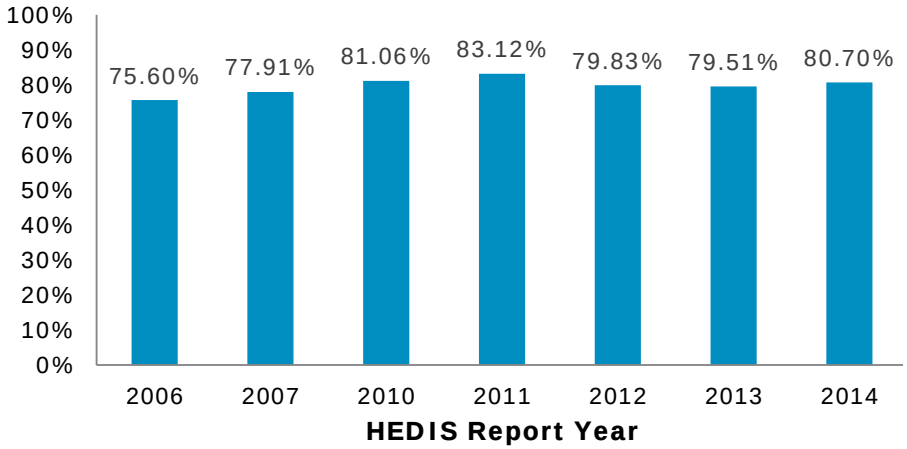


Fig. 109. PPC—Postpartum Care

Statewide Weighted Rates

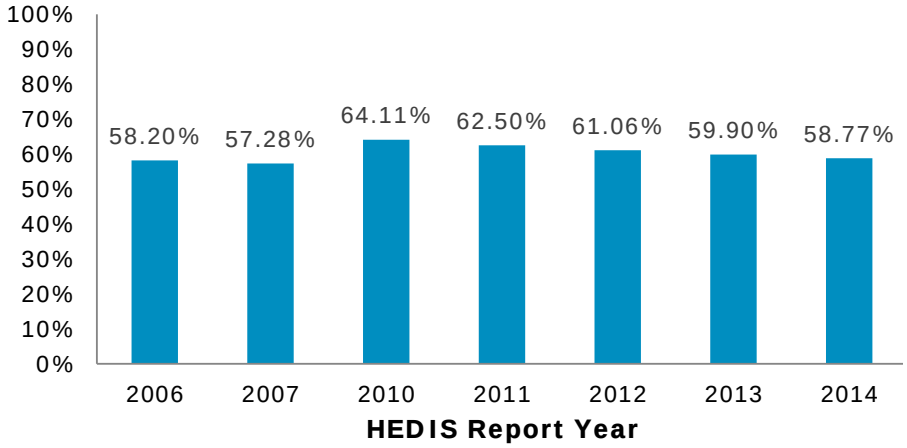
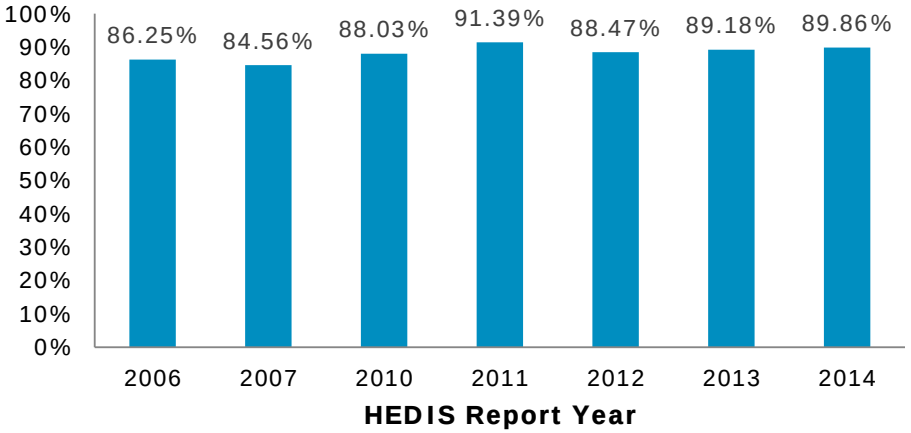


Fig. 110. Call Answer Timeliness (CAT)

Statewide Weighted Rates



Footnote: United American Healthcare Corporation, Unison and Windsor did not report this measure in 2006; hence, these health plans were excluded from statewide weighted average calculation.

Utilization and Relative Resource Use

Fig. 111. Frequency of Ongoing Prenatal Care (FPC) ≥ 81 %

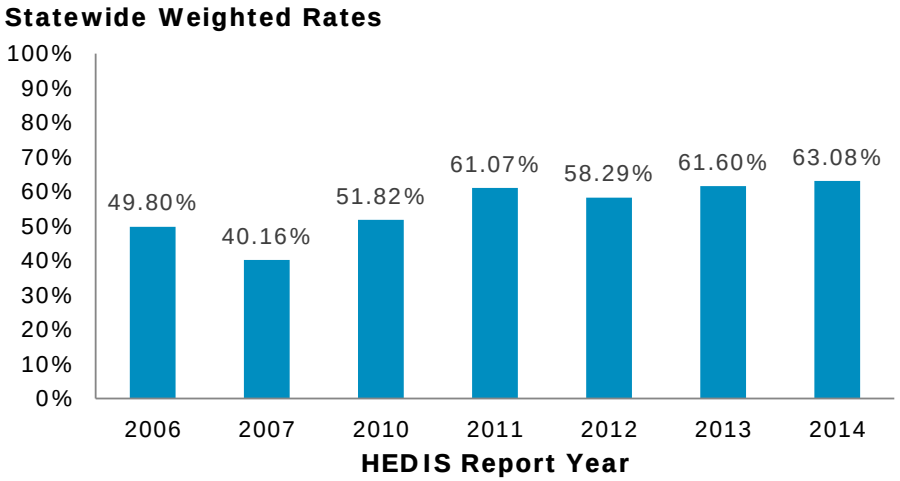


Fig. 112. Well-Child Visits in the First 15 Months of Life (W15)—6 or More Visits

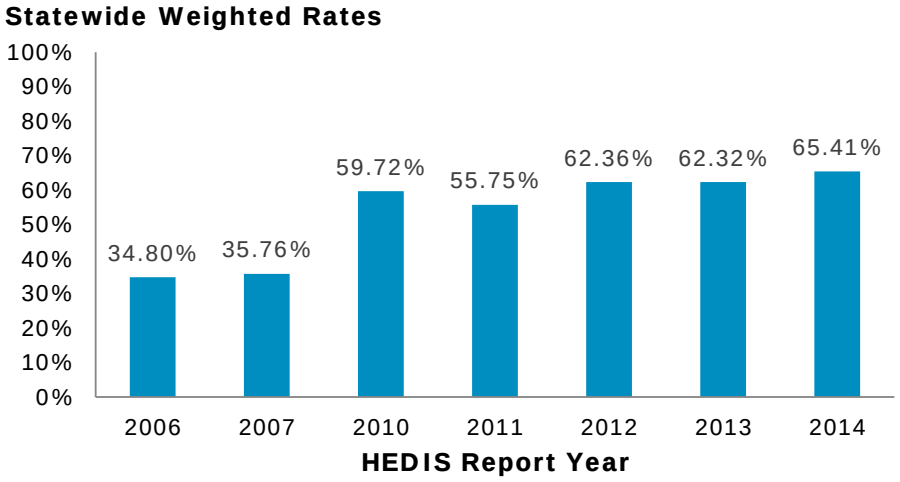


Fig. 113. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)

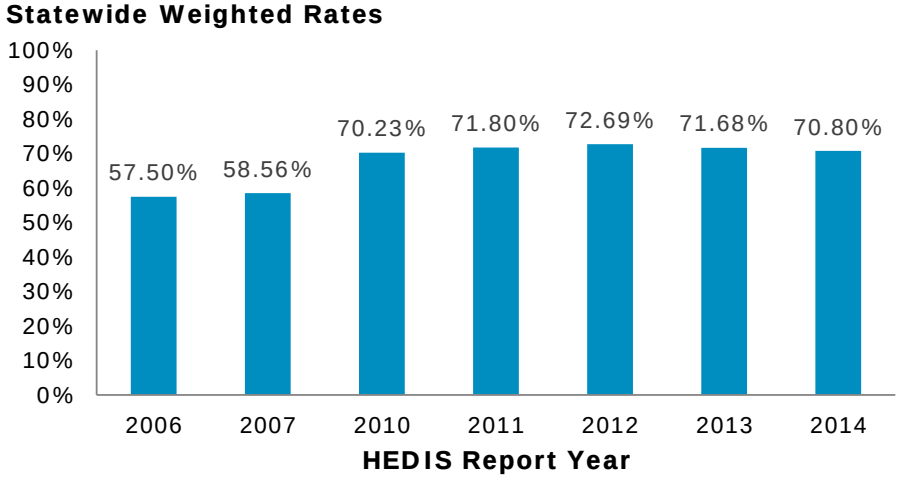
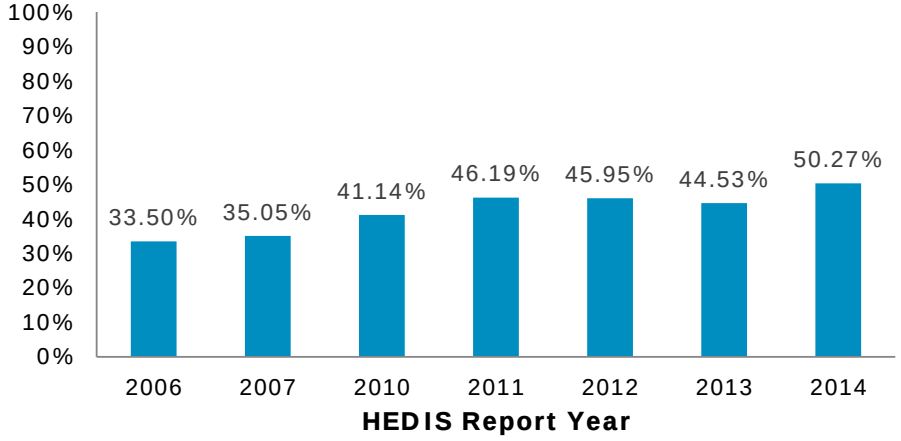


Fig. 114. Adolescent Well-Care Visits (AWC)



APPENDIX A | 2014 HEDIS Additional Measures, Rates and Benchmarks

Utilization Measures

Added Initially in 2009 Reporting

Frequency of Selected Procedure (FSP)

This measure summarized the utilization of frequently performed procedures that often show wide regional variation and have generated concern regarding potentially inappropriate utilization.

Ambulatory Care (AMB)

This measure summarizes utilization of ambulatory care in the following categories:

- Outpatient Visits
- Emergency Department (ED) Visits

Inpatient Utilization – General Hospital/Acute Care (IPU)

This measure summarizes utilization of acute inpatient (IP) care and services in the following categories:

- Total IP
- Medicine
- Surgery
- Maternity

Identification of Alcohol and Other Drug Services (IAD)

This measure summarizes the number and percentage of members with an alcohol and drug (AOD) claim who received the following chemical dependency services during the measurement year:

- Any services
- IP
- Intensive outpatient or partial hospitalization
- Outpatient or ED

Mental Health Utilization (MPT)

The number and percentage of members receiving the following mental health services during the measurement year:

- Any services
- IP
- Intensive outpatient or partial hospitalization
- Outpatient or ED

Antibiotic Utilization (ABX)

This measure summarizes the following data on outpatient utilization of antibiotic prescriptions during the measurement year, stratified by age and gender:

- Average number of antibiotic prescription per member per year (PMPY)
- Average days supplied per antibiotic prescription
- Average number of prescription PMPY for antibiotic of concern
- Percentage of antibiotic of concern for all antibiotic prescriptions
- Average number of antibiotics PMPY reported by drug class:
  - For selected 'antibiotics of concern'
  - For all other antibiotics

Utilization Measures: Plan-Specific Rates / National Benchmarks

In **Table A**, cells are shaded gray for those measures where age and/or sex segregation data were not available, and 'NA' is used for Not Applicable.

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures

Measure by Age / as Stated	Sex	AG	BCE	BCW	TCS	UHCE	UHCM	UHCW	HEDIS 2013 National Medicaid Means and Percentiles					
									Mean	P10	P25	P50	P75	P90
Frequency of Ongoing Prenatal Care (FPC):														
<21%	NA	4.63%	2.50%	9.76%	8.78%	5.21%	10.76%	10.95%	12.32%	2.32%	4.24%	8.27%	13.83%	27.39%
21–40%	NA	3.01%	4.72%	9.51%	7.63%	7.29%	5.13%	8.03%	5.94%	1.64%	2.78%	4.25%	6.56%	12.27%
41–60%	NA	9.26%	5.83%	11.95%	17.18%	6.51%	8.31%	15.33%	7.68%	3.89%	4.92%	6.83%	9.51%	12.99%
61–80%	NA	12.96%	11.67%	17.07%	24.81%	12.76%	14.43%	18.25%	13.62%	7.55%	10.55%	13.53%	16.31%	20.77%
≥81%	NA	70.14%	75.28%	51.71%	41.60%	68.23%	61.37%	47.45%	60.45%	36.25%	50.97%	64.70%	73.97%	80.12%
Well-Child Visits in the First 15 Months of Life (W15):														
0 Visits	NA	1.39%	0.28%	1.46%	3.41%	1.17%	1.35%	1.22%	1.80%	0.29%	0.73%	1.22%	2.13%	3.55%
1 Visits	NA	1.39%	1.13%	1.46%	2.68%	1.46%	0.00%	3.17%	1.81%	0.58%	1.01%	1.55%	2.26%	3.31%
2 Visits	NA	0.69%	1.41%	3.89%	6.08%	1.46%	1.08%	2.68%	2.91%	1.10%	2.03%	2.73%	3.64%	4.74%
3 Visits	NA	5.32%	7.06%	7.06%	8.27%	4.97%	4.31%	7.32%	5.01%	2.14%	3.58%	4.66%	6.12%	7.79%
4 Visits	NA	9.26%	6.78%	14.36%	15.82%	5.26%	5.93%	9.76%	8.98%	4.68%	6.70%	8.61%	10.95%	12.96%
5 Visits	NA	15.74%	13.56%	19.95%	18.25%	11.70%	11.86%	18.54%	15.51%	9.15%	12.24%	15.34%	18.73%	21.65%
6 or More Visits	NA	66.20%	69.77%	51.82%	45.50%	73.98%	75.47%	57.32%	63.65%	49.70%	55.95%	65.16%	70.90%	77.44%
Frequency of Selected Procedures (FSP)														
Bariatric weight loss surgery: *Procedures /1,000 Member Years*														
0–19	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
20–44		0.00	0.00	0.00	0.00	0.01	0.01	0.00	0.03	0.00	0.00	0.01	0.04	0.07
45–64		0.01	0.00	0.00	0.00	0.00	0.04	0.00	0.03	0.00	0.00	0.00	0.04	0.07
0–19	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
20–44		0.01	0.01	0.00	0.00	0.06	0.06	0.01	0.10	0.00	0.02	0.07	0.15	0.24
45–64		0.06	0.02	0.00	0.00	0.06	0.08	0.01	0.11	0.00	0.00	0.08	0.16	0.26
Tonsillectomy: *Procedures /1,000 Member Years*														
0–9	M&F	0.94	1.27	0.64	1.04	1.22	0.99	0.66	0.73	0.26	0.51	0.74	0.93	1.16
10–19		0.45	0.58	0.28	0.27	0.54	0.47	0.34	0.35	0.11	0.22	0.35	0.48	0.59

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age / as Stated	**Sex**	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid Means and Percentiles**					
									Mean	**P10**	**P25**	**P50**	**P75**	**P90**
Hysterectomy—Abdominal (A) and Vaginal (V): *Procedures /1,000 Member Years*														
A 15–44	F	0.16	0.15	0.15	0.03	0.20	0.30	0.15	0.19	0.06	0.14	0.18	0.24	0.32
A 45–64		0.31	0.23	0.28	0.00	0.23	0.36	0.34	0.37	0.21	0.27	0.35	0.45	0.59
V 15–44	F	0.26	0.32	0.06	0.00	0.41	0.22	0.10	0.18	0.03	0.09	0.16	0.24	0.31
V 45–64		0.19	0.33	0.09	0.00	0.22	0.22	0.09	0.22	0.05	0.12	0.19	0.29	0.41
Cholecystectomy—Open (O) and Closed (C) / Laparoscopic: *Procedures /1,000 Member Years*														
O 30–64	M	0.03	0.03	0.01	0.53	0.05	0.03	0.06	0.04	0.00	0.00	0.03	0.06	0.08
O 15–44	F	0.01	0.01	0.02	0.01	0.02	0.01	0.02	0.02	0.00	0.01	0.01	0.02	0.03
O 45–64		0.05	0.03	0.03	0.32	0.07	0.07	0.07	0.05	0.00	0.01	0.05	0.08	0.11
C 30–64	M	0.51	0.53	0.29	1.06	0.64	0.41	0.22	0.35	0.16	0.22	0.30	0.41	0.55
C 15–44	F	0.93	1.04	0.60	1.27	1.14	1.13	0.52	0.79	0.44	0.58	0.78	0.95	1.21
C 45–64		0.89	1.03	0.52	3.19	0.77	0.86	0.60	0.72	0.39	0.55	0.72	0.86	1.09
Back Surgery: *Procedures /1,000 Member Years*														
20–44	M	0.40	0.46	0.24	0.05	0.50	0.49	0.31	0.34	0.07	0.17	0.30	0.45	0.61
	F	0.36	0.29	0.11	0.00	0.34	0.44	0.09	0.31	0.07	0.12	0.19	0.29	0.38
45–64	M	0.83	0.78	0.49	0.00	0.90	1.39	0.29	0.66	0.19	0.36	0.59	0.91	1.10
	F	0.90	0.70	0.40	0.32	0.94	1.32	0.44	0.62	0.26	0.37	0.57	0.80	0.95
Mastectomy: *Procedures /1,000 Member Years*														
15–44	F	0.02	0.04	0.03	0.04	0.03	0.05	0.02	0.03	0.00	0.01	0.02	0.04	0.05
45–64		0.40	0.68	0.59	0.00	0.27	0.63	0.19	0.19	0.00	0.09	0.14	0.23	0.37
Lumpectomy: *Procedures /1,000 Member Years*														
15–44	F	0.18	0.18	0.14	0.04	0.14	0.17	0.13	0.15	0.09	0.12	0.15	0.18	0.22
45–64		0.65	0.68	1.11	0.00	0.39	0.99	0.47	0.48	0.25	0.35	0.43	0.55	0.74
Ambulatory Care: Total (AMB)														
Outpatient Visits: *Visits/1,000 Member Months*														
<1	NA	792.71	830.53	701.45	815.15	715.98	748.36	636.52						
1–9	NA	315.20	331.34	302.89	363.72	280.16	318.40	265.27						
10–19	NA	249.28	278.98	234.92	250.59	230.75	245.24	196.63						
20–44	NA	385.23	417.33	381.54	225.33	374.92	469.39	338.57						
45–64	NA	722.46	766.73	670.18	353.59	683.46	851.54	599.31						
65–74	NA	536.89	433.88	471.30	750.00	823.91	870.86	660.60						
75–84	NA	357.95	163.77	208.71	0.00	718.96	612.50	536.15						
≥85	NA	267.07	76.19	58.93	0.00	530.58	356.46	378.25						
Total	**NA**	**369.68**	**404.12**	**349.61**	**306.91**	**366.06**	**409.59**	**314.44**	**376.06**	**267.87**	**318.74**	**361.58**	**410.96**	**469.74**

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	Sex	AG	BCE	BCW	TCS	UHCE	UHCM	UHCW	HEDIS 2013 National Medicaid Means and Percentiles					
									Mean	P10	P25	P50	P75	P90
ED Visits: *Visits/1,000 Member Months*														
<1	NA	96.45	119.13	115.86	77.72	124.46	94.44	113.20						
1–9	NA	52.29	69.33	55.62	50.59	67.58	55.03	54.10						
10–19	NA	48.57	64.40	42.43	45.63	64.70	52.61	43.13						
20–44	NA	123.00	138.96	107.24	75.64	141.81	135.07	109.99						
45–64	NA	101.43	113.12	98.43	61.25	117.96	114.78	100.45						
65–74	NA	47.12	51.88	48.18	164.29	83.62	78.28	69.80						
75–84	NA	29.74	5.80	13.51	142.86	73.50	67.29	46.69						
≥85	NA	31.71	8.33	0.00	0.00	51.31	40.80	36.95						
Total	**NA**	**75.25**	**93.20**	**71.55**	**50.19**	**93.92**	**82.27**	**72.52**	**65.58**	**44.56**	**53.98**	**65.65**	**75.53**	**85.99**
Inpatient Utilization—General Hospital/Acute Care: Total (IPU)														
Total Inpatient														
Discharges: *Discharges/1,000 Member Months*														
<1	NA	10.18	9.30	9.06	26.56	10.64	8.57	8.90						
1–9	NA	1.22	1.45	1.48	7.31	1.22	1.25	1.30						
10–19	NA	3.03	3.02	2.85	4.72	3.08	3.13	3.03						
20–44	NA	16.35	16.63	15.13	22.77	15.38	18.17	15.39						
45–64	NA	27.10	23.61	24.35	33.08	25.15	27.96	23.86						
65–74	NA	18.15	19.84	20.53	321.43	33.72	33.76	27.47						
75–84	NA	17.44	2.90	18.02	685.71	34.22	33.83	34.05						
≥85	NA	8.54	7.14	6.93	900.00	35.32	24.12	29.56						
Total	**NA**	**7.95**	**8.40**	**7.49**	**7.72**	**9.14**	**9.08**	**8.02**	**8.75**	**5.88**	**6.79**	**7.84**	**9.05**	**11.30**
Days: *Days/1,000 Member Months*														
<1	NA	69.28	64.68	59.62	399.65	94.40	56.84	84.38						
1–9	NA	3.98	4.52	5.48	46.13	4.02	3.55	4.43						
10–19	NA	9.00	9.79	8.51	27.01	9.31	10.32	10.80						
20–44	NA	51.25	54.42	51.20	97.62	52.70	54.69	50.62						
45–64	NA	137.55	124.60	159.77	210.61	124.98	125.10	137.86						
65–74	NA	101.97	163.78	173.02	1757.14	160.85	166.49	142.56						
75–84	NA	82.05	60.87	150.15	4428.57	153.03	143.88	194.67						
≥85	NA	69.51	88.10	140.38	4400.00	172.52	96.78	140.39						
Total	**NA**	**30.63**	**33.46**	**32.20**	**50.85**	**38.67**	**33.06**	**34.65**	**35.23**	**20.43**	**22.82**	**28.28**	**35.08**	**46.07**

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age / as Stated	**Sex**	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid Means and Percentiles**					
									Mean	**P10**	**P25**	**P50**	**P75**	**P90**
Average Length of Stay: *Average # of Days*														
<1	NA	6.80	6.96	6.58	15.05	8.87	6.63	9.48						
1–9	NA	3.27	3.12	3.70	6.31	3.29	2.84	3.41						
10–19	NA	2.97	3.25	2.99	5.72	3.03	3.30	3.57						
20–44	NA	3.14	3.27	3.38	4.29	3.43	3.01	3.29						
45–64	NA	5.08	5.28	6.56	6.37	4.97	4.47	5.78						
65–74	NA	5.62	8.26	8.43	5.47	4.77	4.93	5.19						
75–84	NA	4.71	21.00	8.33	6.46	4.47	4.25	5.72						
≥85	NA	8.14	12.33	20.25	4.89	4.88	4.01	4.75						
Unknown	NA	NA	NA	NA	NA	NA	NA	NA						
Total	**NA**	**3.85**	**3.98**	**4.30**	**6.59**	**4.23**	**3.64**	**4.32**	**3.77**	**2.98**	**3.35**	**3.70**	**4.06**	**4.43**
Medicine														
Discharges: *Discharges/1,000 Member Months*														
<1	NA	8.32	8.15	7.72	19.99	9.02	7.20	6.31						
1–9	NA	0.87	1.26	1.25	5.83	0.92	0.93	0.97						
10-19	NA	0.80	0.82	0.75	3.27	0.83	0.79	0.67						
20–44	NA	3.32	4.20	3.75	10.71	4.13	3.85	3.64						
45–64	NA	18.00	18.40	19.08	22.93	16.64	18.28	15.48						
65–74	NA	11.97	15.26	17.60	207.14	24.90	23.45	17.88						
75–84	NA	13.33	2.90	13.51	371.43	25.81	25.53	27.30						
≥85	NA	4.88	5.95	6.93	900.00	28.63	20.25	23.22						
Total	**NA**	**3.13**	**3.85**	**3.37**	**5.38**	**4.39**	**3.68**	**3.27**	**4.19**	**1.66**	**2.57**	**3.32**	**4.30**	**6.05**
Days: *Days/1,000 Member Months*														
<1	NA	38.30	52.36	33.12	180.38	73.65	42.49	26.12						
1–9	NA	1.99	3.70	3.95	31.12	2.33	2.04	2.58						
10–19	NA	2.42	2.96	2.40	18.03	2.41	2.66	2.22						
20–44	NA	11.30	18.72	18.14	49.19	15.07	12.17	12.56						
45–64	NA	69.92	89.38	110.10	111.86	63.88	63.59	66.37						
65–74	NA	52.53	116.48	137.83	814.29	97.35	92.93	72.30						
75–84	NA	54.36	60.87	90.09	2628.57	101.78	90.81	135.18						
≥85	NA	28.05	82.14	140.38	4400.00	126.79	82.19	95.36						
Total	**NA**	**11.36**	**17.87**	**16.42**	**30.43**	**17.74**	**13.02**	**12.49**	**16.20**	**5.40**	**9.02**	**11.82**	**15.68**	**22.11**

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age / as Stated	**Sex**	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid Means and Percentiles**					
									Mean	**P10**	**P25**	**P50**	**P75**	**P90**
Average Length of Stay: *Average # of Days*														
<1	NA	4.61	6.42	4.29	9.02	8.17	5.90	4.14						
1–9	NA	2.28	2.93	3.17	5.34	2.55	2.20	2.65						
10–19	NA	3.00	3.63	3.19	5.51	2.89	3.37	3.31						
20–44	NA	3.41	4.46	4.83	4.59	3.65	3.16	3.45						
45–64	NA	3.88	4.86	5.77	4.88	3.84	3.48	4.29						
65–74	NA	4.39	7.63	7.83	3.93	3.91	3.96	4.04						
75–84	NA	4.08	21.00	6.67	7.08	3.94	3.56	4.95						
≥85	NA	5.75	13.80	20.25	4.89	4.43	4.06	4.11						
Unknown	NA	NA	NA	NA	NA	NA	NA	NA						
Total	**NA**	**3.63**	**4.64**	**4.88**	**5.65**	**4.04**	**3.54**	**3.82**	**3.59**	**2.95**	**3.25**	**3.57**	**3.80**	**4.20**
Surgery														
Discharges: *Discharges/1,000 Member Months*														
<1	NA	1.87	1.13	1.34	6.57	1.50	1.30	2.57						
1–9	NA	0.35	0.19	0.23	1.48	0.29	0.32	0.33						
10–19	NA	0.46	0.32	0.35	0.79	0.44	0.46	0.47						
20–44	NA	2.12	1.56	1.15	4.57	2.29	2.32	1.79						
45–64	NA	9.05	5.20	5.24	10.15	8.35	9.60	8.32						
65–74	NA	6.18	4.58	2.93	114.29	8.47	10.26	9.60						
75–84	NA	4.10	0.00	4.50	314.29	8.05	8.30	6.74						
≥85	NA	3.66	1.19	0.00	0.00	6.51	3.87	6.33						
Total	**NA**	**1.55**	**1.10**	**0.92**	**1.56**	**1.98**	**1.80**	**1.61**	**1.67**	**0.78**	**0.99**	**1.38**	**1.71**	**2.81**
Days: *Days/1,000 Member Months*														
<1	NA	30.98	12.31	26.51	219.27	20.43	14.24	58.21						
1–9	NA	1.99	0.82	1.53	15.01	1.65	1.50	1.85						
10–19	NA	2.04	1.73	1.67	7.13	2.20	2.59	3.36						
20–44	NA	11.09	8.72	7.32	31.71	14.28	11.43	13.12						
45–64	NA	67.51	35.19	49.62	98.76	60.16	61.26	71.32						
65–74	NA	49.44	47.30	35.19	942.86	62.56	73.39	70.26						
75–84	NA	27.69	0.00	60.06	1800.00	49.95	53.08	59.50						
≥85	NA	41.46	5.95	0.00	0.00	45.18	14.59	45.04						
Total	**NA**	**10.66**	**6.94**	**7.71**	**18.49**	**13.64**	**10.65**	**14.15**	**11.48**	**4.11**	**5.72**	**8.31**	**11.75**	**18.01**

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age / as Stated	**Sex**	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid Means and Percentiles**					
									Mean	**P10**	**P25**	**P50**	**P75**	**P90**
Average Length of Stay: *Average # of Days*														
<1	NA	16.59	10.86	19.74	33.36	13.61	10.92	22.69						
1–9	NA	5.77	4.39	6.58	10.11	5.68	4.64	5.66						
10–19	NA	4.42	5.39	4.72	9.09	5.00	5.63	7.10						
20–44	NA	5.24	5.60	6.38	6.94	6.24	4.93	7.34						
45–64	NA	7.46	6.77	9.47	9.73	7.20	6.38	8.57						
65–74	NA	8.00	10.33	12.00	8.25	7.39	7.15	7.32						
75–84	NA	6.75	NA	13.33	5.73	6.21	6.39	8.83						
≥85	NA	11.33	5.00	NA	NA	6.94	3.77	7.11						
Total	**NA**	**6.86**	**6.29**	**8.38**	**11.84**	**6.90**	**5.93**	**8.79**	**6.34**	**4.37**	**5.23**	**6.42**	**7.12**	**8.18**
Maternity (calculated using member months for members 10-64 years)														
Discharges: *Discharges/1,000 Member Months*														
10–19	NA	1.77	1.88	1.74	0.67	1.80	1.88	1.88						
20–44	NA	10.91	10.88	10.23	7.49	8.96	12.00	9.97						
45–64	NA	0.05	0.01	0.03	0.00	0.16	0.08	0.06						
Total	**NA**	**5.52**	**5.52**	**5.27**	**1.28**	**4.44**	**6.09**	**5.17**	**5.05**	**1.96**	**3.54**	**4.63**	**6.46**	**8.53**
Days: *Days/1,000 Member Months*														
10–19	NA	4.54	5.10	4.44	1.84	4.71	5.07	5.23						
20–44	NA	28.86	26.98	25.74	16.72	23.35	31.10	24.94						
45–64	NA	0.13	0.03	0.05	0.00	0.95	0.25	0.18						
Total	**NA**	**14.54**	**13.87**	**13.29**	**3.17**	**11.67**	**15.88**	**13.16**	**13.11**	**4.58**	**9.50**	**11.90**	**16.37**	**23.11**
Average Length of Stay: *Average # of Days*														
10–19	NA	2.57	2.71	2.55	2.76	2.61	2.69	2.78						
20–44	NA	2.64	2.48	2.52	2.23	2.61	2.59	2.50						
45–64	NA	2.86	2.33	1.75	NA	5.97	2.93	3.11						
Unknown	NA	NA	NA	NA	NA	NA	NA	NA						
Total	**NA**	**2.63**	**2.51**	**2.52**	**2.48**	**2.63**	**2.61**	**2.55**	**2.66**	**2.32**	**2.47**	**2.63**	**2.74**	**2.95**

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	Sex	AG	BCE	BCW	TCS	UHCE	UHCM	UHCW	HEDIS 2013 National Medicaid Means and Percentiles					
									Mean	P10	P25	P50	P75	P90
Identification of Alcohol and Other Drug Services: Total (IAD)														
Any Services														
0–12	M	0.04%	0.05%	0.05%	0.14%	0.05%	0.06%	0.03%						
	F	0.03%	0.06%	0.05%	0.13%	0.05%	0.05%	0.02%						
	M&F	0.03%	0.06%	0.05%	0.14%	0.05%	0.06%	0.03%						
13–17	M	2.06%	2.59%	2.03%	5.15%	2.19%	2.34%	1.80%						
	F	1.17%	1.44%	0.97%	5.11%	1.41%	1.27%	0.95%						
	M&F	1.61%	2.02%	1.50%	5.13%	1.80%	1.81%	1.36%						
18–24	M	5.20%	4.51%	3.86%	3.78%	5.99%	5.00%	4.75%						
	F	4.52%	7.16%	3.78%	3.42%	6.52%	5.14%	3.63%						
	M&F	4.73%	6.36%	3.81%	3.65%	6.33%	5.10%	3.97%						
25–34	M	9.33%	11.60%	10.96%	1.37%	11.30%	12.22%	11.15%						
	F	7.34%	12.38%	7.03%	2.47%	9.92%	10.38%	6.22%						
	M&F	7.75%	12.21%	7.59%	1.84%	10.25%	10.75%	6.99%						
35–64	M	13.86%	14.95%	15.82%	4.67%	15.13%	16.76%	16.58%						
	F	8.52%	11.31%	8.89%	4.75%	9.34%	13.70%	8.17%						
	M&F	10.43%	12.52%	10.76%	4.71%	11.63%	14.74%	11.06%						
≥65	M	3.81%	6.75%	8.38%	0.00%	6.28%	9.55%	9.77%						
	F	1.44%	2.47%	0.97%	0.00%	2.53%	6.02%	3.66%						
	M&F	2.46%	3.78%	3.31%	0.00%	3.77%	7.18%	5.50%						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**2.97%**	**3.60%**	**2.72%**	**2.25%**	**4.31%**	**3.72%**	**3.46%**						
	F	**3.31%**	**5.45%**	**3.43%**	**2.07%**	**4.42%**	**5.06%**	**3.11%**						
	M&F	**3.17%**	**4.67%**	**3.15%**	**2.18%**	**4.37%**	**4.50%**	**3.26%**	**4.59%**	**1.20%**	**2.26%**	**2.94%**	**5.65%**	**7.87%**
Inpatient														
0–12	M	0.01%	0.00%	0.01%	0.04%	0.00%	0.01%	0.00%						
	F	0.00%	0.00%	0.01%	0.02%	0.00%	0.01%	0.00%						
	M&F	0.01%	0.00%	0.01%	0.03%	0.00%	0.01%	0.00%						
13–17	M	0.46%	0.46%	0.53%	0.83%	0.44%	0.46%	0.60%						
	F	0.38%	0.29%	0.29%	1.03%	0.36%	0.34%	0.48%						
	M&F	0.42%	0.38%	0.41%	0.90%	0.40%	0.40%	0.54%						

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	**Sex**	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid Means and Percentiles**					
									Mean	**P10**	**P25**	**P50**	**P75**	**P90**
18–24	M	2.16%	0.97%	1.15%	1.20%	1.86%	2.04%	1.62%						
	F	1.77%	2.90%	1.05%	1.02%	2.95%	2.30%	1.18%						
	M&F	1.90%	2.32%	1.09%	1.13%	2.57%	2.22%	1.32%						
25–34	M	3.90%	2.80%	2.76%	0.46%	4.24%	4.22%	4.10%						
	F	2.89%	3.92%	1.61%	1.24%	3.74%	3.39%	1.88%						
	M&F	3.10%	3.67%	1.77%	0.79%	3.86%	3.56%	2.23%						
35–64	M	6.42%	4.69%	6.23%	1.65%	6.33%	6.57%	7.02%						
	F	2.97%	2.78%	2.30%	1.85%	3.10%	3.82%	2.58%						
	M&F	4.20%	3.41%	3.36%	1.75%	4.38%	4.75%	4.11%						
≥65	M	2.54%	2.25%	5.24%	0.00%	2.57%	3.67%	3.97%						
	F	0.48%	0.99%	0.00%	0.00%	0.88%	1.51%	1.08%						
	M&F	1.37%	1.37%	1.65%	0.00%	1.44%	2.22%	1.95%						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**1.26%**	**0.98%**	**0.92%**	**0.48%**	**1.64%**	**1.35%**	**1.37%**						
	F	**1.23%**	**1.62%**	**0.86%**	**0.49%**	**1.61%**	**1.59%**	**0.99%**						
	M&F	**1.24%**	**1.35%**	**0.89%**	**0.48%**	**1.62%**	**1.49%**	**1.15%**	**1.39%**	**0.36%**	**0.59%**	**0.94%**	**1.61%**	**2.36%**
Intensive Outpatient/Partial Hospitalization														
0–12	M	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%						
	F	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%						
	M&F	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%						
13–17	M	1.03%	1.19%	0.65%	1.64%	0.58%	1.13%	0.29%						
	F	0.31%	0.58%	0.21%	2.12%	0.32%	0.30%	0.09%						
	M&F	0.67%	0.89%	0.43%	1.81%	0.45%	0.72%	0.19%						
18–24	M	1.04%	1.11%	0.72%	0.81%	0.68%	1.18%	0.38%						
	F	1.09%	1.71%	0.77%	0.71%	0.80%	0.97%	0.45%						
	M&F	1.08%	1.53%	0.75%	0.78%	0.76%	1.03%	0.43%						
25–34	M	1.59%	2.70%	1.57%	0.00%	0.91%	1.71%	0.87%						
	F	1.26%	2.85%	1.26%	0.00%	1.20%	1.40%	0.71%						
	M&F	1.33%	2.82%	1.31%	0.00%	1.13%	1.46%	0.73%						
35–64	M	1.11%	1.85%	1.32%	0.00%	0.51%	0.97%	0.79%						
	F	0.83%	1.68%	0.99%	0.00%	0.46%	0.74%	0.47%						
	M&F	0.93%	1.74%	1.08%	0.00%	0.48%	0.82%	0.58%						

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	**Sex**	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid Means and Percentiles**					
									Mean	**P10**	**P25**	**P50**	**P75**	**P90**
≥65	M	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%						
	F	0.00%	0.00%	0.00%	0.00%	0.00%	0.06%	0.00%						
	M&F	0.00%	0.00%	0.00%	0.00%	0.00%	0.04%	0.00%						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**0.46%**	**0.70%**	**0.37%**	**0.61%**	**0.29%**	**0.48%**	**0.22%**						
	F	**0.52%**	**1.10%**	**0.52%**	**0.67%**	**0.40%**	**0.51%**	**0.27%**						
	M&F	**0.49%**	**0.93%**	**0.46%**	**0.63%**	**0.35%**	**0.50%**	**0.25%**	**0.83%**	**0.00%**	**0.01%**	**0.08%**	**0.38%**	**0.70%**
Outpatient/ED														
0–12	M	0.03%	0.05%	0.04%	0.11%	0.04%	0.06%	0.02%						
	F	0.02%	0.06%	0.03%	0.11%	0.05%	0.04%	0.02%						
	M&F	0.03%	0.05%	0.04%	0.11%	0.05%	0.05%	0.02%						
13–17	M	0.98%	1.63%	1.56%	3.68%	1.61%	1.31%	1.16%						
	F	0.70%	0.90%	0.64%	3.72%	1.00%	0.80%	0.53%						
	M&F	0.84%	1.27%	1.09%	3.69%	1.30%	1.06%	0.83%						
18–24	M	3.17%	3.37%	2.94%	2.64%	4.69%	3.15%	3.29%						
	F	2.90%	4.43%	2.83%	2.36%	4.36%	3.37%	2.50%						
	M&F	2.99%	4.11%	2.86%	2.54%	4.48%	3.30%	2.74%						
25–34	M	6.80%	8.54%	9.04%	1.37%	8.30%	9.35%	8.06%						
	F	5.47%	9.04%	5.62%	1.24%	7.24%	8.12%	4.74%						
	M&F	5.75%	8.93%	6.11%	1.31%	7.49%	8.37%	5.26%						
35–64	M	10.30%	11.47%	12.51%	3.85%	11.57%	13.06%	12.85%						
	F	6.38%	9.06%	7.56%	3.43%	7.46%	11.33%	6.43%						
	M&F	7.79%	9.86%	8.90%	3.64%	9.09%	11.92%	8.64%						
≥65	M	1.27%	4.50%	5.24%	0.00%	4.21%	6.73%	7.28%						
	F	1.44%	1.98%	0.97%	0.00%	1.76%	5.00%	2.94%						
	M&F	1.37%	2.75%	2.31%	0.00%	2.57%	5.57%	4.25%						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**2.06%**	**2.68%**	**2.15%**	**1.61%**	**3.27%**	**2.75%**	**2.59%**						
	F	**2.39%**	**4.02%**	**2.78%**	**1.49%**	**3.31%**	**3.98%**	**2.35%**						
	M&F	**2.25%**	**3.46%**	**2.53%**	**1.57%**	**3.29%**	**3.46%**	**2.45%**	**‡‡**	**0.99%**	**1.98%**	**2.77%**	**5.76%**	**8.18%**

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	Sex	AG	BCE	BCW	TCS	UHCE	UHCM	UHCW	HEDIS 2013 National Medicaid Means and Percentiles					
									Mean	P10	P25	P50	P75	P90
Mental Health Utilization: Total (MPT)														
Any Services														
0–12	M	8.25%	11.33%	5.98%	24.85%	8.30%	7.80%	4.81%						
	F	4.83%	7.48%	3.71%	18.60%	5.16%	4.47%	2.71%						
	M&F	6.57%	9.45%	4.85%	22.38%	6.76%	6.15%	3.77%						
13–17	M	12.71%	17.68%	9.90%	38.87%	13.82%	12.30%	8.19%						
	F	12.85%	17.98%	9.74%	39.64%	13.97%	11.82%	7.00%						
	M&F	12.78%	17.83%	9.82%	39.15%	13.89%	12.06%	7.58%						
18–64	M	15.02%	15.77%	12.30%	20.67%	16.19%	13.35%	12.79%						
	F	16.51%	19.62%	11.95%	21.38%	18.66%	15.39%	9.73%						
	M&F	16.06%	18.50%	12.04%	20.94%	17.81%	14.80%	10.58%						
≥65	M	15.89%	30.37%	16.75%	19.05%	6.28%	5.75%	3.97%						
	F	32.21%	31.67%	17.40%	12.00%	9.92%	9.45%	5.59%						
	M&F	25.18%	31.27%	17.19%	14.72%	8.72%	8.23%	5.10%						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**10.69%**	**13.58%**	**8.08%**	**28.20%**	**11.59%**	**9.89%**	**7.45%**						
	F	**11.13%**	**14.71%**	**8.43%**	**24.74%**	**12.69%**	**10.41%**	**6.61%**						
	M&F	**10.94%**	**14.23%**	**8.29%**	**26.87%**	**12.21%**	**10.19%**	**6.96%**	**11.90%**	**4.02%**	**7.20%**	**10.83%**	**14.96%**	**22.03%**
Inpatient														
0–12	M	0.09%	0.10%	0.13%	1.11%	0.10%	0.12%	0.08%						
	F	0.06%	0.09%	0.08%	0.63%	0.08%	0.05%	0.09%						
	M&F	0.07%	0.10%	0.10%	0.92%	0.09%	0.09%	0.09%						
13–17	M	0.93%	0.85%	0.83%	2.81%	0.92%	0.98%	0.99%						
	F	1.35%	1.11%	1.11%	4.17%	1.28%	1.29%	1.33%						
	M&F	1.14%	0.98%	0.98%	3.30%	1.10%	1.13%	1.16%						
18–64	M	2.39%	1.47%	1.95%	2.44%	2.45%	2.31%	2.94%						
	F	1.61%	1.44%	1.21%	2.79%	1.83%	1.81%	1.49%						
	M&F	1.84%	1.45%	1.38%	2.57%	2.04%	1.96%	1.89%						
≥65	M	13.35%	25.87%	12.57%	19.05%	1.50%	1.35%	0.83%						
	F	26.44%	27.71%	9.67%	0.00%	1.93%	2.47%	2.44%						
	M&F	20.80%	27.15%	10.58%	7.36%	1.79%	2.10%	1.95%						

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	**Sex**	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid Means and Percentiles**					
									Mean	**P10**	**P25**	**P50**	**P75**	**P90**
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**0.84%**	**0.63%**	**0.68%**	**1.85%**	**1.00%**	**0.83%**	**0.99%**						
	F	**0.97%**	**0.93%**	**0.77%**	**1.96%**	**1.10%**	**1.04%**	**0.94%**						
	M&F	**0.91%**	**0.80%**	**0.73%**	**1.89%**	**1.05%**	**0.95%**	**0.96%**	**0.97%**	**0.36%**	**0.57%**	**0.86%**	**1.19%**	**1.36%**
Intensive Outpatient/Partial Hospitalization														
0–12	M	0.02%	0.03%	0.05%	0.18%	0.02%	0.00%	0.08%						
	F	0.00%	0.01%	0.03%	0.08%	0.02%	0.00%	0.04%						
	M&F	0.01%	0.02%	0.04%	0.14%	0.02%	0.00%	0.06%						
13–17	M	0.12%	0.34%	0.22%	0.62%	0.25%	0.05%	0.26%						
	F	0.01%	0.17%	0.40%	1.03%	0.24%	0.01%	0.34%						
	M&F	0.06%	0.26%	0.31%	0.77%	0.25%	0.03%	0.30%						
18–64	M	0.12%	0.13%	0.17%	0.50%	0.09%	0.03%	0.18%						
	F	0.11%	0.17%	0.22%	0.52%	0.15%	0.06%	0.29%						
	M&F	0.11%	0.16%	0.21%	0.51%	0.13%	0.05%	0.25%						
≥65	M	0.00%	1.12%	0.00%	19.05%	0.00%	0.00%	0.00%						
	F	0.00%	0.49%	0.00%	0.00%	0.00%	0.00%	0.07%						
	M&F	0.00%	0.69%	0.00%	7.36%	0.00%	0.00%	0.05%						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**0.06%**	**0.11%**	**0.11%**	**0.37%**	**0.07%**	**0.02%**	**0.13%**						
	F	**0.05%**	**0.11%**	**0.17%**	**0.41%**	**0.10%**	**0.03%**	**0.19%**						
	M&F	**0.05%**	**0.11%**	**0.14%**	**0.39%**	**0.09%**	**0.02%**	**0.17%**	**3.61%**	**0.00%**	**0.02%**	**0.12%**	**0.40%**	**1.77%**
Outpatient/ED														
0–12	M	8.24%	9.29%	5.24%	20.85%	8.29%	7.79%	4.79%						
	F	4.83%	5.82%	3.13%	14.07%	5.15%	4.47%	2.69%						
	M&F	6.56%	7.60%	4.20%	18.17%	6.75%	6.15%	3.75%						
13–17	M	12.50%	14.87%	8.43%	33.79%	13.62%	12.13%	7.92%						
	F	12.65%	13.97%	8.02%	31.82%	13.75%	11.50%	6.67%						
	M&F	12.58%	14.43%	8.22%	33.07%	13.68%	11.82%	7.28%						
18–64	M	14.35%	12.99%	10.10%	17.48%	15.40%	12.52%	12.17%						
	F	16.11%	16.24%	10.00%	18.56%	18.15%	14.87%	9.33%						
	M&F	15.58%	15.30%	10.02%	17.89%	17.20%	14.19%	10.12%						

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	**Sex**	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid Means and Percentiles**					
									Mean	**P10**	**P25**	**P50**	**P75**	**P90**
≥65	M	3.18%	4.50%	5.24%	19.05%	4.92%	4.53%	3.64%						
	F	7.21%	3.46%	8.22%	12.00%	8.41%	7.65%	3.80%						
	M&F	5.47%	3.78%	7.27%	14.72%	7.26%	6.62%	3.75%						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**10.45%**	**11.19%**	**6.87%**	**24.02%**	**11.28%**	**9.63%**	**7.23%**						
	F	**10.87%**	**11.89%**	**7.03%**	**19.63%**	**12.37%**	**10.10%**	**6.35%**						
	M&F	**10.69%**	**11.60%**	**6.97%**	**22.34%**	**11.90%**	**9.90%**	**6.71%**	**11.57%**	**3.65%**	**6.88%**	**10.60%**	**14.77%**	**21.48%**
Antibiotic Utilization: Total (ABX)														
Antibiotic Utilization														
Average Scripts PMPY for Antibiotics														
0–9	M	1.26	1.58	1.16	1.39	1.37	1.28	1.00						
	F	1.29	1.61	1.17	1.58	1.40	1.34	1.00						
	M&F	1.27	1.60	1.17	1.47	1.39	1.31	1.00						
10–17	M	0.77	0.99	0.65	0.83	0.85	0.76	0.57						
	F	1.06	1.31	0.93	1.24	1.17	1.05	0.80						
	M&F	0.91	1.15	0.79	0.98	1.01	0.90	0.69						
18–34	M	0.92	0.98	0.81	0.79	0.84	0.88	0.73						
	F	2.00	2.02	2.04	1.58	1.81	1.90	1.70						
	M&F	1.71	1.75	1.77	1.08	1.52	1.64	1.47						
35–49	M	1.12	1.18	1.18	0.74	1.07	1.19	1.05						
	F	1.87	1.90	1.97	0.95	1.76	1.85	1.67						
	M&F	1.65	1.68	1.80	0.85	1.52	1.65	1.51						
50–64	M	1.25	1.17	1.20	1.00	1.10	1.30	1.11						
	F	1.77	1.78	1.77	0.80	1.78	1.92	1.69						
	M&F	1.53	1.55	1.55	0.90	1.47	1.67	1.42						
65–74	M	1.22	0.89	0.78	1.53	1.59	1.52	1.23						
	F	1.23	1.42	1.09	1.03	2.20	2.26	1.75						
	M&F	1.22	1.23	1.00	1.20	1.98	1.99	1.57						
75–84	M	0.72	0.33	0.48	0.00	1.62	1.23	1.26						
	F	1.15	0.57	1.37	0.00	2.13	1.93	1.30						
	M&F	0.97	0.50	1.06	0.00	1.98	1.72	1.29						

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	**Sex**	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid Means and Percentiles**					
									Mean	**P10**	**P25**	**P50**	**P75**	**P90**
≥85	M	1.67	0.00	1.16	0.00	1.38	1.05	0.84						
	F	1.31	0.59	0.44	0.00	1.61	1.26	1.19						
	M&F	1.43	0.47	0.64	0.00	1.57	1.22	1.15						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**1.07**	**1.29**	**0.98**	**1.03**	**1.12**	**1.09**	**0.87**	**0.93**	**0.66**	**0.76**	**0.88**	**1.07**	**1.26**
	F	**1.54**	**1.73**	**1.53**	**1.43**	**1.56**	**1.55**	**1.30**	**1.29**	**0.91**	**1.06**	**1.25**	**1.41**	**1.69**
	M&F	**1.34**	**1.54**	**1.31**	**1.18**	**1.37**	**1.36**	**1.12**	**1.13**	**0.80**	**0.93**	**1.09**	**1.23**	**1.49**
Average Days Supplied per Antibiotic Script														
0–9	M	9.27	9.19	9.32	10.50	9.10	9.31	9.24						
	F	9.43	9.31	9.38	10.94	9.23	9.41	9.28						
	M&F	9.35	9.25	9.35	10.69	9.17	9.36	9.26						
10–17	M	9.51	9.96	9.64	11.36	9.90	9.59	9.63						
	F	9.07	9.48	9.10	10.38	9.43	9.12	9.09						
	M&F	9.25	9.69	9.32	10.91	9.63	9.32	9.31						
18–34	M	9.46	9.52	9.06	12.41	9.54	9.46	9.41						
	F	8.15	8.38	7.94	10.09	8.35	8.25	7.89						
	M&F	8.34	8.54	8.05	11.16	8.55	8.41	8.07						
35–49	M	9.99	9.77	10.14	14.76	9.69	10.02	10.25						
	F	8.77	8.85	8.79	11.20	8.83	8.77	8.73						
	M&F	9.02	9.04	8.98	12.73	9.04	9.04	9.01						
50–64	M	10.06	9.89	10.73	9.97	9.89	9.89	10.27						
	F	8.88	8.84	9.08	11.70	8.92	9.11	8.97						
	M&F	9.33	9.14	9.57	10.76	9.25	9.36	9.45						
65–74	M	10.82	12.04	8.73	8.00	9.69	9.94	9.51						
	F	9.56	9.36	9.62	10.63	9.43	8.88	8.66						
	M&F	10.14	10.07	9.40	9.50	9.51	9.18	8.90						
75–84	M	8.83	11.80	6.11	NA	9.28	9.70	8.53						
	F	10.84	7.58	7.78	NA	10.29	9.74	8.11						
	M&F	10.23	8.31	7.53	NA	10.05	9.73	8.21						
≥85	M	7.85	NA	5.19	NA	8.35	10.80	7.48						
	F	7.21	9.18	6.07	NA	9.58	8.24	9.56						
	M&F	7.47	9.18	5.61	NA	9.38	8.68	9.38						

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	**Sex**	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid Means and Percentiles**					
									Mean	**P10**	**P25**	**P50**	**P75**	**P90**
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**9.44**	**9.46**	**9.48**	**11.07**	**9.43**	**9.48**	**9.49**	**9.70**	**9.22**	**9.37**	**9.62**	**10.01**	**10.31**
	F	**8.77**	**8.91**	**8.63**	**10.60**	**8.92**	**8.85**	**8.58**	**8.98**	**8.57**	**8.71**	**8.91**	**9.20**	**9.43**
	M&F	**9.00**	**9.11**	**8.89**	**10.85**	**9.10**	**9.06**	**8.87**	**9.24**	**8.85**	**8.97**	**9.16**	**9.47**	**9.76**
Average Scripts PMPY for Antibiotics of Concern														
0–9	M	0.58	0.84	0.56	0.68	0.74	0.61	0.47						
	F	0.57	0.80	0.54	0.71	0.71	0.61	0.44						
	M&F	0.57	0.82	0.55	0.69	0.72	0.61	0.46						
10–17	M	0.35	0.50	0.32	0.37	0.43	0.38	0.28						
	F	0.46	0.61	0.42	0.53	0.56	0.49	0.35						
	M&F	0.41	0.55	0.37	0.43	0.50	0.43	0.31						
18–34	M	0.39	0.44	0.38	0.32	0.38	0.41	0.34						
	F	0.80	0.83	0.82	0.62	0.78	0.80	0.68						
	M&F	0.69	0.73	0.73	0.43	0.66	0.70	0.60						
35–49	M	0.53	0.59	0.58	0.24	0.54	0.63	0.54						
	F	0.88	0.97	0.95	0.38	0.92	0.94	0.80						
	M&F	0.77	0.85	0.87	0.31	0.78	0.84	0.73						
50–64	M	0.63	0.64	0.65	0.42	0.62	0.67	0.57						
	F	0.94	1.00	0.98	0.37	1.02	1.07	0.90						
	M&F	0.80	0.86	0.85	0.40	0.83	0.91	0.74						
65–74	M	0.51	0.54	0.35	1.28	0.93	0.82	0.68						
	F	0.63	0.85	0.76	0.52	1.28	1.26	0.93						
	M&F	0.57	0.73	0.63	0.77	1.15	1.10	0.84						
75–84	M	0.45	0.13	0.37	0.00	0.97	0.71	0.65						
	F	0.36	0.36	0.93	0.00	1.15	1.06	0.73						
	M&F	0.39	0.30	0.74	0.00	1.10	0.95	0.71						
≥85	M	0.67	0.00	0.36	0.00	0.91	0.68	0.44						
	F	0.65	0.30	0.20	0.00	0.90	0.71	0.59						
	M&F	0.66	0.24	0.25	0.00	0.90	0.70	0.57						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	**Sex**	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid Means and Percentiles**					
									Mean	**P10**	**P25**	**P50**	**P75**	**P90**
Total	**M**	**0.50**	**0.66**	**0.47**	**0.48**	**0.59**	**0.53**	**0.42**	**0.41**	**0.25**	**0.31**	**0.38**	**0.47**	**0.60**
	F	**0.67**	**0.81**	**0.68**	**0.62**	**0.76**	**0.72**	**0.57**	**0.54**	**0.35**	**0.43**	**0.50**	**0.59**	**0.73**
	M&F	**0.59**	**0.75**	**0.60**	**0.53**	**0.69**	**0.64**	**0.51**	**0.48**	**0.30**	**0.38**	**0.45**	**0.54**	**0.67**
Percentage of Antibiotics of Concern of All Antibiotic Scripts														
0–9	M	46.16%	52.82%	48.02%	49.05%	53.77%	47.72%	47.11%						
	F	43.94%	49.51%	45.94%	44.77%	50.31%	45.51%	44.08%						
	M&F	45.06%	51.19%	46.99%	47.15%	52.06%	46.60%	45.61%						
10–17	M	46.19%	49.95%	49.04%	44.56%	50.93%	49.96%	48.43%						
	F	43.62%	46.57%	45.48%	42.90%	47.94%	46.41%	43.92%						
	M&F	44.69%	48.05%	46.92%	43.80%	49.19%	47.93%	45.76%						
18–34	M	42.79%	45.18%	47.29%	40.27%	45.32%	46.58%	46.71%						
	F	39.87%	40.90%	40.35%	39.46%	42.95%	42.04%	40.03%						
	M&F	40.28%	41.52%	41.04%	39.83%	43.34%	42.65%	40.80%						
35–49	M	47.79%	49.76%	49.44%	32.14%	50.50%	52.68%	51.05%						
	F	46.89%	50.97%	48.04%	39.67%	52.11%	50.70%	47.49%						
	M&F	47.07%	50.71%	48.23%	36.42%	51.71%	51.13%	48.15%						
50–64	M	50.53%	54.30%	54.09%	41.90%	55.78%	51.40%	51.49%						
	F	53.15%	56.36%	55.26%	46.36%	57.11%	55.71%	53.02%						
	M&F	52.15%	55.78%	54.92%	43.94%	56.65%	54.33%	52.45%						
65–74	M	41.80%	60.38%	44.90%	83.33%	58.82%	53.73%	55.23%						
	F	51.41%	59.46%	69.13%	50.00%	58.00%	55.68%	52.90%						
	M&F	46.97%	59.70%	63.13%	64.29%	58.24%	55.13%	53.55%						
75–84	M	62.50%	40.00%	77.78%	NA	60.04%	57.79%	51.25%						
	F	30.91%	62.50%	68.00%	NA	53.88%	54.80%	56.16%						
	M&F	40.51%	58.62%	69.49%	NA	55.36%	55.44%	54.93%						
≥85	M	40.00%	NA	31.25%	NA	65.49%	64.41%	52.17%						
	F	50.00%	51.52%	46.67%	NA	55.74%	55.83%	49.20%						
	M&F	45.92%	51.52%	38.71%	NA	57.30%	57.31%	49.45%						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**46.15%**	**51.26%**	**48.56%**	**46.21%**	**52.35%**	**48.73%**	**48.06%**	**43.94%**	**36.89%**	**40.06%**	**44.27%**	**47.93%**	**50.47%**
	F	**43.28%**	**46.84%**	**44.46%**	**43.18%**	**48.82%**	**46.10%**	**43.72%**	**41.43%**	**35.05%**	**38.54%**	**41.09%**	**44.92%**	**47.88%**
	M&F	**44.27%**	**48.39%**	**45.69%**	**44.81%**	**50.08%**	**46.99%**	**45.09%**	**42.08%**	**35.76%**	**39.02%**	**42.37%**	**45.94%**	**48.33%**

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	Sex	AG	BCE	BCW	TCS	UHCE	UHCM	UHCW	HEDIS 2013 National Medicaid Means and Percentiles					
									Mean	P10	P25	P50	P75	P90
Antibiotics of Concern Utilization														
Average Scripts PMPY for Quinolones														
0–9	M	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
10–17	M	0.01	0.01	0.01	0.02	0.01	0.01	0.01						
	F	0.03	0.03	0.02	0.04	0.03	0.02	0.02						
	M&F	0.02	0.02	0.01	0.03	0.02	0.01	0.01						
18–34	M	0.08	0.08	0.08	0.06	0.06	0.07	0.06						
	F	0.21	0.18	0.20	0.13	0.17	0.18	0.16						
	M&F	0.17	0.15	0.17	0.09	0.14	0.15	0.14						
35–49	M	0.16	0.15	0.17	0.07	0.15	0.18	0.14						
	F	0.28	0.27	0.29	0.10	0.26	0.26	0.22						
	M&F	0.24	0.23	0.26	0.09	0.22	0.24	0.20						
50–64	M	0.26	0.21	0.25	0.17	0.23	0.26	0.21						
	F	0.39	0.35	0.39	0.15	0.35	0.40	0.32						
	M&F	0.33	0.30	0.34	0.16	0.30	0.35	0.26						
65–74	M	0.24	0.29	0.27	0.51	0.36	0.38	0.35						
	F	0.31	0.36	0.38	0.52	0.59	0.54	0.37						
	M&F	0.28	0.33	0.35	0.51	0.50	0.48	0.36						
75–84	M	0.21	0.07	0.21	0.00	0.46	0.42	0.32						
	F	0.21	0.24	0.27	0.00	0.55	0.52	0.36						
	M&F	0.21	0.19	0.25	0.00	0.52	0.49	0.35						
≥85	M	0.33	0.00	0.14	0.00	0.53	0.54	0.25						
	F	0.32	0.18	0.09	0.00	0.44	0.31	0.32						
	M&F	0.32	0.14	0.10	0.00	0.45	0.36	0.32						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**0.04**	**0.04**	**0.03**	**0.02**	**0.05**	**0.04**	**0.04**	**0.03**	**0.01**	**0.02**	**0.03**	**0.04**	**0.05**
	F	**0.12**	**0.12**	**0.12**	**0.05**	**0.13**	**0.12**	**0.10**	**0.09**	**0.05**	**0.06**	**0.07**	**0.09**	**0.12**
	M&F	**0.08**	**0.09**	**0.09**	**0.03**	**0.09**	**0.09**	**0.07**	**0.06**	**0.03**	**0.04**	**0.05**	**0.07**	**0.09**

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	Sex	AG	BCE	BCW	TCS	UHCE	UHCM	UHCW	HEDIS 2013 National Medicaid Means and Percentiles					
									Mean	P10	P25	P50	P75	P90
Average Scripts PMPY for Cephalosporins 2nd–4th Generation														
0–9	M	0.22	0.29	0.19	0.23	0.24	0.23	0.15						
	F	0.23	0.29	0.19	0.26	0.25	0.25	0.14						
	M&F	0.22	0.29	0.19	0.24	0.25	0.24	0.15						
10–17	M	0.07	0.10	0.06	0.08	0.08	0.08	0.05						
	F	0.09	0.13	0.08	0.12	0.12	0.11	0.06						
	M&F	0.08	0.12	0.07	0.09	0.10	0.09	0.05						
18–34	M	0.03	0.03	0.03	0.03	0.03	0.04	0.02						
	F	0.06	0.06	0.05	0.07	0.06	0.06	0.04						
	M&F	0.05	0.06	0.05	0.05	0.05	0.06	0.04						
35–49	M	0.04	0.04	0.04	0.02	0.03	0.05	0.03						
	F	0.07	0.08	0.06	0.04	0.07	0.08	0.05						
	M&F	0.06	0.06	0.05	0.03	0.06	0.07	0.05						
50–64	M	0.05	0.06	0.04	0.02	0.04	0.06	0.03						
	F	0.09	0.08	0.05	0.01	0.09	0.09	0.06						
	M&F	0.07	0.07	0.05	0.01	0.07	0.08	0.05						
65–74	M	0.03	0.03	0.00	0.00	0.10	0.10	0.04						
	F	0.03	0.05	0.03	0.00	0.13	0.13	0.07						
	M&F	0.03	0.04	0.02	0.00	0.12	0.12	0.06						
75–84	M	0.03	0.00	0.11	0.00	0.09	0.09	0.03						
	F	0.02	0.00	0.27	0.00	0.15	0.15	0.06						
	M&F	0.02	0.00	0.22	0.00	0.13	0.13	0.05						
≥85	M	0.00	0.00	0.14	0.00	0.07	0.02	0.07						
	F	0.11	0.04	0.06	0.00	0.19	0.14	0.06						
	M&F	0.07	0.03	0.08	0.00	0.17	0.11	0.06						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**0.13**	**0.17**	**0.12**	**0.13**	**0.13**	**0.14**	**0.09**	**0.07**	**0.02**	**0.03**	**0.05**	**0.09**	**0.15**
	F	**0.13**	**0.15**	**0.10**	**0.17**	**0.14**	**0.14**	**0.08**	**0.07**	**0.02**	**0.03**	**0.05**	**0.09**	**0.14**
	M&F	**0.13**	**0.16**	**0.11**	**0.14**	**0.13**	**0.14**	**0.08**	**0.07**	**0.02**	**0.03**	**0.05**	**0.09**	**0.14**

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age / as Stated	**Sex**	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid Means and Percentiles**					
									Mean	**P10**	**P25**	**P50**	**P75**	**P90**
Average Scripts PMPY for Azithromycins and Clarithromycins														
0–9	M	0.20	0.32	0.19	0.23	0.29	0.20	0.17						
	F	0.19	0.31	0.18	0.22	0.27	0.20	0.16						
	M&F	0.20	0.31	0.19	0.22	0.28	0.20	0.16						
10–17	M	0.17	0.24	0.15	0.15	0.22	0.18	0.13						
	F	0.22	0.29	0.20	0.21	0.27	0.22	0.17						
	M&F	0.19	0.26	0.17	0.18	0.25	0.20	0.15						
18–34	M	0.15	0.16	0.15	0.12	0.15	0.16	0.14						
	F	0.32	0.32	0.34	0.26	0.31	0.32	0.29						
	M&F	0.27	0.28	0.30	0.17	0.26	0.28	0.26						
35–49	M	0.17	0.19	0.19	0.05	0.17	0.21	0.18						
	F	0.31	0.34	0.34	0.12	0.33	0.34	0.30						
	M&F	0.27	0.29	0.31	0.08	0.27	0.30	0.27						
50–64	M	0.17	0.18	0.16	0.08	0.17	0.19	0.17						
	F	0.27	0.33	0.29	0.10	0.32	0.35	0.28						
	M&F	0.22	0.28	0.24	0.09	0.25	0.28	0.23						
65–74	M	0.13	0.10	0.05	0.00	0.27	0.19	0.13						
	F	0.20	0.30	0.18	0.00	0.35	0.35	0.29						
	M&F	0.17	0.23	0.14	0.00	0.32	0.29	0.24						
75–84	M	0.12	0.07	0.00	0.00	0.23	0.14	0.17						
	F	0.06	0.12	0.16	0.00	0.26	0.22	0.18						
	M&F	0.09	0.10	0.11	0.00	0.25	0.20	0.18						
≥85	M	0.04	0.00	0.00	0.00	0.17	0.09	0.00						
	F	0.14	0.04	0.03	0.00	0.17	0.18	0.11						
	M&F	0.10	0.03	0.02	0.00	0.17	0.16	0.10						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**0.18**	**0.26**	**0.17**	**0.17**	**0.23**	**0.19**	**0.15**	**0.19**	**0.12**	**0.14**	**0.19**	**0.23**	**0.25**
	F	**0.25**	**0.31**	**0.26**	**0.22**	**0.29**	**0.26**	**0.23**	**0.25**	**0.16**	**0.19**	**0.24**	**0.28**	**0.32**
	M&F	**0.22**	**0.29**	**0.22**	**0.19**	**0.27**	**0.23**	**0.20**	**0.22**	**0.14**	**0.18**	**0.22**	**0.25**	**0.28**

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	**Sex**	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid Means and Percentiles**					
									Mean	**P10**	**P25**	**P50**	**P75**	**P90**
Average Scripts PMPY for Amoxicillin/Clavulanates														
0–9	M	0.14	0.21	0.14	0.18	0.19	0.15	0.12						
	F	0.13	0.19	0.13	0.18	0.17	0.14	0.11						
	M&F	0.13	0.20	0.13	0.18	0.18	0.15	0.12						
10–17	M	0.08	0.12	0.07	0.08	0.10	0.09	0.06						
	F	0.09	0.13	0.08	0.10	0.11	0.10	0.07						
	M&F	0.09	0.12	0.07	0.09	0.11	0.09	0.06						
18–34	M	0.08	0.10	0.07	0.06	0.08	0.08	0.06						
	F	0.12	0.14	0.13	0.09	0.13	0.13	0.11						
	M&F	0.11	0.13	0.12	0.07	0.11	0.12	0.10						
35–49	M	0.10	0.12	0.11	0.05	0.10	0.10	0.11						
	F	0.14	0.17	0.17	0.08	0.16	0.15	0.14						
	M&F	0.13	0.16	0.15	0.07	0.14	0.14	0.13						
50–64	M	0.10	0.11	0.13	0.06	0.11	0.10	0.09						
	F	0.13	0.16	0.16	0.06	0.15	0.13	0.15						
	M&F	0.11	0.14	0.15	0.06	0.13	0.12	0.12						
65–74	M	0.06	0.08	0.02	0.77	0.16	0.10	0.10						
	F	0.07	0.11	0.12	0.00	0.15	0.14	0.14						
	M&F	0.06	0.10	0.09	0.26	0.15	0.12	0.13						
75–84	M	0.03	0.00	0.05	0.00	0.17	0.04	0.07						
	F	0.06	0.00	0.14	0.00	0.11	0.11	0.08						
	M&F	0.05	0.00	0.11	0.00	0.13	0.09	0.08						
≥85	M	0.21	0.00	0.07	0.00	0.11	0.04	0.11						
	F	0.09	0.05	0.03	0.00	0.08	0.04	0.07						
	M&F	0.13	0.04	0.04	0.00	0.08	0.04	0.07						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**0.11**	**0.16**	**0.11**	**0.12**	**0.14**	**0.12**	**0.10**	**0.09**	**0.05**	**0.07**	**0.09**	**0.12**	**0.14**
	F	**0.12**	**0.16**	**0.13**	**0.13**	**0.14**	**0.13**	**0.11**	**0.10**	**0.06**	**0.07**	**0.10**	**0.11**	**0.14**
	M&F	**0.12**	**0.16**	**0.12**	**0.12**	**0.14**	**0.13**	**0.10**	**0.10**	**0.06**	**0.07**	**0.09**	**0.11**	**0.14**

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	**Sex**	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid Means and Percentiles**					
									Mean	**P10**	**P25**	**P50**	**P75**	**P90**
Average Scripts PMPY for Ketolides														
0–9	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
10–17	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
18–34	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
35–49	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
50–64	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
65–74	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
75–84	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
≥85	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
	F	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
	M&F	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	**Sex**	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid Means and Percentiles**					
									Mean	**P10**	**P25**	**P50**	**P75**	**P90**
Average Scripts PMPY for Clindamycins														
0–9	M	0.02	0.02	0.04	0.03	0.01	0.02	0.03						
	F	0.02	0.01	0.04	0.04	0.01	0.02	0.03						
	M&F	0.02	0.02	0.04	0.03	0.01	0.02	0.03						
10–17	M	0.02	0.02	0.03	0.04	0.02	0.03	0.03						
	F	0.03	0.03	0.04	0.05	0.03	0.03	0.04						
	M&F	0.03	0.03	0.04	0.04	0.03	0.03	0.03						
18–34	M	0.05	0.08	0.05	0.04	0.06	0.06	0.05						
	F	0.09	0.11	0.10	0.06	0.11	0.10	0.08						
	M&F	0.08	0.10	0.09	0.05	0.09	0.09	0.07						
35–49	M	0.05	0.08	0.07	0.04	0.08	0.08	0.07						
	F	0.08	0.11	0.09	0.05	0.10	0.10	0.09						
	M&F	0.07	0.10	0.09	0.04	0.09	0.09	0.08						
50–64	M	0.05	0.07	0.06	0.08	0.06	0.05	0.06						
	F	0.06	0.07	0.08	0.06	0.09	0.08	0.08						
	M&F	0.05	0.07	0.07	0.07	0.08	0.07	0.07						
65–74	M	0.05	0.03	0.02	0.00	0.05	0.05	0.05						
	F	0.02	0.04	0.04	0.00	0.05	0.08	0.05						
	M&F	0.03	0.04	0.03	0.00	0.05	0.07	0.05						
75–84	M	0.06	0.00	0.00	0.00	0.04	0.02	0.06						
	F	0.00	0.00	0.00	0.00	0.05	0.05	0.05						
	M&F	0.02	0.00	0.00	0.00	0.04	0.04	0.05						
≥85	M	0.00	0.00	0.00	0.00	0.02	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.02	0.03	0.02						
	M&F	0.00	0.00	0.00	0.00	0.02	0.02	0.02						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**0.03**	**0.04**	**0.04**	**0.03**	**0.03**	**0.03**	**0.04**	**0.02**	**0.01**	**0.02**	**0.02**	**0.03**	**0.04**
	F	**0.05**	**0.06**	**0.07**	**0.05**	**0.06**	**0.06**	**0.06**	**0.04**	**0.02**	**0.03**	**0.04**	**0.05**	**0.06**
	M&F	**0.04**	**0.05**	**0.06**	**0.04**	**0.05**	**0.05**	**0.05**	**0.03**	**0.02**	**0.02**	**0.03**	**0.04**	**0.05**

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	**Sex**	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid Means and Percentiles**					
									Mean	**P10**	**P25**	**P50**	**P75**	**P90**
Average Scripts PMPY for Misc. Antibiotics of Concern														
0–9	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
10–17	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
18–34	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
35–49	M	0.01	0.01	0.00	0.01	0.01	0.01	0.01						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.01	0.00						
50–64	M	0.01	0.00	0.00	0.00	0.01	0.01	0.01						
	F	0.01	0.01	0.01	0.00	0.01	0.01	0.01						
	M&F	0.01	0.01	0.01	0.00	0.01	0.01	0.01						
65–74	M	0.00	0.00	0.00	0.00	0.00	0.01	0.00						
	F	0.01	0.00	0.00	0.00	0.01	0.01	0.00						
	M&F	0.00	0.00	0.00	0.00	0.01	0.01	0.00						
75–84	M	0.00	0.00	0.00	0.00	0.00	0.02	0.00						
	F	0.00	0.00	0.08	0.00	0.03	0.00	0.01						
	M&F	0.00	0.00	0.05	0.00	0.02	0.01	0.00						
≥85	M	0.08	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.03	0.00	0.00	0.00	0.00	0.00	0.00						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
	F	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
	M&F	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	Sex	AG	BCE	BCW	TCS	UHCE	UHCM	UHCW	HEDIS 2013 National Medicaid Means and Percentiles					
									Mean	P10	P25	P50	P75	P90
All Other Antibiotics Utilization														
Average Scripts PMPY for Absorbable Sulfonamides														
0–9	M	0.06	0.08	0.07	0.12	0.07	0.06	0.06						
	F	0.10	0.13	0.10	0.17	0.11	0.10	0.09						
	M&F	0.08	0.11	0.08	0.14	0.09	0.08	0.07						
10–17	M	0.07	0.08	0.05	0.09	0.07	0.05	0.04						
	F	0.14	0.14	0.10	0.18	0.12	0.11	0.09						
	M&F	0.11	0.11	0.08	0.12	0.10	0.08	0.07						
18–34	M	0.15	0.13	0.09	0.10	0.11	0.11	0.08						
	F	0.28	0.22	0.21	0.22	0.20	0.21	0.17						
	M&F	0.25	0.20	0.18	0.14	0.17	0.19	0.15						
35–49	M	0.20	0.17	0.17	0.10	0.15	0.16	0.13						
	F	0.29	0.22	0.21	0.10	0.20	0.22	0.17						
	M&F	0.26	0.21	0.20	0.10	0.18	0.20	0.16						
50–64	M	0.23	0.15	0.16	0.13	0.14	0.19	0.13						
	F	0.25	0.19	0.18	0.07	0.17	0.23	0.17						
	M&F	0.24	0.17	0.17	0.10	0.16	0.21	0.15						
65–74	M	0.15	0.08	0.06	0.00	0.18	0.19	0.10						
	F	0.13	0.13	0.10	0.26	0.21	0.27	0.17						
	M&F	0.14	0.12	0.09	0.17	0.20	0.24	0.14						
75–84	M	0.03	0.13	0.00	0.00	0.14	0.17	0.11						
	F	0.36	0.05	0.11	0.00	0.17	0.20	0.11						
	M&F	0.22	0.07	0.07	0.00	0.16	0.19	0.11						
≥85	M	0.29	0.00	0.36	0.00	0.06	0.20	0.18						
	F	0.18	0.05	0.03	0.00	0.16	0.11	0.12						
	M&F	0.22	0.04	0.12	0.00	0.15	0.13	0.13						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**0.09**	**0.10**	**0.08**	**0.10**	**0.09**	**0.08**	**0.07**	**0.06**	**0.04**	**0.04**	**0.06**	**0.07**	**0.09**
	F	**0.19**	**0.18**	**0.15**	**0.18**	**0.15**	**0.16**	**0.13**	**0.11**	**0.07**	**0.09**	**0.11**	**0.13**	**0.16**
	M&F	**0.15**	**0.14**	**0.12**	**0.13**	**0.13**	**0.12**	**0.10**	**0.09**	**0.06**	**0.07**	**0.09**	**0.10**	**0.13**

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	**Sex**	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid Means and Percentiles**					
									Mean	**P10**	**P25**	**P50**	**P75**	**P90**
Average Scripts PMPY for Aminoglycosides														
0–9	M	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
10–17	M	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
18–34	M	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
35–49	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
50–64	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.01	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
65–74	M	0.02	0.00	0.00	0.00	0.01	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.01	0.00	0.00	0.00	0.00	0.00	0.00						
75–84	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.02	0.00	0.00	0.00	0.01	0.02	0.00						
	M&F	0.01	0.00	0.00	0.00	0.00	0.02	0.00						
≥85	M	0.04	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.01	0.00	0.03						
	M&F	0.01	0.00	0.00	0.00	0.01	0.00	0.03						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**0.00**	**0.00**	**0.00**	**0.01**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
	F	**0.00**	**0.00**	**0.00**	**0.01**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
	M&F	**0.00**	**0.00**	**0.00**	**0.01**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	Sex	AG	BCE	BCW	TCS	UHCE	UHCM	UHCW	HEDIS 2013 National Medicaid Means and Percentiles					
									Mean	P10	P25	P50	P75	P90
Average Scripts PMPY for 1st Generation Cephalosporins														
0–9	M	0.06	0.06	0.05	0.05	0.05	0.06	0.04						
	F	0.07	0.08	0.06	0.07	0.07	0.07	0.04						
	M&F	0.06	0.07	0.06	0.06	0.06	0.06	0.04						
10–17	M	0.07	0.08	0.05	0.06	0.06	0.06	0.05						
	F	0.08	0.09	0.06	0.07	0.08	0.08	0.06						
	M&F	0.07	0.08	0.06	0.07	0.07	0.07	0.05						
18–34	M	0.09	0.09	0.07	0.06	0.07	0.09	0.07						
	F	0.14	0.16	0.13	0.12	0.13	0.14	0.11						
	M&F	0.13	0.14	0.12	0.08	0.12	0.13	0.10						
35–49	M	0.10	0.12	0.11	0.05	0.10	0.11	0.09						
	F	0.14	0.14	0.13	0.13	0.13	0.14	0.13						
	M&F	0.13	0.14	0.13	0.09	0.12	0.13	0.12						
50–64	M	0.12	0.11	0.09	0.08	0.10	0.12	0.11						
	F	0.15	0.14	0.14	0.05	0.14	0.17	0.15						
	M&F	0.13	0.13	0.12	0.06	0.12	0.15	0.13						
65–74	M	0.05	0.08	0.03	0.00	0.11	0.15	0.11						
	F	0.07	0.15	0.07	0.00	0.16	0.15	0.18						
	M&F	0.06	0.13	0.06	0.00	0.14	0.15	0.16						
75–84	M	0.00	0.00	0.00	0.00	0.21	0.12	0.16						
	F	0.04	0.02	0.14	0.00	0.18	0.18	0.19						
	M&F	0.02	0.02	0.09	0.00	0.19	0.16	0.18						
≥85	M	0.17	0.00	0.29	0.00	0.15	0.04	0.07						
	F	0.09	0.04	0.00	0.00	0.11	0.12	0.16						
	M&F	0.12	0.03	0.08	0.00	0.11	0.10	0.15						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**0.07**	**0.08**	**0.06**	**0.06**	**0.07**	**0.07**	**0.06**	**0.07**	**0.04**	**0.05**	**0.06**	**0.08**	**0.10**
	F	**0.10**	**0.12**	**0.10**	**0.08**	**0.10**	**0.11**	**0.08**	**0.09**	**0.06**	**0.07**	**0.09**	**0.11**	**0.14**
	M&F	**0.09**	**0.10**	**0.08**	**0.07**	**0.09**	**0.09**	**0.07**	**0.08**	**0.05**	**0.06**	**0.08**	**0.09**	**0.12**

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	**Sex**	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid Means and Percentiles**					
									Mean	**P10**	**P25**	**P50**	**P75**	**P90**
Average Scripts PMPY for Lincosamides														
0–9	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
10–17	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
18–34	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
35–49	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
50–64	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
65–74	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
75–84	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
≥85	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
	F	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
	M&F	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	**Sex**	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid Means and Percentiles**					
									Mean	**P10**	**P25**	**P50**	**P75**	**P90**
Average Scripts PMPY for Macrolides (not azith. or clarith.)														
0–9	M	0.00	0.00	0.00	0.02	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.02	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.02	0.00	0.00	0.00						
10–17	M	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
18–34	M	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
	F	0.01	0.01	0.01	0.01	0.01	0.01	0.00						
	M&F	0.01	0.01	0.01	0.01	0.01	0.01	0.00						
35–49	M	0.00	0.01	0.00	0.07	0.00	0.00	0.00						
	F	0.01	0.01	0.01	0.01	0.01	0.01	0.01						
	M&F	0.01	0.01	0.01	0.04	0.01	0.01	0.00						
50–64	M	0.01	0.01	0.00	0.16	0.01	0.00	0.00						
	F	0.01	0.01	0.00	0.01	0.01	0.01	0.01						
	M&F	0.01	0.01	0.00	0.08	0.01	0.01	0.00						
65–74	M	0.00	0.00	0.00	0.00	0.01	0.01	0.00						
	F	0.00	0.00	0.01	0.00	0.01	0.01	0.00						
	M&F	0.00	0.00	0.01	0.00	0.01	0.01	0.00						
75–84	M	0.00	0.00	0.00	0.00	0.00	0.01	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.01						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
≥85	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.01	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.01	0.00	0.00						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**0.00**	**0.00**	**0.00**	**0.01**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.01**
	F	**0.00**	**0.01**	**0.00**	**0.01**	**0.00**	**0.00**	**0.00**	**0.01**	**0.00**	**0.00**	**0.00**	**0.01**	**0.01**
	M&F	**0.00**	**0.01**	**0.00**	**0.01**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.01**	**0.01**

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	Sex	AG	BCE	BCW	TCS	UHCE	UHCM	UHCW	HEDIS 2013 National Medicaid Means and Percentiles					
									Mean	P10	P25	P50	P75	P90
Average Scripts PMPY for Penicillins														
0–9	M	0.55	0.60	0.48	0.50	0.51	0.55	0.43						
	F	0.55	0.59	0.46	0.57	0.51	0.55	0.42						
	M&F	0.55	0.60	0.47	0.53	0.51	0.55	0.43						
10–17	M	0.23	0.27	0.18	0.23	0.22	0.21	0.16						
	F	0.29	0.34	0.23	0.30	0.29	0.27	0.21						
	M&F	0.26	0.30	0.20	0.25	0.26	0.24	0.18						
18–34	M	0.20	0.23	0.18	0.17	0.20	0.18	0.16						
	F	0.34	0.36	0.34	0.28	0.32	0.30	0.28						
	M&F	0.30	0.33	0.30	0.21	0.29	0.27	0.25						
35–49	M	0.20	0.21	0.18	0.08	0.19	0.19	0.18						
	F	0.28	0.29	0.29	0.18	0.25	0.25	0.26						
	M&F	0.25	0.27	0.26	0.13	0.23	0.23	0.24						
50–64	M	0.17	0.16	0.18	0.07	0.14	0.17	0.16						
	F	0.21	0.20	0.22	0.07	0.18	0.20	0.23						
	M&F	0.19	0.19	0.20	0.07	0.16	0.19	0.20						
65–74	M	0.28	0.03	0.19	0.00	0.16	0.16	0.22						
	F	0.11	0.09	0.06	0.13	0.19	0.23	0.24						
	M&F	0.19	0.07	0.10	0.09	0.18	0.20	0.23						
75–84	M	0.15	0.07	0.11	0.00	0.13	0.12	0.13						
	F	0.02	0.00	0.11	0.00	0.16	0.14	0.10						
	M&F	0.07	0.02	0.11	0.00	0.15	0.13	0.11						
≥85	M	0.25	0.00	0.00	0.00	0.10	0.05	0.07						
	F	0.07	0.04	0.00	0.00	0.08	0.08	0.12						
	M&F	0.13	0.03	0.00	0.00	0.08	0.07	0.12						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**0.38**	**0.40**	**0.33**	**0.32**	**0.33**	**0.36**	**0.29**	**0.33**	**0.22**	**0.27**	**0.31**	**0.37**	**0.44**
	F	**0.39**	**0.41**	**0.35**	**0.41**	**0.35**	**0.37**	**0.31**	**0.35**	**0.25**	**0.30**	**0.34**	**0.39**	**0.44**
	M&F	**0.38**	**0.41**	**0.34**	**0.35**	**0.34**	**0.37**	**0.30**	**0.34**	**0.24**	**0.29**	**0.33**	**0.38**	**0.45**

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age/as Stated	**Sex**	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid Means and Percentiles**					
									Mean	**P10**	**P25**	**P50**	**P75**	**P90**
Average Scripts PMPY for Tetracyclines														
0–9	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
10–17	M	0.04	0.06	0.04	0.06	0.05	0.04	0.04						
	F	0.04	0.06	0.05	0.05	0.06	0.04	0.05						
	M&F	0.04	0.06	0.05	0.05	0.06	0.04	0.04						
18–34	M	0.05	0.05	0.06	0.11	0.05	0.05	0.06						
	F	0.06	0.07	0.10	0.08	0.07	0.07	0.08						
	M&F	0.05	0.06	0.09	0.10	0.06	0.06	0.07						
35–49	M	0.04	0.04	0.08	0.17	0.06	0.06	0.07						
	F	0.06	0.07	0.10	0.03	0.08	0.07	0.09						
	M&F	0.06	0.06	0.10	0.10	0.07	0.07	0.09						
50–64	M	0.05	0.06	0.07	0.03	0.07	0.08	0.08						
	F	0.07	0.08	0.08	0.01	0.11	0.08	0.09						
	M&F	0.06	0.07	0.08	0.02	0.09	0.08	0.09						
65–74	M	0.03	0.02	0.10	0.26	0.14	0.13	0.09						
	F	0.10	0.08	0.02	0.00	0.16	0.12	0.10						
	M&F	0.06	0.06	0.05	0.09	0.15	0.13	0.09						
75–84	M	0.06	0.00	0.00	0.00	0.11	0.07	0.13						
	F	0.06	0.05	0.05	0.00	0.19	0.11	0.07						
	M&F	0.06	0.03	0.04	0.00	0.17	0.10	0.09						
≥85	M	0.08	0.00	0.00	0.00	0.13	0.04	0.04						
	F	0.05	0.00	0.00	0.00	0.15	0.06	0.05						
	M&F	0.06	0.00	0.00	0.00	0.15	0.06	0.05						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**0.02**	**0.03**	**0.03**	**0.05**	**0.03**	**0.03**	**0.03**	**0.04**	**0.02**	**0.03**	**0.04**	**0.04**	**0.05**
	F	**0.04**	**0.05**	**0.06**	**0.03**	**0.05**	**0.04**	**0.05**	**0.06**	**0.04**	**0.05**	**0.06**	**0.07**	**0.08**
	M&F	**0.03**	**0.04**	**0.04**	**0.04**	**0.04**	**0.04**	**0.04**	**0.05**	**0.03**	**0.04**	**0.05**	**0.06**	**0.07**

Table A. HEDIS 2014 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age / as Stated	**Sex**	**AG**	**BCE**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**HEDIS 2013 National Medicaid Means and Percentiles**					
									Mean	**P10**	**P25**	**P50**	**P75**	**P90**
Average Scripts PMPY for Misc. Antibiotics														
0–9	M	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
	F	0.01	0.01	0.00	0.03	0.01	0.01	0.00						
	M&F	0.01	0.01	0.00	0.02	0.01	0.01	0.00						
10–17	M	0.00	0.01	0.00	0.01	0.01	0.00	0.00						
	F	0.05	0.07	0.05	0.10	0.06	0.06	0.05						
	M&F	0.03	0.04	0.03	0.04	0.03	0.03	0.03						
18–34	M	0.03	0.02	0.02	0.02	0.02	0.02	0.02						
	F	0.37	0.37	0.44	0.24	0.31	0.37	0.37						
	M&F	0.28	0.28	0.35	0.10	0.22	0.28	0.29						
35–49	M	0.04	0.04	0.05	0.04	0.03	0.04	0.03						
	F	0.22	0.20	0.28	0.13	0.18	0.22	0.23						
	M&F	0.16	0.15	0.23	0.08	0.13	0.17	0.18						
50–64	M	0.05	0.05	0.05	0.11	0.04	0.06	0.05						
	F	0.14	0.16	0.16	0.22	0.15	0.17	0.14						
	M&F	0.10	0.12	0.12	0.17	0.10	0.12	0.10						
65–74	M	0.18	0.13	0.05	0.00	0.05	0.07	0.04						
	F	0.19	0.13	0.07	0.13	0.20	0.21	0.13						
	M&F	0.19	0.13	0.07	0.09	0.14	0.16	0.10						
75–84	M	0.03	0.00	0.00	0.00	0.06	0.04	0.08						
	F	0.29	0.09	0.03	0.00	0.27	0.22	0.09						
	M&F	0.18	0.07	0.02	0.00	0.21	0.16	0.08						
≥85	M	0.17	0.00	0.14	0.00	0.04	0.05	0.04						
	F	0.27	0.16	0.20	0.00	0.20	0.19	0.11						
	M&F	0.23	0.13	0.19	0.00	0.17	0.16	0.11						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**0.01**	**0.01**	**0.01**	**0.01**	**0.01**	**0.01**	**0.01**	**0.01**	**0.00**	**0.01**	**0.01**	**0.01**	**0.02**
	F	**0.15**	**0.16**	**0.19**	**0.09**	**0.14**	**0.16**	**0.16**	**0.13**	**0.08**	**0.09**	**0.12**	**0.15**	**0.16**
	M&F	**0.09**	**0.10**	**0.12**	**0.04**	**0.08**	**0.10**	**0.10**	**0.08**	**0.05**	**0.06**	**0.07**	**0.09**	**0.10**

‡‡ NCQA has yet to determine the mean.

APPENDIX B | *HEDIS 2013 National Medicaid Means and Percentiles*

Table B. HEDIS 2013 National Medicaid Means and Percentiles						
Measure	**Mean**	**Percentile**				
		10th	**25th**	**50th**	**75th**	**90th**
HEDIS Effectiveness of Care Measures						
Prevention and Screening						
Adult BMI Assessment (ABA)	67.63%	49.15%	62.62%	72.09%	78.77%	84.39%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC):						
BMI Percentile: 3–11 years	51.48%	21.32%	36.42%	52.88%	69.86%	80.93%
12–17 years	52.31%	23.87%	39.86%	53.66%	68.75%	80.26%
Total	**51.78%**	**22.87%**	**37.96%**	**52.31%**	**69.68%**	**80.24%**
Counseling for Nutrition: 3–11 years	56.68%	30.88%	48.93%	60.19%	69.35%	76.63%
12–17 years	51.34%	29.68%	41.41%	55.29%	64.34%	72.73%
Total	**55.01%**	**31.02%**	**47.45%**	**59.11%**	**67.91%**	**75.18%**
Counseling for Physical Activity: 3–11 years	42.81%	18.38%	34.01%	43.51%	54.81%	65.75%
12–17 years	47.30%	24.80%	38.27%	50.00%	58.91%	67.07%
Total	**44.23%**	**20.92%**	**34.55%**	**46.23%**	**55.26%**	**64.72%**
Childhood Immunization Status (CIS):						
DTaP/DT	80.95%	73.50%	77.08%	81.51%	85.89%	88.13%
IPV	91.61%	86.75%	89.29%	92.70%	94.65%	96.07%
MMR	91.60%	86.81%	89.81%	92.21%	94.29%	95.38%
HiB	92.01%	87.50%	90.27%	93.16%	94.79%	96.03%
HepB	89.51%	81.51%	87.22%	91.39%	93.81%	95.45%
VZV	91.10%	85.65%	89.54%	91.59%	93.75%	95.13%
PCV	80.07%	73.32%	76.16%	81.13%	84.95%	88.08%
HepA	76.36%	47.93%	72.99%	80.79%	88.32%	91.20%
RV	66.00%	56.45%	60.88%	66.67%	72.51%	77.20%
Influenza	49.51%	30.37%	41.36%	50.00%	58.64%	64.48%
Combination 2	75.74%	65.97%	70.44%	76.89%	81.74%	85.40%
Combination 3	72.08%	61.95%	66.08%	72.88%	78.30%	83.32%
Combination 4	60.89%	36.25%	56.07%	63.02%	71.78%	77.80%
Combination 5	55.27%	44.53%	48.91%	55.41%	61.81%	69.38%
Combination 6	41.76%	25.93%	33.33%	41.89%	49.57%	56.93%
Combination 7	48.73%	27.04%	42.09%	50.33%	58.06%	65.61%
Combination 8	37.28%	19.91%	29.20%	38.66%	45.13%	52.53%
Combination 9	34.72%	19.68%	27.25%	34.38%	41.50%	49.31%
Combination 10	31.38%	16.06%	24.82%	31.39%	38.43%	45.70%
Immunizations for Adolescents (IMA):						
Meningococcal	69.37%	52.31%	60.34%	71.07%	79.17%	89.06%
Tdap/Td	81.33%	66.00%	76.66%	85.19%	89.78%	93.19%
Combination 1	67.19%	50.93%	58.06%	68.59%	77.08%	85.64%

Table B. HEDIS 2013 National Medicaid Means and Percentiles						
Measure	**Mean**	**Percentile**				
		10th	**25th**	**50th**	**75th**	**90th**
Human Papillomavirus Vaccine for Female Adolescents (HPV)*						
Lead Screening in Children (LSC)	67.49%	36.57%	58.50%	72.26%	82.24%	86.96%
Breast Cancer Screening (BCS)**	51.82%	41.72%	46.51%	51.32%	57.71%	62.88%
Cervical Cancer Screening (CCS)***						
Chlamydia Screening in Women (CHL):						
16–20 years	53.50%	41.05%	46.93%	53.80%	59.48%	66.38%
21–24 years	63.66%	51.52%	58.98%	64.58%	70.71%	73.45%
Total	**57.10%**	**46.22%**	**50.97%**	**57.30%**	**63.72%**	**68.81%**
Respiratory Conditions						
Appropriate Testing for Children With Pharyngitis (CWP)	68.03%	50.84%	60.82%	70.30%	77.97%	85.09%
Appropriate Treatment for Children With Upper Respiratory Infection (URI)	85.08%	77.03%	81.40%	85.86%	90.29%	92.99%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)	24.22%	14.88%	17.92%	22.18%	28.18%	35.45%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	31.52%	19.05%	26.22%	31.31%	38.07%	42.80%
Pharmacotherapy Management of COPD Exacerbation (PCE):						
Systemic Corticosteroid	65.30%	48.43%	60.66%	67.00%	73.33%	77.17%
Bronchodilator	81.48%	71.65%	78.18%	83.24%	87.37%	90.29%
Use of Appropriate Medications for People With Asthma (ASM):						
5–11 years	89.65%	83.77%	86.97%	90.31%	92.92%	94.92%
12–18 years	85.59%	78.88%	81.96%	85.88%	88.99%	92.16%
19–50 years	73.87%	61.67%	68.25%	74.76%	80.69%	84.32%
51–64 years	71.32%	55.80%	65.03%	72.50%	77.89%	82.97%
Total	**83.88%**	**77.30%**	**80.67%**	**84.70%**	**87.64%**	**89.76%**
Medication Management for People With Asthma (MMA)						
Medication Compliance 50%: 5–11 years*						
12–18 years*						
19–50 years*						
51–64 years*						
Total*						
Medication Compliance 75%: 5–11 years	25.35%	16.21%	18.52%	24.40%	29.46%	36.00%
12–18 years	25.11%	15.65%	18.36%	23.92%	30.11%	35.94%
19–50 years	34.14%	24.10%	28.30%	33.15%	38.78%	44.07%
51–64 years	50.16%	38.14%	43.83%	48.91%	54.86%	63.07%
Total	**28.70%**	**19.20%**	**22.17%**	**27.62%**	**32.82%**	**38.62%**
Asthma Medical Ratio (AMR)†						
5–11 years						
12–18 years						
19–50 years						
51–64 years						
Total						

Table B. HEDIS 2013 National Medicaid Means and Percentiles						
Measure	**Mean**	**Percentile**				
		10th	**25th**	**50th**	**75th**	**90th**
Cardiovascular Conditions						
Cholesterol Management for Patients With Cardiovascular Conditions (CMC):						
LDL-C Screening	81.62%	73.94%	78.72%	82.42%	85.25%	88.86%
LDL-C Control (<100 mg/dL)	41.37%	28.21%	34.94%	41.82%	47.52%	54.06%
Controlling High Blood Pressure (CBP)	56.36%	44.90%	50.33%	56.20%	62.97%	69.55%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	82.05%	71.15%	78.90%	82.98%	87.93%	90.98%
Diabetes						
Comprehensive Diabetes Care (CDC):						
HbA1c Testing	82.98%	75.75%	79.21%	83.16%	87.33%	91.11%
HbA1c Control (<7.0%)	34.03%	23.95%	30.46%	34.76%	39.90%	43.24%
HbA1c Control (<8.0%)	46.60%	34.58%	39.93%	48.57%	53.77%	58.64%
Retinal Eye Exam Performed	53.17%	37.14%	44.37%	54.31%	62.46%	67.64%
LDL-C Screening	75.56%	66.71%	71.05%	76.28%	80.54%	83.52%
LDL-C Control (<100 mg/dL)	33.93%	21.76%	27.87%	34.89%	40.10%	43.80%
Medical Attention for Nephropathy	78.38%	69.76%	75.00%	79.23%	82.73%	85.85%
Blood Pressure Control (<140/80 mm Hg)	37.91%	27.69%	31.36%	38.89%	44.53%	50.61%
Blood Pressure Control (<140/90 mm Hg)	59.02%	46.29%	53.81%	61.03%	68.20%	74.55%
Musculoskeletal Conditions						
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	69.96%	57.14%	64.96%	69.46%	75.80%	82.59%
Use of Imaging Studies for Low Back Pain (LBP)	75.55%	68.31%	71.52%	75.14%	79.06%	82.34%
Behavioral Health						
Antidepressant Medication Management (AMM):						
Effective Acute Phase Treatment	52.79%	45.12%	48.30%	51.47%	56.05%	61.03%
Effective Continuation Phase Treatment	36.65%	28.13%	32.07%	35.26%	40.06%	45.86%
Follow-Up Care for Children Prescribed ADHD Medication (ADD):						
Initiation Phase	39.05%	23.89%	31.40%	39.76%	45.65%	51.86%
Continuation and Maintenance Phase	45.29%	25.00%	35.48%	46.76%	56.84%	63.75%
Follow-Up After Hospitalization for Mental Illness (FUH):						
7-day follow-up	43.83%	21.33%	31.28%	44.66%	54.80%	68.79%
30-day follow-up	63.75%	38.13%	57.21%	65.85%	75.68%	82.01%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)†						
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)†						
Cardiovascular Monitoring for People With Cardio-vascular Disease and Schizophrenia (SMC)†						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)†						
Medication Management						
Annual Monitoring for Patients on Persistent Medications (MPM):						
ACE Inhibitors or ARBs	86.30%	80.80%	84.58%	86.98%	89.17%	91.21%
Digoxin	90.15%	83.72%	87.50%	90.91%	93.15%	94.95%

Table B. HEDIS 2013 National Medicaid Means and Percentiles						
Measure	**Mean**	**Percentile**				
		10th	**25th**	**50th**	**75th**	**90th**
Diuretics	85.96%	79.98%	83.76%	86.68%	89.05%	91.30%
Anticonvulsants	65.70%	55.56%	61.76%	65.98%	70.67%	73.58%
Total	**84.47%**	**79.28%**	**82.38%**	**85.39%**	**87.27%**	**89.00%**
Measures Collected Through CAHPS Health Plan Survey						
Medical Assistance With Smoking Cessation (MSC):						
Advising Smokers and Tobacco Users to Quit	75.56%	69.88%	72.09%	76.20%	79.55%	81.26%
Discussing Cessation Medications	45.81%	36.03%	40.46%	45.18%	51.38%	57.50%
Discussing Cessation Strategies	41.14%	33.44%	36.65%	40.25%	44.77%	50.69%
HEDIS Effectiveness of Care Measures Where Lower Rates Indicated Better Performance						
Prevention and Screening						
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)‡						
Diabetes						
Comprehensive Diabetes Care (CDC):						
HbA1c Poor Control (>9.0%)	44.63%	59.48%	52.31%	43.02%	35.76%	31.14%
HEDIS Access/Availability of Care Measures						
Adults' Access to Preventive/Ambulatory Health Services (AAP):						
20–44 years	80.37%	68.53%	77.34%	82.39%	85.27%	88.32%
45–64 years	86.54%	79.52%	84.55%	87.50%	90.30%	91.14%
Children and Adolescents' Access to Primary Care Practitioners (CAP):						
12–24 months	95.97%	92.37%	95.51%	96.89%	97.84%	98.49%
25 months–6 years	88.32%	82.76%	86.37%	89.39%	91.29%	93.60%
7-11 years	89.88%	83.43%	87.77%	90.88%	93.26%	95.25%
12–19 years	88.38%	81.35%	86.09%	89.58%	91.85%	93.77%
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET):						
Initiation of AOD Treatment: 13–17 years	39.14%	23.22%	33.90%	40.00%	45.24%	50.72%
≥18 years	39.38%	28.68%	34.97%	39.14%	43.54%	48.03%
Total	**39.35%**	**28.62%**	**36.03%**	**39.16%**	**43.43%**	**48.24%**
Engagement of AOD Treatment: 13–17 years	16.53%	3.61%	9.60%	16.61%	23.23%	28.40%
≥18 years	10.18%	2.65%	5.03%	8.90%	15.63%	19.50%
Total	**10.84%**	**2.85%**	**5.14%**	**10.19%**	**16.17%**	**19.84%**
Prenatal and Postpartum Care (PPC):						
Timeliness of Prenatal Care	82.93%	70.59%	79.85%	85.88%	89.72%	92.82%
Postpartum Care	63.05%	50.69%	57.91%	63.99%	70.20%	73.83%
Call Answer Timeliness (CAT)	83.83%	70.34%	80.30%	86.16%	90.36%	94.66%
HEDIS Utilization and Relative Resource Use Measures						
Utilization						
Frequency of Ongoing Prenatal Care (FPC):						
<21%	12.32%	2.32%	4.24%	8.27%	13.83%	27.39%
21–40%	5.94%	1.64%	2.78%	4.25%	6.56%	12.27%
41–60%	7.68%	3.89%	4.92%	6.83%	9.51%	12.99%
61–80%	13.62%	7.55%	10.55%	13.53%	16.31%	20.77%
≥81%	60.45%	36.25%	50.97%	64.70%	73.97%	80.12%

Table B. HEDIS 2013 National Medicaid Means and Percentiles						
Measure	Mean	Percentile				
		10th	25th	50th	75th	90th
Well-Child Visits in the First 15 Months of Life (W15):						
0 Visits	1.80%	0.29%	0.73%	1.22%	2.13%	3.55%
1 Visits	1.81%	0.58%	1.01%	1.55%	2.26%	3.31%
2 Visits	2.91%	1.10%	2.03%	2.73%	3.64%	4.74%
3 Visits	5.01%	2.14%	3.58%	4.66%	6.12%	7.79%
4 Visits	8.98%	4.68%	6.70%	8.61%	10.95%	12.96%
5 Visits	15.51%	9.15%	12.24%	15.34%	18.73%	21.65%
6 or More Visits	63.65%	49.70%	55.95%	65.16%	70.90%	77.44%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	72.00%	60.81%	67.40%	72.26%	78.51%	82.08%
Adolescent Well-Care Visits (AWC)	49.69%	37.27%	41.72%	48.18%	57.40%	65.45%

** Measure deemed first-year status again in 2013.*
*** The age group for this measure changed; NCQA has yet to determine if results are trendable with the previous year.*
**** The measure's specification changed and results cannot be trended with previous years.*
† Benchmarks are not reported by Quality Compass for 2013 first year measures.
‡Measure is first-year in 2014.

APPENDIX C | *MCO Population Reported in Member Months*

Table C. HEDIS 2014 MCO Population Reported in Member Months by Age and Sex

Age Group	AG			BCE			BCW			TCS			UHCE			UHCM			UHCW		
Age	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
<1	55124	50920	106,044	52263	49172	101,435	43293	41581	84,874	7546	7212	14,758	44582	42697	87,279	53187	53417	106,604	42199	40033	82,232
1–4	183558	175177	358,735	173544	165942	339,486	161224	152484	313,708	42778	34897	77,675	156282	148928	305,210	180970	176496	357,466	155796	151680	307,476
5–9	202250	195325	397,575	196138	189845	385,983	172338	173197	345,535	74989	46042	121,031	187950	180777	368,727	202885	198950	401,835	170155	169743	339,898
10–14	158130	156194	314,324	163148	154887	318,035	139771	143528	283,299	87618	48043	135,661	151154	151620	302,774	158612	153500	312,112	132952	135349	268,301
15–17	74568	78848	153,416	80751	81231	161,982	71759	72739	144,498	63098	35962	99,060	75210	77530	152,740	74890	73633	148,523	68117	73536	141,653
18–19	39506	51967	91,473	41091	52102	93,193	37990	47005	84,995	38794	21939	60,733	39555	50690	90,245	38015	46233	84,248	38224	50818	89,042
0–19 Subtotal	**713,136**	**708,431**	**1,421,567**	**706,935**	**693,179**	**1,400,114**	**626,375**	**630,534**	**1,256,909**	**314,823**	**194,095**	**508,918**	**654,733**	**652,242**	**1,306,975**	**708,559**	**702,229**	**1,410,788**	**607,443**	**621,159**	**1,228,602**
0–19 Subtotal %	**78.00%**	**58.36%**	**66.80%**	**76.31%**	**54.22%**	**63.50%**	**82.05%**	**55.27%**	**66.00%**	**93.63%**	**92.70%**	**93.27%**	**70.21%**	**53.89%**	**60.99%**	**76.91%**	**55.42%**	**64.47%**	**77.16%**	**54.78%**	**63.95%**
20–24	37795	113830	151,625	30523	113041	143,564	28504	106585	135,089	14299	8592	22,891	41224	98556	139,780	31394	106182	137,576	36617	120544	157,161
25–29	23824	99929	123,753	28879	112510	141,389	17010	107685	124,695	1374	959	2,333	25117	86500	111,617	25164	109643	134,807	15815	95127	110,942
30–34	26082	89002	115,084	31110	98245	129,355	17384	96582	113,966	1271	1040	2,311	28943	85790	114,733	28074	99344	127,418	17228	84419	101,647
35–39	22871	67079	89,950	28181	76733	104,914	13645	66662	80,307	741	647	1,388	29590	69290	98,880	25377	71703	97,080	17620	64460	82,080
40–44	20957	45471	66,428	24907	53686	78,593	12137	41979	54,116	696	803	1,499	28746	51404	80,150	22488	50460	72,948	16147	42571	58,718
20–44 Subtotal	**131,529**	**415,311**	**546,840**	**143,600**	**454,215**	**597,815**	**88,680**	**419,493**	**508,173**	**18,381**	**12,041**	**30,422**	**153,620**	**391,540**	**545,160**	**132,497**	**437,332**	**569,829**	**103,427**	**407,121**	**510,548**
20–44 Subtotal %	**14.39%**	**34.21%**	**25.69%**	**15.50%**	**35.53%**	**27.11%**	**11.62%**	**36.77%**	**26.69%**	**5.47%**	**5.75%**	**5.58%**	**16.47%**	**32.35%**	**25.44%**	**14.38%**	**34.51%**	**26.04%**	**13.14%**	**35.90%**	**26.57%**
45–49	17864	30209	48,073	21806	41587	63,393	10900	29389	40,289	826	877	1,703	27071	38904	65,975	19943	35485	55,428	15922	29228	45,150
50–54	19439	24630	44,069	21268	35697	56,965	13226	24450	37,676	890	806	1,696	29728	36905	66,633	20203	29813	50,016	19516	24419	43,935
55–59	18968	19750	38,718	18882	28655	47,537	14064	20677	34,741	783	960	1,743	30317	32420	62,737	18382	24687	43,069	20248	21306	41,554
60–64	11501	13056	24,557	12848	22644	35,492	9006	13852	22,858	468	496	964	20182	24182	44,364	11866	17612	29,478	13443	14033	27,476
45–64 Subtotal	**67,772**	**87,645**	**155,417**	**74,804**	**128,583**	**203,387**	**47,196**	**88,368**	**135,564**	**2,967**	**3,139**	**6,106**	**107,298**	**132,411**	**239,709**	**70,394**	**107,597**	**177,991**	**69,129**	**88,986**	**158,115**
45–64 Subtotal %	**7.41%**	**7.22%**	**7.30%**	**8.07%**	**10.06%**	**9.22%**	**6.18%**	**7.75%**	**7.12%**	**0.88%**	**1.50%**	**1.12%**	**11.51%**	**10.94%**	**11.19%**	**7.64%**	**8.49%**	**8.13%**	**8.78%**	**7.85%**	**8.23%**
65–69	856	1007	1,863	549	1023	1,572	588	1254	1,842	36	57	93	7341	11550	18,891	4160	7097	11,257	3528	5513	9,041
70–74	344	382	726	165	225	390	165	379	544	11	36	47	4447	8424	12,871	2598	4567	7,165	1874	4300	6,174
75–79	215	291	506	80	232	312	133	230	363	23	10	33	2569	5952	8,521	1459	3121	4,580	971	2529	3,500
80–84	186	283	469	104	274	378	94	209	303	1	1	2	1483	3791	5,274	916	2455	3,371	547	1886	2,433
85–89	188	316	504	99	353	452	77	186	263	1	9	10	666	2616	3,282	470	1602	2,072	209	1272	1,481
≥90	99	217	316	70	318	388	89	225	314	0	0	0	314	1783	2,097	202	1084	1,286	121	1240	1,361
≥65 Subtotal	**1,888**	**2,496**	**4,384**	**1,067**	**2,425**	**3,492**	**1,146**	**2,483**	**3,629**	**72**	**113**	**185**	**16,820**	**34,116**	**50,936**	**9,805**	**19,926**	**29,731**	**7,250**	**16,740**	**23,990**
≥65 Subtotal: %	**0.21%**	**0.21%**	**0.21%**	**0.12%**	**0.19%**	**0.16%**	**0.15%**	**0.22%**	**0.19%**	**0.02%**	**0.05%**	**0.03%**	**1.80%**	**2.82%**	**2.38%**	**1.06%**	**1.57%**	**1.36%**	**0.92%**	**1.48%**	**1.25%**
Total	**914,325**	**1,213,883**	**2,128,208**	**926,406**	**1,278,402**	**2,204,808**	**763,397**	**1,140,878**	**1,904,275**	**336,243**	**209,388**	**545,631**	**932,471**	**1,210,309**	**2,142,780**	**921,255**	**1,267,084**	**2,188,339**	**787,249**	**1,134,006**	**1,921,255**

APPENDIX D | *Measure Reporting Options*

The reporting options are presented for each measure: administrative and/or hybrid. Currently, when the hybrid option is available, TennCare MCOs are required to use the hybrid method.

Table D. HEDIS Measure Reporting Options

Measure	Administrative	Hybrid
HEDIS Effectiveness of Care		
Prevention and Screening		
Adult BMI Assessment (ABA)	✓	✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	✓	✓
Childhood Immunization Status (CIS)	✓	✓
Immunizations for Adolescents (IMA)	✓	✓
Human Papillomavirus Vaccine for Female Adolescents (HPV)	✓	✓
Lead Screening in Children (LSC)	✓	✓
Breast Cancer Screening (BCS)	✓	
Cervical Cancer Screening (CCS)	✓	✓
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	✓	
Chlamydia Screening in Women (CHL)	✓	
Respiratory Conditions		
Appropriate Testing for Children With Pharyngitis (CWP)	✓	
Appropriate Treatment for Children With Upper Respiratory Infection (URI)	✓	
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)	✓	
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	✓	
Pharmacotherapy Management of COPD Exacerbation (PCE)	✓	
Use of Appropriate Medications for People With Asthma (ASM)	✓	
Medication Management for People With Asthma (MMA)	✓	
Asthma Medical Ratio (AMR)	✓	
Cardiovascular Conditions		
Cholesterol Management for Patients With Cardiovascular Conditions (CMC)	✓	✓
Controlling High Blood Pressure (CBP)		✓
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	✓	
Diabetes		
Comprehensive Diabetes Care (CDC)	✓	✓
Musculoskeletal Conditions		
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	✓	
Use of Imaging Studies for Low Back Pain (LBP)	✓	
Behavioral Health		
Antidepressant Medication Management (AMM)	✓	
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	✓	
Follow-Up After Hospitalization for Mental Illness (FUH)	✓	
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	✓	
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	✓	
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	✓	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	✓	

Table D. HEDIS Measure Reporting Options		
Measure	**Administrative**	**Hybrid**
Medication Management		
Annual Monitoring for Patients on Persistent Medications (MPM)	✓	
Measures Collected Through CAHPS Health Plan Survey		
Medical Assistance With Smoking Cessation (MSC)		
HEDIS Access/Availability of Care Measures		
Adults' Access to Preventive/Ambulatory Health Services (AAP)	✓	
Children and Adolescents' Access to Primary Care Practitioners (CAP)	✓	
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)	✓	
Prenatal and Postpartum Care (PPC)	✓	✓
Call Answer Timeliness (CAT)	✓	
HEDIS Utilization and Relative Resource Use Measures		
Utilization		
Frequency of Ongoing Prenatal Care (FPC)	✓	✓
Well-Child Visits in the First 15 Months of Life (W15)	✓	✓
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	✓	✓
Adolescent Well-Care Visits (AWC)	✓	✓

ATTACHMENT F

QUALITY IMPROVEMENT STRATEGY

Required by STC 43.c.

STATE OF TENNESSEE

BUREAU OF TENNCARE

2014

Annual Update Report

OF THE

2013 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY

TABLE OF CONTENTS

Acronyms

AAAD	Area Agency on Aging and Disability
ACS	Affiliated Computer Services Inc.
ADHD	Attention Deficit Hyperactivity Disorder
ANA	Annual Network Adequacy and Benefit Delivery Review
AQS	Annual Quality Survey
ASH	Abortion, Sterilization, Hysterectomy
ASO	Administrative Services Only
BCBST	BlueCross BlueShield of Tennessee
BHO	Behavioral Health Organization
CAD	Coronary Artery Disease
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CFR	Code of Federal Regulations
CHCS	Center for Health Care Strategies
CHF	Congestive Heart Failure
CLIA	Clinical Laboratory Improvement Amendments
CM	Case Management
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
COTS	Commercial Off-the-Shelf
CQM	Clinical Quality Measure
CRA	Contractor Risk Agreement
DBM	Dental Benefits Manager
D-SNPs	Dual Special Needs Populations
DHS	Department of Human Services
DHHS	Department of Health and Human Services
DM	Disease Management
DOJ	Department of Justice
DUR	Drug Utilization Review
ED	Emergency Department
EDS	Electronic Data Systems
EH	Eligible Hospital
EHR	Electronic Health Record
EP	Eligible Professional
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
F/EA	Fiscal/Employer Agent
FHSC	First Health Services Corp.
HCBS	Home and Community-Based Services

HCFA	Health Care Finance and Administration
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIPTN	Health Information Partnership Tennessee
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health
HHS	Health and Human Services
HSAG	Health Services Advisory Group
ICD	International Classification of Diseases
ICF-MR	Intermediate Care Facility for the Mentally Retarded
LDL-C	Low-Density Lipoprotein Cholesterol
LEIE	List of Excluded Individuals and Entities
LEP	Limited English Proficiency
LOC	Level of Care
LTC	Long Term Care
LTSS	Long Term Services and Supports
MAC	Maximum Allowable Cost
MAR	Management and Administrative Reporting
MCC	Managed Care Contractor
MCO	Managed Care Organization
MFCU	Medicaid Fraud Control Unit
MFP	Money Follows the Person
MIPPA	Medicare Improvements for Patients and Providers Act
MLTSS	Medicaid Managed Long Term Services and Supports
MMIS	Medicaid Management Information System
MMR	Measles, Mumps and Rubella
MRR	Medical Record Review
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NF	Nursing Facility
NPI	National Provider Identifier
NQF	National Quality Forum
OIG	Office of Inspector General
PA	Performance Activity or Prior Authorization
PAC	Pharmacy Advisory Committee
PAE	Pre-Admission Evaluation
PAHP	Prepaid Ambulatory Health Plan
PBM	Pharmacy Benefits Manager
PCP	Primary Care Provider
PCS	Procedural Coding System
PDL	Preferred Drug List

PDV	Provider Data Validation
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PLHSO	Prepaid Limited Health Services Organization
PMV	Performance Measure Validation
POC	Plan of Care
POS	Point of Sale
ProDUR	Prospective Drug Utilization Review
QI	Quality Improvement
QI/QM	Quality Improvement/Quality management
QIA	Quality Improvement Activity
QM/QI	Quality Management/Quality Improvement
QMP	Quality Management Program
QP	Quality Process
RFP	Request for Proposal
RTF	Residential Treatment Facility
SED	Serious Emotional Disturbance
SPIG	Strategic Planning and Innovation Group
SPMI	Serious and Persistent Mental Illness
SSI	Supplemental Security Income
TBI	Tennessee Bureau of Investigation
TCMIS	TennCare Management Information System
TDCI	Tennessee Department of Commerce and Insurance
TDOH	Tennessee Department of Health
THA	Tennessee Hospital Association
TPCA	Tennessee Primary Care Association
TMA	Tennessee Medical Association
UM	Utilization Management
VOB	Verification of Benefits
VSHP	Volunteer State Health Plan

SECTION I: INTRODUCTION

Managed Care Goals, Objectives, and Overview

CMS Requirement: Include a brief history of the State's Medicaid managed care programs.

On January 1, 1994, Tennessee launched TennCare, a new health care reform program. This original TennCare waiver, TennCare I, essentially replaced the Medicaid program in Tennessee; Tennessee moved almost its entire Medicaid program into a managed care model.

TennCare I was implemented as a five-year demonstration program and received several extensions after the initial waiver expiration date of December 30, 1999. The original TennCare design was extraordinarily ambitious. TennCare I extended coverage to large numbers of uninsured and uninsurable people, and almost all benefits were delivered by Managed Care Organizations (MCOs) of varying size, operating at full risk. Enrollees under the TennCare program are eligible to receive only those medical items and services that are within the scope of defined benefits for which the enrollee is eligible and determined by the TennCare program to be medically necessary. To be medically necessary, a medical item or service must be recommended by a health care provider and must satisfy each of the following criteria:

- It must be required in order to diagnose or treat an enrollee's medical condition
- It must be safe and effective
- It must be the least costly alternative course of diagnosis or treatment that is adequate for the medical condition
- It must not be experimental or investigational

TennCare II, the demonstration program that started on July 1, 2002, revised the structure of the original program in several important ways. The program was divided into "TennCare Medicaid" and "TennCare Standard." TennCare Medicaid serves Medicaid eligibles, while TennCare Standard serves the demonstration population.

When TennCare II began, several MCOs were either leaving the program or at risk of leaving the program due to their inability to maintain financial viability. A Stabilization Plan was introduced under TennCare II whereby the MCOs were temporarily removed from risk. Pharmacy benefits and dental benefits were carved out of the MCO scope of services, and new single benefit managers were selected for those services. Enrollment of demonstration eligibles was sharply curtailed, with new enrollment being open only to uninsurable persons with incomes below poverty and "Medicaid rollovers," persons losing Medicaid eligibility who met the criteria for the demonstration population.

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, Governor Phil Bredesen proposed a TennCare Reform package to accomplish goals such as "rightsizing" program enrollment and reducing the dramatic growth in pharmacy spending. With approval from the Centers for Medicare & Medicaid Services (CMS), the state began implementing these modifications in 2005.

On October 5, 2007, the waiver for the TennCare II extension was approved for three additional years. The TennCare II extension made additional revisions in the program, one of which was to require that

children in the demonstration population who have incomes below 200 percent of poverty be classified as Title XXI children. The extension also mandated a new cap on supplemental payments to hospitals.

The integration of behavioral health into the managed care model evolved from the TennCare I waiver. In 1996, behavioral health services were carved out and the Partner's program was established whereby Behavioral Health Organizations (BHOs) contracted directly with the Bureau of TennCare to manage behavioral health services. A primary focus of the carve-out was to provide services for the priority population, a group that included adults with serious and persistent mental illness (SPMI) and children with serious emotional disturbance (SED). The Bureau began integrating behavioral and medical health care delivery for Middle Tennessee members in 2007 with the implementation of two expanded MCOs. TennCare continued the process with the implementation of new MCO contracts in West Tennessee in November 2008 and East Tennessee in January 2009. The transferring of behavioral health services to Volunteer State Health Plan of Tennessee for TennCare Select members completed the Bureau's phased-in implementation of a fully integrated service delivery system that works with health care providers, including doctors and hospitals, to ensure that TennCare members receive all of their medical and behavioral services in a coordinated and cost-effective manner.

On December 15, 2009, TennCare received approval from CMS for another three-year extension of the waiver, to begin on July 1, 2010, and to continue through June 30, 2013. The extension contained several new amendments including approval for the implementation of the CHOICES program outlined by the General Assembly's Long-term Care and Community Choices Act of 2008. Under the amendment, the State provides new community alternatives to people who would otherwise require Medicaid-reimbursed care in a Nursing Facility. The new CHOICES program utilizes the existing Medicaid MCOs to provide eligible individuals with nursing facility services or home and community based services. Tennessee is now one of the few states in the country to deliver managed Medicaid long-term care and the only state to do so in a manner that does not require enrollees to change their MCO.

The CHOICES program was implemented in stages over time in different geographic areas of the state. The first phase of the CHOICES program was successfully implemented in Middle Tennessee on March 1, 2010, with the East and West Grand Region MCOs' implementation occurring in August 2010. Also, in August 2010, the Statewide Home and Community Based Waiver for the Elderly and Disabled was terminated as it was no longer needed with full implementation of the CHOICES program.

With implementation of the CHOICES program, the MCOs became responsible for coordination of all medical, behavioral, and long-term care services provided to their members. Currently, the only remaining carve-out services are for dental and pharmacy services.

MCO Contracting and Turnover Experience

Traditionally, MCOs have been "at risk." However, because of instability among some of the MCOs participating in TennCare, the "at risk" concept was replaced in July 2002 with an "administrative services only" arrangement. The state added its own MCO, TennCare Select, to serve as a backup if other plans failed or there was inadequate MCO capacity in any area of the state. TennCare Select is administered by BlueCross BlueShield of Tennessee (BCBST). TennCare Select serves enrollees such as foster children, children receiving SSI benefits, and nursing facility or Intermediate Care Facility for Persons with Intellectual Disabilities residents under age 21.

Maintaining MCO participation in Middle Tennessee has been problematic over the years. During the 2006-2007 state fiscal year, one of the major TennCare priorities was recruiting well-run, well-capitalized MCOs to Middle Tennessee. In addition to bringing in new MCOs, the Bureau wanted to establish a new service-delivery model – an integrated medical and behavioral health model. Another crucial factor in the implementation was structuring the MCOs' contracts to return the organizations to full financial risk. To meet these goals, the state conducted its first Request for Proposal (RFP) process for TennCare MCOs. The Bureau secured contracts with two successful bidders. The two new MCOs "went live" on schedule on April 1, 2007. TennCare placed the managed care contracts for the East and West grand regions of the state up for competitive bid in January 2008. In April 2008, the state awarded the regional contracts to two companies in each region. The MCO contractors accepted full financial risk to participate in the program and the new contracts also established an integrated medical and behavioral health care system for members. The plans began serving West region members on November 1, 2008 and began serving members in the East region January 1, 2009. In September 2009, behavioral health services for TennCare Select enrollees were transferred to BCBST. Beginning in January 2015, TennCare will contract with three statewide MCOs.

Between 1994 and 2002, dental services were part of physical health services delivered by TennCare's medical MCOs. Some MCOs chose to contract directly with dentists and operate their own dental networks, while others subcontracted their dental program to a Dental Benefits Manager (DBM). During this time, dentists did not participate in the TennCare program to the extent desired or anticipated by the State. Differences in the practice of dentistry versus medicine made participation in a managed care "medical" model a challenging business decision for dentists. Dentists complained of red tape and inefficiencies associated with participation in multiple MCOs relative to credentialing, authorization, billing, and reimbursement. Each MCO or its dental subcontractor negotiated dental reimbursement rates individually with dentists, and fees were a confidential, contractual matter. Most dentists only signed contracts with certain MCOs, which complicated enrollee access. Effective October 2002, in an effort to strengthen dental provider networks and improve enrollee access to care, the State moved from a managed care medical model to a managed care dental model for administration of dental services. The dental benefit was removed (carved-out) from the MCOs. Definitive funding was allocated for the revamped dental program, and administration of the dental benefit was awarded to a single DBM following a competitive bid process. The dental contract was an Administrative Services Only (ASO) contract where the DBM was not financially "at risk" for delivery of dental care. The State paid the DBM an administrative fee for managing the dental benefit and covered expenditures associated with dental claims.

The Dental carve-out model has proven to be beneficial for the State, enrollees, and providers. DBM administration has resulted in more streamlined administrative processes making the program more "dental" friendly for providers. Dentists sign one provider agreement, are subjected to one credentialing process, and are reimbursed on a fee-for-service basis using one approved maximum allowable dental fee schedule. A single DBM means there is one set of program policies, one provider agreement, one provider reference manual, one claims processor, and one organization responsible for all contract deliverables. State oversight of Medicaid dental services is simplified because the Bureau of TennCare is responsible for one DBM versus multiple MCOs delivering or subcontracting for dental care.

The DBM has also been responsible, among other things, for maintaining and managing an adequate statewide dental provider network, processing and paying claims, managing program data, conducting

utilization management and utilization review, detecting fraud and abuse, as well as meeting utilization benchmarks or outreach efforts reasonable calculated to ensure participation of all children who have not received screenings.

In February 2013, the Bureau of TennCare issued an RFP for Dental Management and Administrative Services. Following a competitive bid process, the contract for the new DBM was awarded to DentaQuest on April 24th and signed on May 3rd. The new DBM took effect October 1, 2013. The contract with DentaQuest is a three-year, partial risk-bearing contract with two one-year extension options. TennCare decided to transition from an ASO contract to a partial risk-bearing contract to properly incentivize the DBM to improve quality of dental care while lowering costs.

As mentioned in an earlier paragraph, the pharmacy program was carved out of the managed care plans in 2003 and transformed to a singular Pharmacy Benefits Manager (PBM) payor system, which still remains in place today. The first PBM, ACS, went into effect for the latter half of 2003 and established the preferred drug list. First Health Services Corporation became the PBM in 2004 and remained until 2008. SXC Health Solutions (which later became known as Catamaran) followed FHSC until 2013 at which time Magellan Medicaid Administration became the current PBM.

The largest drivers of change in pharmacy utilization since the carve-out came with a change in the Grier Consent Decree in 2005 and establishment of the Medicare Part D program in 2006. These changes allowed TennCare to more effectively manage the pharmacy program and shifted most dual eligible members to a Medicare drug plan. The program has recently implemented changes due to the Affordable Care Act, but so far the required changes mostly affect drug manufacturers and processes internal to the Medicaid program and are transparent to the plan members.

Currently, TennCare services are offered through several managed care contractors (MCCs). Each enrollee has an MCO for his/her primary care, medical/surgical, mental health and substance abuse, and long-term health services and a Pharmacy Benefits Manager (PBM) for his/her pharmacy services. Children under the age of 21 and enrolled in the TennCare program are eligible for dental services, which are provided by a Dental Benefits Manager (DBM).

Population Description/Changes

All Medicaid and demonstration eligibles are enrolled in TennCare, including those who are dually eligible for TennCare and Medicare. There are approximately 1.2 million persons currently enrolled in TennCare. There are several mechanisms for TennCare eligibility.

TennCare Medicaid serves Tennesseans who are eligible for a Medicaid program. Some of the groups TennCare Medicaid covers include:

- Children under age 21
- Women who are pregnant
- Single parents or caretakers of a minor child
- Two-parent families with a minor child living at home
- Individuals who need treatment for breast or cervical cancer
- People who receive a Supplemental Security Income (SSI) check

- People who have received both an SSI check and a Social Security check in the same month at least once since April 1977 AND who still receive a Social Security check
- People who live in a nursing home and have income below $2,022 per month (300% of SSI benefit) OR receive other long-term care services that TennCare pays for

TennCare Standard is only available for children under age 19 who are already enrolled in TennCare Medicaid AND:

- Lack access to group health insurance through their parents' employer, OR
- Their time of eligibility is ending and they don't qualify anymore for TennCare Medicaid.

There are two ways these children can qualify and be able to keep their healthcare benefits:

- The Uninsured category is only available to children under age 19 whose TennCare Medicaid eligibility is ending, who do not have access to insurance through a job or a family member's job, and whose family incomes are below two-hundred percent (200%) of the poverty level.
- The Medically Eligible category is only available to children under age 19 whose TennCare Medicaid eligibility is ending and whose family income equals or is greater than 200% of the poverty level. To be medically eligible, the child must have health conditions that make the child "uninsurable." The family is unable to purchase healthcare insurance for the child in the private market because of the child's health conditions.

Coinsurance for some services is required for members with TennCare Standard if the family income is over ninety-nine percent (99%) of the poverty level.

Long-Term Care Community Choices Act of 2008 (CHOICES)

In July 2009, CMS approved an amendment to the TennCare waiver that allows MCOs to coordinate all of the care a TennCare member needs, including medical, behavioral, and long-term services and supports for specified populations. Implementation of CHOICES for the Middle Grand Region MCOs occurred on March 1, 2010, and subsequently for the East and West Grand Region MCOs on August 1, 2010. Initial implementation included two CHOICES groups: CHOICES Group 1 and CHOICES Group 2, with CHOICES Group 3 beginning on July 1, 2012.

CHOICES Group 1 is for individuals receiving services in a Nursing Facility (NF). These individuals are enrolled in TennCare Medicaid, except for individuals continuously enrolled in CHOICES Group 1 since before July 1, 2012 that do not meet the new nursing facility level of care criteria in effect as of July 1, 2012, but continue to meet the level of care criteria in effect prior to July 1, 2012, and are eligible in the demonstration CHOICES 1 and 2 Carryover Group.

CHOICES Group 2 is for individuals who meet the NF Level of Care (LOC) and are receiving Home and Community-Based Services (HCBS) as an alternative to NF care. Those in CHOICES 2 may be enrolled in either TennCare Medicaid, if they are SSI-eligible, or in the demonstration CHOICES 217-Like HCBS Group or CHOICES 1 and 2 Carryover Group. The CHOICES 217-Like HCBS Group is composed of adults age 65 and older, or age 21 and older with physical disabilities, who:

- Meet the NF level of care requirement;
- Are receiving HCBS; and

- Would be eligible in the same manner as specified under 42 CFR § 435.217, 435.236, and 435.726, and Section 1924 of the Social Security Act, if the HCBS were provided under a Section 1915(c) waiver. With the statewide implementation of CHOICES, the Bureau will no longer provide HCBS under a Section 1915(c) waiver.

Individuals continuously enrolled in CHOICES Group 2 since before July 1, 2012 who do not meet the new nursing facility level of care criteria in effect as of July 1, 2012, but continue to meet the level of care criteria in effect prior to July 1, 2012, and who meet institutional income standards are eligible in the demonstration CHOICES 1 and 2 Carryover Group.

Interim CHOICES Group 3 was implemented July 1, 2012. This option is for individuals age 65 and older, and adults age 21 and older with physical disabilities, who qualify for TennCare as SSI recipients or in the At Risk Demonstration Group, who do not meet the nursing facility level of care, but who, in the absence of HCBS, are "at-risk" for nursing facility care, as defined by the State.

In November 2010, Tennessee was recognized by the Center for Health Care Strategies (CHCS) for its statewide implementation of the new TennCare CHOICES Long Term Services and Supports program. In its report *Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services*, CHCS identified Tennessee as one of five innovative states with demonstrated expertise in managed care approaches to long-term care. Tennessee, along with Arizona, Hawaii, Texas and Wisconsin, was noted as a "true pioneer" in designing innovative approaches to delivering care to the elderly and adults with disabilities. Tennessee in particular was recognized for its open communication and collaboration with the public and stakeholders in designing and implementing the new program.

The key component of the CHOICES program is person-centered care coordination. The "whole person" care coordination approach includes:

- Implementation of active transition and diversion programs for people who can be safely and effectively supported at home or in another community setting outside the nursing home; and
- Installation of an electronic visit verification system to monitor home care quality.

Other components of CHOICES include:

- Consumer Choice and Options
  - Consumer-directed care options, including the ability to hire non-traditional providers like family members, friends, and neighbors with accountability for taxpayer funds.
  - Broadening of residential care choices in the community beyond nursing facilities with options such as companion care, family care homes, and improved access to assisted care living facilities.
- Simplified Process for Accessing Services
  - Streamlining the member's eligibility process for faster service delivery and the enrollment process for new providers.
  - Maintaining a single point of entry for people who are not on TennCare today and need access to long-term care services through Medicaid or other available programs.
  - Use of existing Medicaid funds to serve more people in cost-effective home and community settings.

Evolution of Health Information Technology

TennCare continues to work to enhance accurate and timely data collection, analysis, and distribution. The Bureau's comprehensive information management strategy affects every aspect of Tennessee's "Medicaid Enterprise," from medical policy to eligibility policy to budget and financial accountability. The process of transforming from a traditional transaction-driven medical program to a health care monitoring and management organization recognizes the advantages of Tennessee's unique, fully managed care framework and builds on the Bureau's commitment to be a wise and efficient contractor of services, steward of public funds, and advocate for quality healthcare for all constituents. With guidance from the Bureau's Health care Informatics group, the State is revamping its data strategy to take into account changes in the Health Information Exchange (HIE) landscape. This includes taking steps to critically examine current data assets and design options to collect and analyze data, make better use of currently available encounter data via the State's Medicaid Management Information System (MMIS), and target methods to distribute the resulting information in ways that are most streamlined and effective for providers through enhanced dashboards, web portals, and DIRECT Messaging.

As an early leader in the work to develop digital health information capacity, Tennessee has built a comprehensive set of health information technology (HIT) and health information exchange (HIE) assets. One of these is the collective level of experience and lessons learned among stakeholders about fostering HIT and HIE innovation amidst evolving health systems, technology environments, and data priorities. In his State of the State address of 2003, Governor Bredesen pledged resources to build Tennessee's health information infrastructure. Subsequently, various eHealth initiatives spanning the entire state were pursued. Seeded with capital investments from federal, state, and local sources, these initiatives have evolved with the continued support of Governor Haslam's administration. As is the case in many other states, Tennessee has fine-tuned its HIT/HIE strategy in response to policy and marketplace drivers while continuing to expand the Medicaid Electronic Health Record (EHR) Incentive Program and offer HIE resources that promote adoption and meaningful use of HIT. A robust Medicaid EHR Incentive Program is now well established and providing incentive payments to Tennessee providers. Now having successfully moved beyond the start-up phase, this program is actively engaged in activities to foster meaningful use, conduct auditing, and support ongoing provider outreach and technical assistance.

Both the Bureau of TennCare and the Office of eHealth Initiatives (OeHI) within Tennessee's Health Care Finance and Administration Division play integral leadership roles in the promotion of statewide HIT/HIE. Given the interdependencies between health IT adoption and health information exchange, efforts to administer Health Information Technology for Economic and Clinical Health (HITECH) Act programs in Tennessee are a highly integrated collaboration between TennCare and OeHI. These programs include the State HIE Cooperative agreement Program and the CMS Medicaid EHR Incentive Program. Strategies and activities are guided with input and active participation by an array of other state partners and stakeholders such as state government agencies, TennCare MCOs, health information organizations throughout the state, and provider associations. For example, to disseminate information about specific EHR Incentive Program features and policies, both TennCare and OeHI have conducted dedicated outreach to entities such as the Tennessee Medical Association, Tennessee Hospital Association, Tennessee Primary Care Association, the Children's Hospital Alliance of Tennessee, and TennCare's MCOs.

The structure for oversight and public-private collaborative efforts has itself evolved since 2010 due to shifts in the HIE landscape and revised strategies to address statewide interoperability. The original governance roles and functions of the intergovernmental Internal Health Council and the state level non-profit HIE organization, Health Information Partnership Tennessee, are being reconfigured. A consolidated Advisory Council is being implemented to best align with the State's revised, two-part HIE strategy. This strategy is focused first on implementing DIRECT Messaging to accelerate and spread adoption and meaningful use of HIT. On a longer-term basis, the State will revisit its strategy for more robust query-based HIE. In addition, the Office of the Insurance Exchange Planning Initiative will be reorganized into the Strategic Planning and Innovation Group. This group may work with the Bureau of TennCare and the OeHI on initiatives related to the implementation of health care reform in the state.

CMS Requirement: Include an overview of the quality management structure that is in place at the state level.

Although the Bureau of TennCare established a Division of Quality Oversight several years ago, a culture of quality has also been fostered throughout the Bureau. Both TennCare's Vision and Mission statements reflect that culture:

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."

Core Values:

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

All quality improvement activities are consistent with the "three aims" outlined in the National Quality Strategy for better care, healthy people/healthy communities, and affordable care.

Darin Gordon is the Director of the Health Care Finance and Administration Division for the state of Tennessee, with Wendy Long, M.D. serving as the Deputy Director. The Chief Medical Officer for the Bureau of TennCare, Vaughn Frigon, M.D., reports directly to Darin Gordon and in turn provides supervision for the Quality Oversight, Pharmacy, Dental, and Provider Networks divisions of the Bureau. The Division of Quality Oversight is led by Judith Womack, R.N. and is comprised of a staff of 25 individuals.

The Division of Quality Oversight is responsible for monitoring many of the activities of the MCOs and for enforcing quality requirements defined in the MCO Contractor Risk Agreement. This Division is also responsible for developing and monitoring the External Quality Review Organization (EQRO) contract as well as a contract with the Tennessee Department of Health. Several collaborative workgroups,

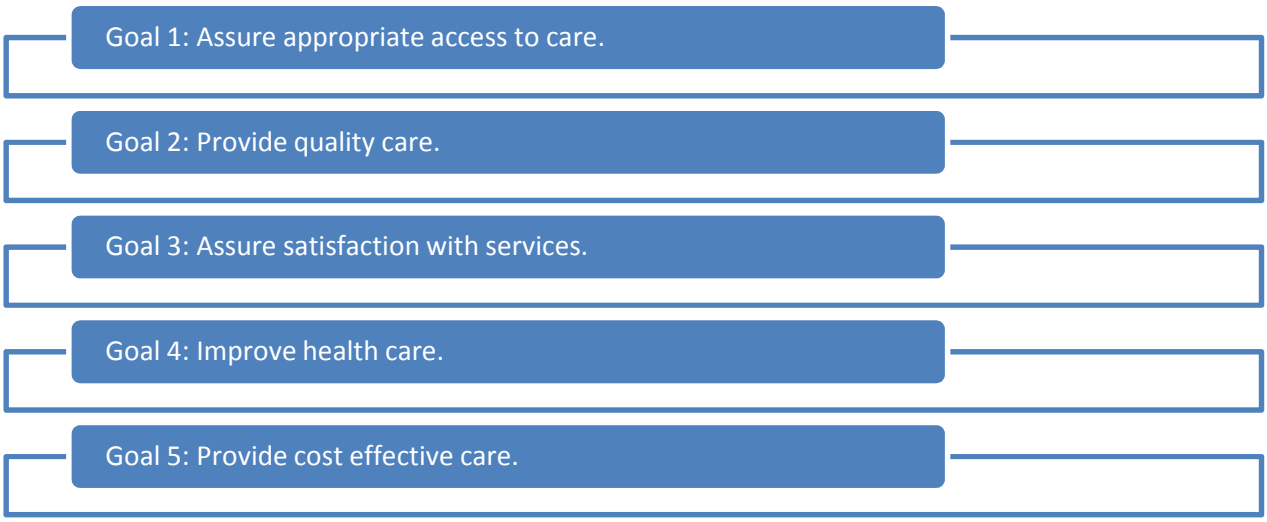
composed of individuals from each MCO, Quality Oversight, the EQRO, and Healthcare Informatics, have been formed to address specific issues or HEDIS measures. Currently there are workgroups addressing Population Health, High Risk Maternity, and Early Periodic Screening, Diagnosis, and Treatment (EPSDT). Often outside agencies such as Belmont University and the Department of Health are also involved. Recently the Division also held a series of workgroups addressing coordination of care for the dual eligible population. This workgroup was composed of Quality Oversight and Long Term Services and Supports staff as well as representatives from each of the MCOs. This group also included individuals from the two Dual Special Needs Populations (D-SNPs) from companies also contracting for Medicaid services as well as three other D-SNPs who have entered into a MIPPA agreement with the Bureau.

CMS Requirement: Include general information about the state's decision to contract with MCOs/PIHPs (i.e., to address issues of cost, quality, and/or access). Include the reasons why the state believes the use of a managed care system will positively impact the quality of care delivered in Medicaid.

The State's decision to contract with MCOs and a PIHP for most services, as well as two PAHPs for pharmacy and dental, is rooted in nearly 20 years of experience with managed care in Tennessee. The use of these Managed Care Contractors (MCCs) has allowed the State to move from the role of being primarily a payer of claims to a role of orchestrating and coordinating an entire system of care. The use of MCCs without appropriate oversight and direction cannot guarantee a cost-effective system that delivers quality care. However, we have learned that when the state is willing and able to leverage meaningful oversight strategies, managed care offers the best chance of delivering the kind of system we want. Goals addressing cost, quality, and access can be built into the system, along with carrots and sticks to make sure these goals are reached. Such levers are largely unavailable in a fee-for-service system.

CMS Requirement: Include a description of the goals and objectives of the state's managed care program. This description should include priorities, strategic partnerships, and quantifiable performance driven objectives. These objectives should reflect the state's priorities and areas of concern for the population covered by the MCO/PIHP contracts.

Five primary goals for TennCare enrollees shape the Quality Strategy. Ensuring appropriate access to care, providing quality care, and assuring satisfaction with services are processes that ultimately contribute to the fourth and fifth goals of improving health care and providing cost-effective care.



These five goals and their associated objectives align with the three aims of the National Quality Strategy:

- ***Better Care*** **-** Improve the overall quality of care by making health care more patient-centered, reliable, accessible, and safe.
- ***Healthy People/Healthy Communities*** **-** Improve the health of the United States population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.
- ***Affordable Care*** **-** Reduce the cost of quality health care for individuals, families, employers, and government.

Progress toward these five goals is gauged by physical and behavioral health performance measures implemented in 2007 with others added as needed. These objectives are drawn from nationally recognized and respected measure sets. Many of the strategy objectives are statewide weighted Healthcare Effectiveness Data and Information Set (HEDIS) rates or statewide average Consumer Assessment of Healthcare Providers and Systems (CAHPS) rates. The MCOs annually complete and submit all applicable HEDIS measures designated by the National Committee for Quality Assurance (NCQA) as relevant to Medicaid. The MCOs are required to contract with an NCQA-certified HEDIS auditor to validate the processes of the health plan in accordance with NCQA requirements. In addition, MCOs annually conduct CAHPS surveys (adult survey, child survey, and children with chronic conditions survey) using an NCQA-certified CAHPS survey vendor.

Since the CHOICES benefits are integrated into TennCare's managed care structure, progress towards the five primary goals set forth in the Quality Strategy is also assessed using the Long Term Services and Supports performance measures. 2011 served as the baseline year for these performance measures. In anticipation of standardized Medicaid Managed Long Term Services and Supports (MLTSS) measures in development by NCQA, new measures have been added for 2014 for needs assessment and care planning domains.

Strategy Goals and Objectives

The tables below present the Quality Strategy goals and objectives established by the State for physical and behavioral health as well as Long Term Services and Supports.

Physical and Behavioral Health Goals	
Goal 1: Assure appropriate access to care for enrollees	
Objective 1.1: By 2016, the statewide weighted HEDIS rate for adults' access to preventive/ambulatory health services will increase to 83.4% for enrollees 20-44 years old, and the rate for enrollees 45-64 years old will be maintained at 88.6% or above.	Data Source: *A Comparative Analysis of Audited Results from TennCare MCOs.*
Objective 1.2: By 2016, the statewide weighted HEDIS rate for children and adolescents' access to primary care practitioners will increase to 95.3% for enrollees 7-11 years old and 93.09% for enrollees 12-19 years old.	Data Source: *A Comparative Analysis of Audited Results from TennCare MCOs.*
Objective 1.3: By 2016, 97% of TennCare heads of household and 98% or greater of TennCare children will go to a doctor or clinic when they are first seeking care rather than a hospital (emergency room).	Data Source: *The Impact of TennCare: A Survey of Recipients.*

Physical and Behavioral Health Goals	
Goal 2: Provide quality care to enrollees	
Objective 2.1: By 2016, the statewide weighted HEDIS rate for adolescent well-care visits will increase to 47.20%.	Data Source: *A Comparative Analysis of Audited Results from TennCare MCOs.*
Objective 2.2: By 2016, the statewide weighted HEDIS rate for timeliness of prenatal care will be maintained at 82.7% or above.	Data Source: *A Comparative Analysis of Audited Results from TennCare MCOs.*
Objective 2.3: By 2016, the statewide weighted HEDIS rate for breast cancer screening will increase to 46.9%.	Data Source: *A Comparative Analysis of Audited Results from TennCare MCOs.*
Objective 2.4: By 2016, the statewide weighted HEDIS rate for cervical cancer screening will increase to 71.29%.	Data Source: *A Comparative Analysis of Audited Results from TennCare MCOs.*
Goal 3: Assure enrollees' satisfaction with services.	
Objective 3.1: By 2016, 95% of TennCare enrollees will be satisfied with TennCare.	Data source: *The Impact of TennCare: A Survey of Recipients.*
Objective 3.2: By 2016, the statewide average for adult CAHPS getting needed care-always or usually will increase to 87.05%.	Data Source: *A Comparative Analysis of Audited Results from TennCare MCOs.*
Objective 3.3: By 2016, the statewide average for child CAHPS getting care quickly-always or usually will increase to 92.42%.	Data Source: *A Comparative Analysis of Audited Results from TennCare MCOs.*
Goal 4: Improve health care for program enrollees.	
Objective 4.1: By 2016, the statewide weighted HEDIS rate for HbA1c testing will be increased to 83.51%.	Data Source: *A Comparative Analysis of Audited Results from TennCare MCOs.*
Objective 4.2: By 2016, the statewide weighted HEDIS rate for controlling high blood pressure will increase to 59.14%.	Data Source: *A Comparative Analysis of Audited Results from TennCare MCOs.*
Objective 4.4: By 2016, the state will maintain a total statewide EPSDT screening rate of at least 80%.	Data source: *CMS-416.*
Objective 4.5: By 2016, the statewide weighted HEDIS rate for antidepressant medication management will be increased to 52.04% for acute phase and 32.64% for continuation phase.	Data Source: *A Comparative Analysis of Audited Results from TennCare MCOs.*

Long-Term Services and Supports

Performance measures in the Quality Strategy specific to CHOICES were initially established based on certain Section 1915(c) waiver assurances and sub-assurances, including level of care, service plan, qualified providers, health and welfare, administrative authority, and participant rights. The table below reflects these core domains and performance measures and how TennCare monitors each under the 1115 waiver authority to ensure prompt remediation of individual findings and promote system improvements in the

managed long-term services and supports delivery system. Additional measures have been added for 2014 in anticipation of new standardized MLTSS program measures under development by NCQA.

Long-Term Services and Supports Goals		
Goal 1: CHOICES Group 2 members have a level of care determination indicating the need for institutional services prior to enrollment in CHOICES and receipt of Medicaid-reimbursed HCBS.		
Domain	**Performance Measure**	**Measurement Method**
Level of Care	Number and percent of CHOICES Group 2 members who had an approved CHOICES Pre-Admission Evaluation (i.e., nursing facility level of care eligibility) prior to enrollment in CHOICES and receipt of Medicaid-reimbursed HCBS.	Data Source: MMIS report Sampling Approach: 100% of all CHOICES Group 2 members enrolled Frequency: Quarterly Remediation: TennCare is responsible for quarterly reports and review/analysis of data, as well as remediation of individual findings.
Goal 2: CHOICES members are offered a choice between institutional (NF) services and HCBS.		
Domain	**Performance Measure**	**Measurement Method**
Service Plan	Number and percent of CHOICES Group 2 member records reviewed with an appropriately completed and signed freedom of choice form that specifies choice was offered between institutional services and HCBS.	Data Source: Member record review Sampling Approach: Stratified, with strata comprised of CHOICES Group 2 members enrolled in each of the MCOs per region serving the CHOICES Group 2 population. For the first auditing year, sample size will be 60 records per stratum with a 10% oversample to determine subsequent error for future audits. For following years, sample size will be based on the first auditing year's sampling error in order to achieve a 95% confidence interval. Frequency: Semi-annually in April and October Remediation: TennCare is responsible for semi-annual member record review and review/analysis of data. MCOs will be responsible for remediation of individual findings with review/validation by TennCare.
Goal 3: LTSS Assessment Composite		
Domain	**Performance Measure**	**Measurement Method**
Service Plan	Number and percent of CHOICES Group 2 and 3 members reviewed for whom an assessment, including key elements specified in the CRA or by TennCare protocol, was completed within the timeframes specified in the CRA.	Data Source: Member Record Review Sampling Approach: Stratified, with strata comprised of CHOICES Groups 2 and 3 members enrolled in each of the MCOs per region serving the CHOICES population. The year one chart review will be a convenience sample of 25 records per MCO per region. Subsequent sample size will be based on the first auditing year's sampling error to achieve a 95% confidence interval. Any records used previously in a semi-annual audit will be excluded. Frequency: Annually in October Remediation: TennCare is responsible for annual member record reviews and review/analysis of data. MCOs will be responsible for remediation of individual findings with review/validation by TennCare.

Long-Term Services and Supports Goals		
Goal 4: LTSS Plan of Care Composite		
Domain	**Performance Measure**	**Measurement Method**
Service Plan	Number and percent of CHOICES Group 2 and 3 members reviewed for whom a plan of care, including key elements specified in the CRA or by TennCare protocol, was completed within the timeframes specified in the CRA.	Data Source: Member Record Review Sampling Approach: Stratified, with strata comprised of CHOICES Groups 2 and 3 members enrolled in each of the MCOs per region serving the CHOICES HCBS population. A 95% confidence interval will be achieved. Any records used previously in a semi-annual audit will be excluded. Frequency: Annually in October Remediation: TennCare is responsible for annual member record reviews and review/analysis of data. MCOs will be responsible for remediation of individual findings with review/validation by TennCare.
Goal 5: Plans of Care are reviewed/updated at least annually.		
Domain	**Performance Measure**	**Measurement Method**
Service Plan	Number and percent of CHOICES Groups 2 and 3 member records reviewed whose plans of care were reviewed and updated prior to the member's annual review date.	Data Source: Member record review Sampling Approach: Stratified, with strata comprised of CHOICES Group 2 and 3 members enrolled in each of the MCOs per region serving the CHOICES HCBS population. A 95% confidence interval will be achieved. Any records used previously in a semi-annual audit will be excluded. Frequency: Annually in October Remediation: TennCare is responsible for annual member record review and review/ analysis of data. MCOs will be responsible for remediation of individual findings with review/validation by TennCare.
Goal 6: CHOICES HCBS providers meet minimum provider qualifications established by the State prior to enrollment in CHOICES and delivery of HCBS.		
Domain	**Performance Measure**	**Measurement Method**
Qualified Providers	Number and percent of CHOICES HCBS providers reviewed for whom the MCO provides documentation that the provider meets minimum qualifications established by the State and was credentialed by the MCO prior to enrollment in CHOICES and delivery of HCBS.	Data Source: Provider record review Sampling Approach: Stratified, with strata comprised of HCBS providers contracted with each of the MCOs serving the CHOICES Group 2 and 3 population; sample size-25 records per stratum. Sample size may be adjusted in subsequent years based on individual findings. Frequency: Annually Remediation: TennCare is responsible for annual provider record review and review/analysis of data. MCOs will be responsible for remediation of individual findings with review/validation by TennCare.

Long-Term Services and Supports Goals		
Goal 7: CHOICES Group 2 and 3 members (or their family member/authorized representative, as applicable) receive education/information at least annually about how to identify and report instances of abuse, neglect, and exploitation.		
Domain	**Performance Measure**	**Measurement Method**
Health and Welfare	Number and percent of CHOICES Group 2 and 3 member records reviewed which document that the member (or their family member/authorized representative, as applicable) received education/information at least annually about how to identify and report instances of abuse, neglect and exploitation.	Data Source: Member record review Sampling Approach: Stratified, with strata comprised of CHOICES Group 2 members enrolled in each of the MCOs per region serving the CHOICES Group 2 and 3 population. Sample size will be based on the first auditing year's sampling error in order to achieve a 95% confidence interval. Any records used previously in a semi-annual audit will be excluded. Frequency: Annually in October Remediation: TennCare is responsible for annual member record review and review/analysis of data. MCOs will be responsible for remediation of individual findings with review/validation by TennCare.
Goal 8: Critical incidents are reported within timeframes specified in the Contractor Risk Agreement.		
Domain	**Performance Measure**	**Measurement Method**
Health and Welfare	Number and percent of critical incident records reviewed in which the incident was reported within timeframes specified in the Contractor Risk Agreement.	Data Source: Sample record review Sampling Approach: Stratified, with strata comprised of reported incidents for CHOICES Group 2 and 3 members enrolled in each of the MCOs per region serving the CHOICES Group 2 population. For the first auditing year, sample size will consist of 60 records per stratum with a 10% oversample to determine subsequent error for future audits. For following years, sample size will be based on the first auditing year's sampling error in order to achieve a 95% confidence interval. Frequency: Semi-annually, in May and November Remediation: TennCare is responsible for semi-annual record review and review/analysis of data. MCOs will be responsible for remediation of individual findings with review/validation by TennCare.
Goal 9: CHOICES members are informed of and afforded the right to request a Fair Hearing when services are denied, reduced, suspended, or terminated.		
Domain	**Performance Measure**	**Measurement Method**
Participant Rights	Number and percent of CHOICES Group 2 and 3 member records reviewed in which HCBS were denied, reduced, suspended, or terminated as evidenced in PoC and, consequently, member was informed of and afforded the right to request a Fair Hearing as determined by the presence of a Grier consent decree notice.	Data Source: Member record review Sampling Approach: Stratified, with strata comprised of reported incidents for CHOICES Group 2 and 3 members enrolled in each of the MCOs per region serving the HCBS population. Sample size will be a subset of the sample used in Sub-Assurance 2. Frequency: Semi-annually in April and October Remediation: TennCare is responsible for semi-annual record review and review/analysis of data. MCOs will be responsible for remediation of individual findings with review/validation by TennCare.

Data Sources

HEDIS/CAHPS Report: A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs)

Using individual MCO results, the External Quality Review Organization (EQRO) calculates the statewide weighted HEDIS rates and the statewide CAHPS averages in this annual report.

The Impact of TennCare: A Survey of Recipients

Two of the strategy objectives rely on information obtained from an annual survey conducted by the Center for Business and Economic Research at the University of Tennessee Knoxville. TennCare contracts with the Center to conduct a survey of 5,000 Tennesseans to gather information on their perceptions of their health care. The design for the survey is a "household sample," and the interview is conducted with the head of the household. This report allows comparison between responses from all households and households receiving TennCare.

EPSDT Medical Record Review

This review determines the extent to which medical providers are in compliance regarding the documentation of the delivery of the seven components of the EPSDT exam. The onsite medical record review is conducted annually.

CMS-416 Report

The Statewide EPSDT Screening Rate is calculated by utilizing MCO encounter data submissions in accordance with specifications for the annual CMS-416 report.

Medicaid Management Information Systems (MMIS) Report

The MMIS Report is run quarterly based on CHOICES enrollment during the reporting period.

CHOICES Record Review (both member and provider records)

The CHOICES Record Reviews are conducted by TennCare staff from the Quality Oversight Division and/or Long Term Services and Supports to evaluate member or provider records. The reviews are completed annually or semi-annually based on the performance measure associated with each review.

CHOICES Critical Incidents Report

This report is submitted quarterly by each MCO to the LTSS Audit and Compliance Unit. Contents of the report include the number and type of incident, setting in which the incident occurred, and type of provider (provider agency or consumer directed worker) present at the time of the incident. Report data is reviewed by LTSS to identify trends and patterns, and to identify and implement strategies to reduce the occurrence of incidents and improve the quality of CHOICES HCBS.

Development and Review of Quality Strategy

CMS Requirement: Include a description of the formal process used to develop the quality strategy. This must include a description of how the state obtained the input of beneficiaries and other stakeholders in the development of the quality strategy. (CFR 438202(b))

CMS Requirement: Include a description of how the state made (or plans to make) the quality strategy available for public comment before adopting it in final. (CRF 438202(b))

Steps for revising the *TennCare Quality Strategy* include:

- Convening a strategic planning meeting for all Quality Oversight staff, the Division of HealthCare Informatics, and the EQRO. At this meeting, a review of all data submitted by the MCOs, data collected by the EQRO, and statewide data collected from enrollee encounters is conducted.
- Collaboration with appropriate divisions within TennCare, with the Division of Quality Oversight holding responsibility for creating the draft.
- Review of the draft by TennCare's Chief Medical Officer.
- After a final draft is completed, the Quality Strategy will be posted on TennCare's website for public review. MCOs, advocacy groups, and beneficiaries will be notified of the posting and given a specific timeframe and e-mail address for comments to be returned to TennCare.
- After the designated time frame has elapsed, a final report will be developed including appropriate recommendations made during the public review period.

CMS Requirement: Include a timeline for assessing the effectiveness of the quality strategy (e.g., monthly, quarterly, annually). (CRF 438.202 (d))

The effectiveness of the Quality Strategy is assessed annually.

CMS Requirement: Include a timeline for modifying or updating the quality strategy. If this is based on an assessment of "significant changes," include the state's definition of "significant changes." (CFR 438.202 (d))

The Bureau of TennCare will update its quality strategy annually and will include significant changes that have occurred as well as updated evaluation data. Significant changes are defined as changes that: 1) alter the structure of the TennCare Program; 2) change benefits; and 3) include changes in MCCs. Updated interventions/activities will also be provided. Every three years, TennCare will coordinate a comprehensive review and update.

SECTION II: ASSESSMENT

Quality and Appropriateness of Care

CMS Requirement: Summarize state procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs. This must include the state's definition of special health care needs. (CFR 438.204(b)(1)).

Since TennCare's inception, a continuous quality improvement process has been in place and has been refined over time. Assessment occurs in a variety of ways. Examples of these are listed below.

- All of the contracted MCOs are required to submit a full set of HEDIS and CAHPS data to TennCare annually. This information is also provided to Qsource, Tennessee's EQRO, for review and trending. Qsource then prepares an annual report of findings for the Bureau.
- The MCOs are contractually required to submit a variety of reports to various divisions within the Bureau of TennCare. The reports include performance improvement projects, population health, EPSDT, dental, CHOICES care coordination, annual quality improvement/utilization management descriptions, evaluations and work plans, provider satisfaction surveys, dual eligible care coordination, etc. These reports are reviewed either quarterly or annually, depending on the report, and an annual analysis is completed.
- Qsource conducts an Annual Quality Survey for each MCO and the Dental Benefits Manager that evaluates contractual requirements related to quality.
- Qsource conducts an annual EPSDT provider audit to assure that required components are being addressed during EPSDT screenings.
- Periodic audits have been conducted related to compliance with federal requirements for Abortions, Sterilizations, and Hysterectomies. Beginning in 2013, Qsource will conduct this audit annually.
- Quality Oversight and Long Term Services and Supports staff conduct MCO audits related to compliance with the federal Standard Terms and Conditions for TennCare's CHOICES program.
- Collaborative workgroups, with all MCOs, are held quarterly. These workgroups address issues related to the Population Health Program, EPSDT outreach, diabetes, and high risk maternity.
- Periodic meetings are also held collaboratively with both MCOs and D-SNPs to discuss ways of coordinating care.

CMS Requirement: Detail the methods or procedures the state uses to identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment. (CFR 438.204(b)(2))

TennCare identifies the race, ethnicity, and primary language spoken of its enrollees upon application. Eligibility for TennCare and other Medicaid programs is determined by the Bureau of TennCare and the Federally Facilitated Marketplace (FFM). The application includes questions about race and ethnicity and instructs the applicant that response to these questions is voluntary. The application also includes questions about the applicant's preferred written and spoken language.

The contracts with the MCOs contain eligibility and enrollment data exchange requirements in CRA § 2.23.5. The requirements state that the MCOs must receive, process, and update enrollment files sent

daily by TennCare, and the MCOs must update eligibility/enrollment databases within 24 hours of receipt of enrollment files.

TennCare uses information about language and need for an interpreter to identify those Limited English Proficiency (LEP) groups constituting 5%of the TennCare population or 1,000 enrollees, whichever is less. In CRA § 2.17.2.5, the contract with the MCOs requires that all vital documents be translated and available to the LEP groups identified by TennCare within 90 calendar days of notification from TennCare. The contracts with the MCOs also require the MCO to develop written policies and procedures for the provision of language interpreter and translation services to members in CRA § 2.18.2.

The contracts require that member materials such as the member handbook and the quarterly member newsletter contain statements 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 in CRA § 2.17.4.5.23 and 2.17.5.3.2.

CMS Requirement: Document any efforts or initiatives that the state or MCO/PIHP has engaged in to reduce disparities in health care.

TennCare addresses disparities through tracking the rates of illness and chronic conditions in relation to key demographic factors. TennCare contractually requires the MCOs to include QM/QI activities to improve healthcare disparities identified through data collection and requires them to submit a Data Collection Strategy Report describing their data collection process in accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities. Additionally, TennCare is directly working to reduce healthcare disparities through contractually requiring its MCOs to provide essential networks and services required to address disparity issues. These requirements include:

- Ensuring an adequate medical provider network of appropriately credentialed providers increasingly committed to evidence-based practices to improve access to care and higher quality outcomes.
- Requiring opt-out Population Health services to be available to all TennCare members while providing intensive case management to those high-risk members who choose to opt-in to the program.
- Proactively promoting health screenings and preventive healthcare services to all TennCare members.
- Providing care coordination and direct support services for CHOICES HCBS enrollees. CHOICES care coordination provides access to several important determinants of health often lacking for our long-term care population, including:
    - Nutritious food delivered by local meals-on wheels programs or prepared by homecare providers;
    - Safer home environments by building ramps and installing safety equipment, providing Personal Emergency Response Systems (PERS) and pest control services, and providing light housekeeping support; and
    - Personal care and other medical, behavioral, and long-term care services identified as needed through regular home visits by care coordinators.

Coordination of Care for Dual Members

Although TennCare did not receive a Dual Integration Grant, in May 2013, a coordination of care program for an estimated 30,000 TennCare enrollees who have both Medicaid and Medicare (Duals) was implemented. These dual members include both frail elderly members and young people with

physical and/or mental disabilities. Ninety-five percent of these members live below 200% of the Federal Poverty Level. Compared with the typical Medicare member, they have more disabilities. Nationally, 87% of Duals have one or more chronic illnesses. In Tennessee, 65% of Duals have heart disease, 30% have diabetes, 24% have COPD, and 14% have depression.

Findings to date: During the first full year of operation, over 14,100 hospital admission notices were exchanged between hospitals, Medicare DSNPs, and Medicaid MCOs. Many of these notices led to requests for assistance with discharge planning and HCBS assessments, Skilled Nursing Facility (SNF) diversions, coordination of services through coordination of the authorization process, and other means of coordinating care between MCOs and DSNPs. Coordination of services upon hospital discharge occurred for almost 9,000 of these members. An additional 1,600 care coordination touches were provided for these dual members, ranging from requests for assistance with assessment and care planning to referrals for service coordination. We celebrated our first year of collaboration with a joint Medicaid MCO and Medicare DSNP review and planning meeting.

Prescription for Success

In 2014, TennCare partnered with the Tennessee Department of Mental Health and Substance Abuse Services, in conjunction with the U.S. Drug Enforcement Administration, the Tennessee Bureau of Investigation, and the State Departments of Health, Safety and Homeland Security, Corrections, and Children's Services to develop a report entitled *Prescription for Success: Statewide Strategies to Prevent and Treat the Prescription Drug Abuse Epidemic in Tennessee*. This report outlines a comprehensive, multi-faceted plan to combat prescription drug abuse in Tennessee and includes information on each partner's current strategies in addition to the partnership's future collaborative goals. TennCare's current strategies include:

- *Covered Treatment Services* – TennCare covers a comprehensive continuum of substance abuse services for its beneficiaries, including outpatient, inpatient, and residential treatment/detoxification and medication-assisted treatment.
- *Formulary Regulations* – The TennCare Formulary has regulations in place (i.e., five prescription limit per month, policy for tamper-resistant prescriptions, and strict limitations on coverage of products containing buprenorphine) to prevent doctor shopping and prescription abuse.
- *Pharmacy "Lock-In" Program* – TennCare possesses the authority to restrict or "lock-in" TennCare enrollees to a limited and specified number of pharmacy providers if it is determined that the enrollee has abused TennCare's Pharmacy Program. There were 511 beneficiaries locked-in in 2012.
- *Prescriber Identification* – TennCare has developed a unique and innovative algorithm to identify prescribers who are potentially prescribing opioids in a way that is very inconsistent with their peers. Identified providers are manually evaluated by TennCare's pharmacy staff, and appropriate interventions (e.g., targeted education, blocking of prescriptions by the TennCare Drug Utilization Review Board, etc.) are employed based on the results of the manual evaluation.

National Performance Measures

CMS Requirement: Include a description of any required national performance measures and levels identified and developed by CMS in consultation with states and other stakeholders. (CFR 438.204(c))

At this time, CMS has not identified any required national performance measures.

CMS Requirement: Indicate whether the state plans to voluntarily collect any of the CMS core performance measures for children and adults in Medicaid/CHIP. If so, identify state targets/goals for any of the core measures selected by the state for voluntary reporting.

Child Health Quality Measures:

Goals reflect significant improvement over 2013 rates using the NCQA Minimum Effect Size Change Methodology.

Measure Name	*2013 Data*	*2014 Data Update*	*2016 Goal*
Timeliness of Prenatal Care	79.51%	80.70%	82.69%
Frequency of Ongoing Prenatal Care (≥ 81% of expected visits) *	61.60%	63.08%	64.68%
Childhood Immunization Status			
• DTaP/DT	80.17%	79.00%	83.34%
• IPV	93.86%	93.07%	95.47%
• MMR	91.44%	91.10%	94.18%
• HiB	93.73%	92.62%	95.60%
• Hepatitis B	93.33%	93.15%	95.19%
• VZV	90.72%	91.47%	93.44%
• Pneumococcal Conjugate	82.42%	81.13%	85.71%
• Hepatitis A	89.55%	89.93%	92.23%
• Rotavirus	68.43%	69.66%	71.88%
• Influenza	43.74%	43.73%	46.36%
• Combination 2	76.28%	75.24%	79.33%
• Combination 3	73.02%	72.12%	76.67%
• Combination 4	71.63%	71.18%	75.21%
• Combination 5	56.98%	57.66%	62.04%
• Combination 6	37.88%	38.24%	40.15%
• Combination 7	56.13%	56.88%	59.49%
• Combination 8	37.24%	38.07%	39.47%
• Combination 9	31.99%	33.02%	33.90%
• Combination 10	31.53%	32.89%	33.42%
Adolescent Immunization Status			
• Meningococcal	65.69%	66.27%	68.97%
• Tdap/Td	83.31%	83.57%	86.64%
• Combination 1	64.40%	65.48%	67.62%
Weight Assessment and Counseling for Nutritional and Physical Activity for Children/Adolescents			
• BMI Percentile (3 - 11 years)	49.42%	56.08%	52.39%
• BMI Percentile (12 - 17 years)	49.74%	58.27%	52.72%
• Counseling for Nutrition (3 - 11 years)	59.90%	63.76%	62.90%
• Counseling for Nutrition (12 - 17 years)	55.01%	54.24%	58.31%
• Counseling for Physical Activity (3 - 11 years)	45.54%	52.77%	48.27%
• Counseling for Physical Activity (12 - 17 years)	48.02%	52.67%	50.90%
Chlamydia Screening (16-20 years)	53.62%	51.54%	56.30%
Well-Child Visits in the First 15 Months of Life: Six or More Visits	62.32%	65.41%	65.43%
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	71.68%	70.80%	75.26%
Adolescent Well-Care Visits	44.53%	50.27%	47.20%

Child and Adolescent Access to Primary Care Practitioners			
• 12-24 months	96.94%	97.27%	98.8%
• 25 months – 6 years	90.51%	90.26%	93.22%
• 7 – 11 years	93.47%	93.96%	95.33%
• 12 – 19 years	90.38%	90.91%	93.09%
Appropriate Testing for Children with Pharyngitis	76.03%	77.75%	79.07%
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication			
• Initiation Phase	46.02%	45.82%	48.78%
• Continuation and Follow-Up Phase	57.54%	54.98%	60.99%
Follow-Up After Hospitalization for Mental Illness*			
• 7 day follow- up	48.03%	54.70%	50.91%
• 30 day follow-up	68.80%	71.85%	72.24%

Adult Quality Measures:

Goals reflect significant improvement over 2013 rates using the NCQA Minimum Effect Size Change methodology.

Measure Name	*2013 Data*	*2014 Data Update*	*2016 Goal*
Adult BMI Assessment*	70.95%	78.50%	74.55%
Breast Cancer Screening*	44.27%	52.47%	46.95%
Cervical Cancer Screening	67.73%	66.25%	71.29%
Chlamydia Screening in Women Ages 21-24	62.58%	62.56%	65.73%
Follow-up After Hospitalization for Mental Illness*			
• 7 Day Follow-Up	48.03%	54.70%	50.88%
• 30 Day Follow-Up	68.80%	71.85%	72.24%
Controlling High Blood Pressure*	55.82%	56.98%	59.14%
Comprehensive Diabetes Care: LDL-C Screening*	76.44%	75.56%	79.45%
Comprehensive Diabetes Care: Hemoglobin A1c Testing*	80.32%	79.76%	83.51%
Antidepressant Medication Management*			
• Effective Acute Phase Treatment	49.10%	46.48%	52.04%
• Effective Continuation Phase Treatment	30.78%	30.31%	32.64%
Adherence to Antipsychotics for Individuals with Schizophrenia	61.91%	62.93%	64.99%
Annual Monitoring for Patients on Persistent Medications			
• Annual monitoring for members on ACE Inhibitors or ARBs	90.61%	89.98%	93.31%
• Annual monitoring for members on Digoxin	92.31%	94.06%	94.76%
• Annual monitoring for members on diuretics	91.00%	90.59%	93.73%
• Annual monitoring for members on anticonvulsants	72.89%	72.75%	76.54%
• Total Rate	88.86%	88.48%	91.56%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (age 18+)			
• Initiation of AOD Treatment	36.78%	35.69%	39.88%
• Engagement of AOD Treatment	9.82%	9.62%	11.77%
Prenatal and Postpartum Care: Postpartum Care Rate	59.90%	58.77%	63.49%

*Data was not collected according to ages specified.

Monitoring and Compliance

CMS Requirement: Detail procedures that account for the regular monitoring and evaluation of MCO and PIHP compliance with the standards of subpart D (access, structure and operations, and measurement and improvement standards). (CFR 438.204(b)(3))

NCQA Accreditation – Each MCO must obtain and maintain NCQA accreditation. Failure to obtain and/or maintain accreditation is considered to be a breach of the Contractor Risk Agreement and will result in termination of the Agreement. Achievement of provisional accreditation status requires a corrective action plan within 30 days of receipt of notification from NCQA and may result in termination of the Agreement. Each MCO is required to submit every accreditation report immediately upon receipt of the written report from NCQA. It is then reviewed by staff to determine areas of deficiency. If the reviewer deems necessary, a corrective action plan may be required.

Quarterly and Annual Reports from Managed Care Contractors – All MCCs are required to submit a variety of reports to TennCare both quarterly and annually. When received through a secure tracking system, each report is reviewed by staff and a corrective action plan is required for any report deemed deficient. Liquidated damages may be applied for deficient reports. Examples of reports include Population Health, EPSDT outreach, Enrollment and Disenrollment, Community Outreach, Behavioral Health, Case Management, Nursing Facility Diversion Activities, Nursing Facility to Community Transition, HCBS Late and Missed Visits, CHOICES Care Coordination, HCBS Consumer Direction, Money Follows the Person, Cost and Utilization, Quality Management/Quality Improvement, NCQA Accreditation, Performance Improvement Projects, CHOICES Critical Incidents, HEDIS/CAHPS, Nurse Triage Line, Utilization Management Phone Line, Emergency Department (ED) Assistance Tracking, ED Threshold, Provider Satisfaction, Financial Management, Provider Networks, Customer Service, and Fraud and Abuse.

HEDIS results – Annually each MCO is required to submit all HEDIS measures designated by NCQA as relevant to Medicaid, with an exception for dental measures. The results must be reported separately for each Grand Region in which the MCO operates. The MCO must contract with an NCQA certified HEDIS auditor to validate the processes in accordance with NCQA requirement. HEDIS data is then submitted to both TennCare and the EQRO, which provides analyses of the data as well as a written comparative report.

Performance Improvement Projects (PIPs) – All MCOs are required to submit at least two clinical and three non-clinical PIPs annually. The two clinical PIPs must include one in the area of behavioral health that is relevant to one of the Population Health programs for bipolar disorder, major depression, or schizophrenia, and one in the area of either child health or perinatal (prenatal/postpartum) health. Two of the three non-clinical PIPs must be in the area of long-term services and supports. All PIPs must be in accordance with CMS Protocols for Performance Improvement Projects. After three years, a decision is made jointly between the MCO and TennCare on the continuation of the PIP.

Annual Quality Survey – The EQRO is contractually required to conduct an Annual Quality Survey of each MCC to assure compliance with contractual requirements. As part of the preparation for the survey, the EQRO, in conjunction with TennCare, reviews all contractual standards for changes that have occurred during the previous year and develops the criteria for review. EQRO staff conduct the survey and provide a detailed written report of findings for each MCO. If an MCO scores less than 100% on any element, a corrective action plan must be submitted within two weeks of receipt of the findings. Both

the EQRO and TennCare staff review the corrective action plans to ensure the MCCs take appropriate action. Follow-up on the plans is conducted by the TennCare Division of Quality Oversight.

Site visits/collaborative work groups – Both the Division of Quality Oversight and the Behavioral Health Operations Unit conduct periodic site visits to learn about and monitor various aspects of MCC activities.

Audits/Medical Record Reviews – Each year the following Medical Record Reviews (MRRs) are conducted by either the EQRO or the Division of Quality Oversight.

- The EPSDT MRR is replaced with the Child Health Focus Study beginning in 2014. The 2014 focus study topic is BMI. Focus studies are conducted at least annually by desk audits or, as deemed necessary, onsite at the provider offices, depending on the volume or capability of providers to submit records electronically. Collection of BMI measures is monitored, and education of provider staff is conducted if necessary.
- A sample of provider records is reviewed to determine compliance with Abortion, Sterilization, and Hysterectomy (ASH) federal regulations.
- CHOICES chart reviews are conducted to determine compliance with federal and/or state standards for Level of Care, Plans of Care, Freedom of Choice, Qualified Providers, Critical Incidents, Participant Rights, and Abuse and Neglect Education. Some of these areas are audited annually while some are audited bi-annually.
- Chart reviews are conducted on a quarterly basis by desk audits to determine compliance with the coordination of benefits for members who receive services from an MCO and are also enrolled in a Home and Community Based Services (HCBS), Department of Intellectual and Developmental Disabilities (DIDD) Waiver.

Provider Validation Surveys – TennCare's EQRO is required to conduct a quarterly provider data validation (PDV) survey. The purpose of this activity is to determine the accuracy of the provider data files submitted by the TennCare MCCs and to use the results as a proxy to determine the extent to which providers are available and accessible to TennCare members. Liquidated damages are recommended each quarter if data for more than 10% of providers is incorrect for each data element.

Provider Satisfaction Surveys – Each MCO is required to submit an annual Provider Satisfaction Survey Report that encompasses both physical and behavioral health. The report must summarize the provider survey methods and findings and must provide an analysis of opportunities for improvement. An additional CHOICES Provider Satisfaction Survey Report is also required. This report must address results for CHOICES long-term services and supports providers. It also must include a summary of survey methods and findings as well as an analysis of opportunities for improvement.

Customer Satisfaction Surveys –

- Annually each MCO must conduct a CAHPS survey utilizing a vendor that is certified by NCQA to perform CAHPS surveys. The surveys conducted are the CAHPS Adult Survey, the CAHPS Child Survey, and the CAHPS Children with Chronic Conditions Survey. The data is then submitted to both TennCare and the EQRO, which provides analyses of the data as well as a written report.
- TennCare contracts with The University of Tennessee Center for Business and Economic Research to conduct a survey of 5,000 Tennesseans to gather information on their perceptions of their health care. The design for the survey is a "household sample," and the interview is conducted

with the head of the household. The report, *The Impact of TennCare: A Survey of Recipients*, allows comparison between responses from all households and households receiving TennCare.

- TennCare contracts with the nine Area Agencies on Aging and Disability, the State's Single Point of Entry, to conduct a CHOICES Customer Satisfaction Survey. TennCare contracts with the EQRO, Qsource, to conduct an analysis of the customer satisfaction survey data and compile a report of findings. The report evaluates CHOICES members' satisfaction with the services and supports they receive, as well as their overall contentment.

Prior approval of all member materials – The Division of Quality Oversight, in conjunction with Managed Care Operations staff, reviews all member materials that have clinical information included. Staff review information for clinical accuracy, culturally appropriate information, and appropriateness of clinical references. LTSS staff, in conjunction with MCO staff, review all member materials related to the CHOICES program as well as all materials submitted by the D-SNPs. All member materials must be approved by TennCare before distribution can occur.

Tennessee Department of Commerce and Insurance – The TennCare Oversight Division of the Tennessee Department of Commerce and Insurance is responsible for the administration and enforcement of the Health Maintenance Organization Act (TCA Title 56, Chapter 32), the Prepaid Limited Health Service Organization Act (TCA Title 56, Chapter 51), and the Administrators Act (TCA 56, Chapter 6, Part 4) with respect to the companies that contract with the TennCare Bureau. The TennCare Oversight Program is required to:

- Act upon licensure applications;
- Examine HMOs and Prepaid Limited Health Services Organizations (PLHSOs) at least once every four years (examinations conducted more frequently than once every four years are optional);
- Review and analyze annual reports filed by the Department of Health or its designee, the TennCare Bureau;
- Contract for an independent evaluation of the statutory standards where failures have been identified;
- Process eligible requests for independent review of denied TennCare provider claims;
- Review and either approve or disapprove material modifications to organization documents, contracts, evidences of coverage, rates, marketing materials, management personnel, and any other item that would materially change the operations of the HMO or PLHSO;
- Administer and enforce the TennCare Prompt Pay Act found at TCA 56-32-126; and
- Provide support services to the Selection Panel for TennCare Reviewers, pursuant to the TennCare Prompt Pay Act.

Policies and Procedures, developed by the MCOs, are reviewed by TennCare staff upon readiness review for new contracts or programs and as needed throughout the life of their contracts.

LTSS Audits – The LTSS Audit and Compliance Unit conducts eight types of contract compliance audits as listed below, in addition to other audits conducted as the need arises. The measurement criteria for the audits are determined by the CRA with the MCOs or the contract with other entities.

- <u>New Member Audit for members who are new to Medicaid and/or CHOICES</u> – addresses identification of services in the Plan of Care (POC), MCO authorization of HCBS, and the timely initiation of HCBS.

- Referral Audits for existing Medicaid enrollees who are referred for potential enrollment in CHOICES – addresses MCO performance of applicant telephonic screenings, face-to-face assessments, and Pre-Admission Evaluation submissions.
- Critical Incident Audit – addresses MCO determination, documentation, responsiveness, and investigation of critical incidents within specified timeframes. It also addresses the systemic response to patterns of incidents.
- Fiscal Employer Agent (FEA) Audit – addresses the timeliness of support broker assignment to new Consumer Direction (CD) members, notification and provision of the support broker contact information to CD member and care coordinator, initiation of CD services, and frequency of contact with the member.
- Area Agency on Aging and Disability (AAAD) Audit – addresses AAAD performance related to information and referral requests, contact with members and potential members, processing of referrals related to the Minimum Data Set (MDS), ensuring face-to-face evaluations, and completion/submission of eligibility, evaluation and enrollment information consistent with contractual guidelines.
- Money Follows the Person (MFP) Audit – addresses MCO performance related to member eligibility qualifications, member notification about enrollment and disenrollment, reporting of inpatient admissions and discharges, and post inpatient admission follow-up.
- Provider Qualifications Audit – addresses MCO compliance with contract requirements by examining whether MCOs ensure that providers possess appropriate qualifications before serving CHOICES members.
- Short-Term Stay (STS) Audit – addresses MCO performance related to verification of Nursing Facility level of care prior to admission, verification that the MCO properly managed the STS benefit (i.e., 90 days or less), verification that the MCO reviewed circumstances resulting in multiple STS benefit periods, and verification of the MCO's evaluation of services and supports for members receiving multiple STS.

Dental Benefits Manager (DBM) Reports and Other Deliverables – The DBM is responsible for submitting a variety of monthly, quarterly, and annual reports and other deliverables through Team Track, TennCare's secure tracking system. These reports are reviewed by the appropriate business owner at TennCare and a corrective action plan is issued for reports or other deliverables deemed deficient. Liquidated damages may be applied for deficiencies. Examples of DBM reports include Fraud and Abuse activities, QI/UM Committee Meeting minutes, Quarterly Outreach Activities, Case Referral and Corrective Action Assistance, Enrollee Cost Sharing, Quarterly Non-discrimination Compliance, Annual Member Satisfaction Surveys, Annual Provider Satisfaction Surveys, Annual QIA Dental Studies, and Annual QMP Report.

- The DBM is required to submit two PIPs related to children's clinical dental care or administrative process annually. After three years, a decision will be made jointly between the DBM and TennCare on the continuation of the PIP.
- Qsource conducts an Annual Quality Survey of the DBM to assure compliance with contractual requirements. A detailed written report of findings is provided by the EQRO. If the DBM scores less than 100% on any element, a corrective action plan must be submitted and is reviewed by both Qsource and TennCare to assure the DBM takes appropriate action.
- The DBM is required to conduct both a Customer Satisfaction Survey and a Provider Satisfaction Survey and report on the findings annually.

- The DBM is responsible for maintaining and managing an adequate statewide dental provider network, processing and paying claims, managing program data, conducting utilization management and utilization review, and detecting fraud and abuse, as well as meeting utilization benchmarks for annual dental screening percentages, annual dental participation ratios, or outreach efforts calculated to ensure participation of all children who have not received screenings.

External Quality Review

CMS Requirement: Include a description of the state's arrangements for an annual, external, independent quality review of the quality, access, and timeliness of the services covered under each MCO and PIHP contract. Identify what entity will perform the EQR and for what period of time. (CFR 438.204(d))

Tennessee contracts with Qsource to provide External Quality Review (EQR) activities. The services to be provided under this contract include multiple tasks and deliverables, including an annual quality survey of all MCOs and the DBM, that are consistent with applicable federal EQR regulations and protocols for Medicaid Managed Care Organizations and state-specific requirements related to Federal court orders. This contract allows the State to be compliant with Federal EQR regulations and rules and to measure MCC-specific compliance with State-specific Federal court orders and the TennCare Section 1115 Waiver. The contract period began October 1, 2010. While it was scheduled to expire on September 30, 2013, TennCare has elected to extend the contract until September 30, 2015. At that time, a Request for Proposal will be developed to solicit proposals.

The Annual Quality Survey must include, but not be limited to, review of enrollee rights and protections, quality assessment and performance improvement, structure and operation standards, measurement and improvement standards, and compliance with the appeal process. The survey process includes document review, interviews with key MCC personnel, and an assessment of the adequacy of information management systems. In addition to this survey, Qsource conducts Performance Improvement Project validations and Performance Measure validations in accordance with federal requirements.

In addition, Qsource conducts an Annual Network Adequacy Survey to determine the extent to which the MCCs' networks are compliant with contractual requirements.

CMS Requirement: Identify what, if any optional EQR activities the state has contracted with the External Quality Review Organization (EQRO) to perform. The five optional activities include: validation of encounter data reported by an MCO or PIHP; administration or validation of consumer or provider surveys of quality of care; calculation of performance measures in addition to those reported by an MCO or PIHP and validated by an EQRO; conduct of performance improvement projects (PIPs) in addition to those conducted by an MCO or PIHP and validated by an EQRO; and conduct of studies on quality and focus on a particular aspect of clinical or nonclinical services at a point in time.

While Tennessee has not required the EQRO to conduct any of the specified optional activities, Qsource has assisted TennCare with a number of other activities that are not required by CMS. These activities are as follows:

- Participation in MCO collaborative workgroups.
- Training of MCO staff on conducting Performance Improvement Projects.
- Quarterly validation of the accuracy of provider information reported by the MCOs.

- Preparation of an annual comparative analysis of HEDIS measures, Relative Resource Use Measures, and CAHPS measures provided to TennCare by D-SNPS who have signed a MIPPA Agreement. Because the health plans are required to submit the measures listed above and because of improved statistical capability within the Bureau of TennCare, the measures that Qsource might otherwise calculate are limited.
- Preparation of an annual Impact Analysis Report outlining national initiatives/changes that have potential to impact managed care in Tennessee.
- Planning and execution of an educational meeting three times a year for TennCare's Quality Oversight staff as well as all MCOs and the DBM.
- Analysis of the CHOICES Customer Satisfaction Survey.
- Assisting the Division of Quality Oversight with its strategic planning sessions and Quality Strategy development.
- Providing technical assistance to MCCs on a variety of topics including HEDIS and CAHPS reporting.

Until a few years ago, the EQRO validated encounter data, but with the implementation of the State's information system, the encounter validation process reached a point where there was no added value due to the inherent system edits and checks.

CMS requirement: If applicable, identify the standards for which the EQR will use information from Medicare or private accreditation reviews. This must include an explanation of the rationale for why the Medicare or private accreditation standards are duplicative to those in 42 CFR 438.204(g). (CFR 438.360(b)(4))

Below is a table reflecting those contractual standards that are deemed met by the NCQA Accreditation Survey. Annually all contractual requirements are compared with the most current NCQA standards. Those contractual requirements that are greater than the comparable NCQA standard remain a part of the TennCare Annual Quality Survey. If any contractual standards are equal to or lesser than the NCQA standards they will be deemed met by the NCQA survey.

State Requirements Deemed Met by NCQA Accreditation Survey	
2014 State Standards	**2014 NCQA Accreditation Standards**
CRA § 2.11.1.5.-2.11.1.5.1-4 (E/W, Middle, & TCS)	**QI 3B Affirmative Statement**
The contractor may not prohibit or otherwise restrict a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a member who is his or her patient for the following: • The member's health status or medical, behavioral health, or long-term care treatment options, including alternative treatments that may be self- administered; • Any information the member needs in order to decide among all relevant treatment options; • The risks, benefits, and consequences of treatment or non-treatment; or • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.	Contracts with practitioners include an affirmative statement indicating that practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

State Requirements Deemed Met by NCQA Accreditation Survey	
2014 State Standards	**2014 NCQA Accreditation Standards**
CRA § 2.18.3 & 2.18.2-2.18.3 (E/W, Middle, & TCS)	**QI 4A Cultural Needs and Preferences and RR 4B Interpreter Services**
The CONTRACTOR shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency and diverse cultural and ethnic backgrounds.	The organization assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary.
CRA 2.8.4.3.2	**QI 8, Elements A-J**
The CONTRACTOR shall develop and operate the "opt out" health risk management program per NCQA standards QI 8 for disease management. Program services shall be provided to eligible members unless they specifically ask to be included.	***QI 8A– Program Content*** The content of the organization's programs addresses the following for each condition. 1. Condition monitoring 2. Adherence to treatment plan 3. Medical and behavioral health co-morbidities and other health conditions 4. Health behaviors 5. Psychosocial issues 6. Depression screening 7. Information about the patient's condition provided to caregivers who have patient's consent 8. Encouraging patients to communicate with their practitioners about health conditions and treatment. ***QI 8B–Identifying Members for DM Programs*** The organization uses the following sources to identify members who qualify for DM programs. 1. Claim or encounter data 2. Pharmacy data, if applicable 3. Health risk appraisal results 4. Laboratory results, if applicable 5. Data collected through the UM, case management, or care management process 6. Member and practitioner referrals ***QI 8C–Frequency of Member Identification*** The organization systematically identifies members who qualify for each of its DM programs. ***QI 8D–Providing Members with Information*** The organization provides eligible members with the following written information about the program: 1. How to use services 2. How members become eligible to participate 3. How to opt in or opt out ***QI 8E–Interventions Based on Assessment*** The organization provides intervention to members based on assessment.

State Requirements Deemed Met by NCQA Accreditation Survey	
2014 State Standards	**2014 NCQA Accreditation Standards**
	QI 8F–Eligible Member Active Participation The organization annually measures active member participation rates. ***QI 8G–Informing and Educating Providers*** The organization provides practitioners with written information about the DM program that includes: • Instructions on how to use DM services. • How the organization works with a practitioner's patients in the program. ***QI 8H Integrating Member Information*** The organization integrates information from the following system to facilitate access to member health information for continuity of care: 1. A health information line 2. A DM program 3. A case management 4. A UM program, if applicable 5. A wellness program, if applicable ***QI 8I–Satisfaction with Disease Management*** The organization annually evaluates satisfaction with its disease management services by: 1. Obtaining member feedback 2. Analyzing member complaints and inquiries ***QI 8J–Measuring Effectiveness*** The organization employs and tracks one performance measure for each DM program. Each measurement: 1. Addresses a relevant process or outcome 2. Produces a quantitative result 3. Is population based 4. Uses data and methodology that are valid for process or outcome being measured 5. Has been analyzed in comparison with a benchmark or goal
CRA 2.8.4.7.3	**QI 7 Complex Case Management**
The CONTRACTOR shall develop and implement the Complex Case Management Program according to NCQA standard QI7.	***QI 7A–Population Assessment*** The organization annually: 1. Assesses the characteristics and needs of its member population and relevant subpopulations 2. Reviews and updates its complex case management processes to address member needs, if necessary. ***QI 7B–Identifying Members for Case Management*** The organization uses the following sources to identify members for complex case management: 1. Claim or encounter data 2. Hospital discharge data

State Requirements Deemed Met by NCQA Accreditation Survey	
2014 State Standards	**2014 NCQA Accreditation Standards**
	3. Pharmacy data, if applicable 4. Data collected through UM management process, if applicable 5. Data supplied by purchases, if applicable 6. Data supplied by member or care givers 7. Data supplied by practitioners ***QI 7C–Access to Case Management (CM)*** The organization has multiple avenues for members to be considered for complex CM services, including: 1. Health information line referral, if applicable 2. DM program referral 3. Discharge planner referral 4. UM referral, if applicable 5. Member or caregiver referral 6. Practitioner referral ***QI 7D–Case Management Systems*** The organization uses CM systems that support: • Evidence-based clinical guidelines or algorithms to conduct assessment and management • Automatic documentation of the staff's ;members ID and date and time on the case or when interaction with the member occurred • Automated prompts for follow-up, as required by the case management plan. ***QI 7E–Case Management Process*** The organization's complex case management procedures address the following: 1. Initial assessment of members' health status, including medications 2. Documentation of clinical history, including medications 3. Initial assessment of the activities of daily living 4. Initial assessment of mental health status, including cognitive functions 5. Initial assessment of life-planning activities 6. Evaluation of cultural and linguistic needs, preferences, or limitations 7. Evaluation of visual and hearing needs, preferences, or limitations 8. Evaluation of caregiver resources and involvement 9. Evaluation of available benefits within the organization and from community resources 10. Evaluation of an individualized case management plan, including prioritized goals, that considers the member's and caregivers' goals, preferences and desired level of involvement in the CM plan 11. Identification of barriers to meeting goals or complying with plan

State Requirements Deemed Met by NCQA Accreditation Survey	
2014 State Standards	**2014 NCQA Accreditation Standards**
	12. Facilitation of member referrals to resources and follow-up process to determine whether members act on referrals 13. Development of a schedule for follow-up and communication with members 14. Development and communication of member self-management plans 15. A process to assess progress against case management plans for members ***QI 7F–Initial Assessment*** An NCQA review of a sample of organization's complex case management files demonstrate that the organization follows its' documented processes for: 1. Initial assessment of member health status, including condition-specific issues 2. Documentation of clinical history, including medications 3. Initial assessment of activities of daily living 4. Initial assessment of mental health status, including cognitive functions 5. Evaluation of cultural and linguistic needs, preferences or limitations 6. Evaluation of visual and hearing needs, preferences or limitations 7. Evaluation of caregiver resources and involvement 8. Evaluation of available benefits within the organization and form community resources 9. Initial assessment of life-planning activities ***QI 7G–Case Management-Ongoing Management*** The NCQA review of a sample of organization's complex case management files demonstrate that the organization follows its documented processes for: 1. Development of case management plans, including prioritized goals, that take into account member and caregivers' goals, preferences and desired level of involvement in the program 2. Identification of barriers to meeting goals and complying with the plans 3. Development and communication of member self-management plans 4. Assessment of progress against case management plans and goals, and modifications as needed. ***QI 7H–Satisfaction with Case Management*** At least annually, the organization evaluates satisfaction with its case management program by: 1. Obtaining feedback from members 2. Analyzing member complaints

State Requirements Deemed Met by NCQA Accreditation Survey	
2014 State Standards	**2014 NCQA Accreditation Standards**
CRA 2.14.1.7.2 - 2.14.1.7.5	**UM 2A - UM Criteria**
The UM program shall have criteria that: • Are applied based on individual need. • Are applied based on an assessment of the local delivery system. • Involve practitioners in developing, adopting, and reviewing them. • Are annually reviewed and updated as appropriate.	The organization has written policies for applying the criteria based on individual needs. The organization has written policies for applying the criteria based on an assessment of the local delivery system. Involves appropriate practitioners in developing, adopting, and reviewing criteria. Annually review the UM criteria and the procedures for applying them, and updates the criteria when appropriate.
CRA § 2.14.1.9 (E/W, Middle and TCS)	**UM 4 Licensed Health Professionals**
The CONTRACTOR shall use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorization and decision making. The CONTRACTOR shall have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease or, in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services.	*Element A*: The organization has written procedures • Requiring appropriately licensed professionals to supervise all medical necessity decisions • Specifying the type of personnel responsible for each level of UM decision-making. *Element C*: The organization ensures that a physician or other health care professional, as appropriate, reviews any non-behavioral healthcare denial based on medical necessity. *Element D*: The organization ensures that a physician, appropriate behavioral health care practitioner or pharmacist, as appropriate, reviews any behavioral healthcare denial of care based on medical necessity. *Element E*: The organization • Has written procedures for using board-certified consultants to assist in making medical necessity determinations • Provides evidence that organization uses board-certified consultants for medical necessity determinations.
CRA 2.14.1.11	**UM 4F – Affirmative Statement about Incentives**
The CONTRACTOR shall have mechanisms in place to ensure that required services are not arbitrarily denied or reduced.	The organization distributes a statement to all members and to all practitioners, providers, and employees who make UM decisions, affirming the following: • UM decision making is based only on appropriateness of care and service and existence of coverage. • The organization does not specifically reward practitioners or other individual for issuing denials of coverage. • Financial incentives for UM decision makers do not encourage decisions that result in under utilization.

State Requirements Deemed Met by NCQA Accreditation Survey	
2014 State Standards	**2014 NCQA Accreditation Standards**
CRA 2.14.1.12	**UM 4F – Affirmative Statement about Incentives**
The CONTRACTOR shall assure UM activities are not structured so as to provide incentives to deny, limit, or discontinue medically necessary covered services.	The organization distributes a statement to all members and to all practitioners, providers, and employees who make UM decisions, affirming the following: • UM decision making is based only on appropriateness of care and service and existence of coverage. • The organization does not specifically reward practitioners or other individual for issuing denials of coverage. • Financial incentives for UM decision makers do not encourage decisions that result in under utilization.
CRA.2.14.1.13	**UM 11A – Assessing Satisfaction with UM Process**
The provider survey as required by Section 2.18.7.4 shall assess provider/office staff satisfaction with UM processes to identify areas for improving.	The organization's annual assessment of satisfaction with the UM process includes: 1. Collecting and analyzing data on practitioner satisfaction to identify improvement opportunities. 2. Taking action designed to improve practitioner satisfaction based on its assessment of practitioner data.
CRA 2.14.4.1	**UM 12, Element A**
The CONRACTOR shall provide emergency services without requiring prior authorization or PCP referral, as described in Section 2.7.1, regardless of whether these services are provided by a contract or non-contract provider. The CONTRACTOR shall provide post-stabilization care services in accordance with 42 CFR 422.113	The organization's emergency services policies and procedures require coverage of emergency services in the following situations: 1. To screen and stabilize the member without prior approval, where a prudent layperson, acting reasonable, would have believed that an emergency medical condition existed. 2. If any authorized representative, acting for the organization, authorized provision of emergency services.
CRA 2.15.1.2	**QI 2, Element B**
All information about the QM/QI program will be made available to providers and members.	The organization annually makes information about its QI program available to the following groups: 1. Members 2. Providers
CRA 15.1.6.3	**QI 4, Element A**
The CONTRACTOR shall collect data on race and ethnicity.	The organization: 1. Assesses the cultural, ethnic, racial, and linguistic needs of its members. 2. Adjusts the availability of practitioners within its network, if necessary.
CRA § 2.27.2 & 2.27.2.8 (E/W, Middle, & TCS)	**RR 6C Authorization**
In accordance with HIPAA regulations, the CONTRACTOR shall, at a minimum: Make available to TENNCARE enrollees the right to amend their PHI data in accordance with the federal HIPAA regulations. The CONTRACTOR shall also send information to enrollees educating them of their rights and necessary steps in this regard.	The organization has policies and procedures that address members' right to authorize or deny the release of PHI beyond uses for treatment, payment or health care operations.

State Requirements Deemed Met by NCQA Accreditation Survey	
2014 State Standards	**2014 NCQA Accreditation Standards**
CRA § 2.26.1; 2.26.1.1; 2.26.1.2; 26.1.3; 2.26.1.5	**CR 9 – Elements A, C, and F**
If the CONTRACTOR delegates responsibilities to a subcontractor, the CONTRACTOR shall ensure that the subcontracting relationship and subcontracting document(s) comply with federal requirements, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b) and 42 CFR 434.6 as described below: • The CONTRACTOR shall evaluate the prospective subcontractor's ability to perform the activities to be delegated. • The CONTRACTOR shall require that the agreement be in writing and specify the activities and report responsibilities delegated to the subcontractor and provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. • Effective with any new subcontracts or upon the next amendment to existing subcontracts, the CONTRACTOR shall include a requirement that the subcontract may be terminated by the CONTRACTOR for convenience and without cause upon a specified number of day's written notice. • The CONTRACTOR shall identify deficiencies or areas for improvement, and the CONTRACTOR and the subcontractor shall take corrective action as necessary.	*CR 9A Written Delegation Agreement-* The written delegation document: 1. Is mutually agreed upon 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity 3. Requires at least semiannual reporting of the delegated entity to the organization 4. Describes the process by which the organization evaluates the delegated entity's performance 5. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement. *CR 9C Right to Approve and Terminate-* The organization retains the right to approve, suspend and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation document. *CR 9F Opportunities for Improvement-* For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.

CMS Requirement: If applicable, for MCOs or PIHPs serving only dual eligibles, identify the mandatory activities for which the state has exercised the non-duplication under 438.360(c) and include an explanation of the rationale for why the activities are duplicative to those under 438.358(b)(1) and (b)(2). (CRA 438.360(c)(4))

Not applicable.

SECTION III: STATE STANDARDS

Access Standards

CMS Requirement: This section should include a discussion of the standards that the state has established in the MCO/PIHP contracts for access to care, as required by 42 CFR, Part 438, subpart D. These standards should relate to the overall goals and objectives listed in the quality strategy's introduction. States may either reference the access to care provisions from the state's managed care contracts or provide a summary description of the contract provisions. CMS recommends states minimize reference to contract language in the quality strategy. However, if the state chooses the latter option, the summary description must be sufficiently detailed to offer a clear picture of the specific contract provisions and be written in language that may be understood by stakeholders who are interested in providing input as part of the public comment process.

STATE ACCESS STANDARDS AS REQUIRED BY 42 CFR, PART 438, SUBPART D
42 CFR 438.206 AVAILABILITY OF SERVICES
42 CFR 438.206(b)(1) Maintains and monitors a network of appropriate providers
The Contractor Risk Agreement (CRA) between TennCare and the MCOs addresses provider networks in section 2.11 including primary care providers, specialty service providers, prenatal care providers, behavioral health services, long-term services & supports providers, and safety net providers; credentialing and other certification; and network notice requirements. CRA Section 2.12 addresses provider agreements. CRA Section 2.18 addresses customer service for members, including member services toll-free phone line, interpreter/translation services, cultural competency, and member involvement with behavioral health services. CRA Attachment III addresses general access standards and Attachment IV addresses specialty network standards. Attachment V addresses access and availability for behavioral health services.
438.206(b)(2) Female enrollees have direct access to a women's health specialist
CRA Section 2.11.4 states that a sufficient number of providers must be enrolled in the TennCare program so that prenatal or other medically necessary covered services are not delayed or denied to pregnant women at any time, including during their presumptive eligibility period.
438.206(b)(3) Provides for a second opinion from a qualified health care professional
CRA Section 2.6.4 provides for a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition when requested by a member, parent, and/or legally appointed representative. The second opinion must be provided by a contracted qualified health care professional or the MCO must arrange for a member to obtain one from a non-contract provider. The second opinion shall be provided at no cost to the member.
438.206(b)(4) Adequate and timely coverage of services not available in network
CRA Section 2.11.1.9 States if the MCO is unable to provide medically necessary covered services to a particular member using contract providers, it must adequately and timely cover these services for that member using non-contract providers, for as long as the provider network is unable to provide them.
438.206 (b)(5) Out of network providers coordinate with the MCO or PIHP with respect to payment
CRA Sections 2.13.11-15 address circumstances under which out-of-network providers may seek payment from the MCO. It states the following: • The MCO shall pay for any medically necessary covered services provided to a member by a non-contract provider at the request of a contract provider; • The payment shall not be less than 80% of the rate that would have been paid by the MCO if the member had received the services from a contract provider; and

- The MCO shall only pay for covered long-term care services for which the member was eligible and that were authorized by the MCO in accordance with the requirements of this agreement.

438.206(b)(6) Credential all providers as required by 438.214

CRA Section 2.11.8 addresses credentialing of both contract and non-contract providers.

CRA 2.11.8.1.1 states the MCCs must utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.

CRA 2.11.8.2.1 states the MCCs must utilize the current NCQA standards for credentialing and recredentialing of licensed independent providers with whom it does not contract but with whom it has an independent relationship.

CRA 2.11.8.2.2 states that all credentialing applications must be completely processed within 30 calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed contract/agreement if applicable.

438.206(c)(1)(i) Providers meet state standards for timely access to care and services

CRA Attachment III states that, in general, MCOs shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, and professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24 hour a day, seven day a week basis. At a minimum, this shall include:

Primary Care Physician or Extender

- Rural – 30 miles or 30 minutes.
- Urban – 20 miles.
- Patient Load – 2,500 or less for physician; one-half this for a physician extender.
- Appointment/Waiting times – Not to exceed 3 weeks from date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

Specialty Care and Emergency Care

- Not to exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contract. Waiting times shall not exceed 45 minutes.

Hospital Care

- Transport distance will be the usual and customary, not to exceed 30 miles, except in rural areas where access distance may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.

Long-Term Care Services

- Transport distance to licensed Adult Day Care providers will be the usual and customary, not to exceed 20 miles in urban areas, not to exceed 30 miles for suburban areas, and not to exceed 60 miles in rural areas except where community standards and documentation shall apply.

General Optometry Services

- Transport Distance: Usual and customary, not to exceed 30 miles, except in rural areas where community standards and documentation shall apply.
- Appointment/Waiting Times: Usual and customary, not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

Lab and X-ray services

- Usual and customary, not to exceed 30 minutes, except in rural areas where community access standards and documentation will apply.
- Appointment/Waiting Times: usually and customary, not to exceed 3 weeks, for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

Access to specialty care (CRA Attachment IV)

- The MCO must have provider agreements with providers practicing the following specialties: Allergy,

Cardiology, Dermatology, Endocrinology, Otolaryngology, Gastroenterology, General Surgery, Neonatology, Nephrology, Neurology, Neurosurgery, Oncology/Hematology, Ophthalmology, Orthopedics, Psychiatry (adult, child, and adolescent), and Urology.

- Travel distance must not exceed 60 miles for at least 75% of non-dual members.
- Travel distance must not exceed 90 miles for all non-dual members.

Access for Behavioral Health Services (CRA Attachment V)

- *Psychiatric Inpatient Hospital Services* – Travel does not exceed 90 miles for at least 90% of members. Maximum time for admission/appointment is 4 hours (emergency involuntary), 24 hours (involuntary), and 24 hours (voluntary).
- *24 Hour Psychiatric Residential Treatment* – Must contract with at least one provider of service in the Grand Region for adult members. Travel distance does not exceed 60 miles for at least 75% of child members and does not exceed 90 miles for at least 90% of child members. Maximum time for admission/appointment is within 30 days.
- *Outpatient Non-MD Services* – Travel distance does not exceed 30 miles for all members. Maximum time for admission/appointment is within 10 business days; if urgent, within 48 hours.
- *Intensive Outpatient [may include day treatment (adult), intensive day treatment (children/adolescents), or Partial Hospitalization]* – Travel distance does not exceed 90 miles for at least 90% of members. Maximum time for admission/appointment is within 10 business days; if urgent, within 48 hours.
- *Inpatient Facility Services (Substance Abuse)* – Maximum time is within 10 business days; if urgent, within 48 hours. Maximum time for admission/appointment is within two calendar days, or, for detoxification, within four hours in an emergency and 24 hours for non-emergency.
- *24 Hour Residential Treatment Services (Substance Abuse)* – Must contract with at least one provider of service in the Grand Region for adult members and one provider of service in the Grand Region for child members. Timeframe: within 10 business days.
- *Outpatient Treatment Services (Substance Abuse)* – Travel distance does not exceed 30 miles for all members. Timeframe: within 10 business days; within 24 hours for detoxification.
- *Mental Health Case Management* – Not subject to geographic access standards. Timeframe: within seven calendar days.
- *Psychosocial Rehabilitation (may include Supported Employment, Illness Management & Recovery, Peer Recovery services, or Family Support services)* – Not subject to geographic access standards. Timeframe: within ten business days.
- *Supported Housing* – Not subject to geographic access standards. Timeframe: within 30 calendar days.
- *Crisis Services (Mobile)* – Not subject to geographic access standards. Timeframe: face-to-face contact within one hour for emergency situations and four hours for urgent situations.
- *Crisis Stabilization* – Not subject to geographic access standards. Timeframe: within 4 hours of referral.

438.206(c)(1)(ii) Network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid Fee For Service

CRA section 2.12.9.65 requires that providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees.

438.206(c)(1)(iii) Services included in the contract are available 24 hours a day, 7 days a week

CRA Section 2.7.1.1 requires that emergency services be available 24 hours a day, seven days a week.

438.206(c)(1)(iv-v) Mechanisms/monitoring to ensure compliance by providers

Each MCO has a provider services unit that monitors the network for compliance with certain standards. The Bureau of TennCare has contracted with Qsource, TennCare's EQRO, to conduct a quarterly provider data validation (PDV) survey. The purpose of this activity is to determine the accuracy of the provider data files submitted by the TennCare MCCs and to use the results as a proxy to determine the extent to which providers are available and accessible to TennCare members. The survey is conducted using a hybrid methodology developed to maximize response rates. The survey consists of telephone calls and facsimile follow-up protocol as necessary. The validation tool was programmed into a Microsoft Access database

and pre-populated with data elements from the MCC provider files. Qsource attempts to contact providers up to three times by telephone. Providers were also notified of a toll-free number to allow the provider to call back if the time was not convenient. The following standards are monitored through this survey.

- MCC Data Accuracy - Provider Credentialed Specialty/Behavioral Health Service Code.
- Provider Panel Status (Open/Closed)
- Routine and Urgent Care Services - Provider offices were questioned regarding whether they offered routine and/or urgent care during the time reported for validation. Accuracy was determined by comparing the responses to the thresholds specific to each provider.
- Services for Patients - Two questions were asked of the providers: 1) Do you provide services to patients less than 21 years of age? And 2) Do you provide services to patients 21 years of age and older?
- Primary Care Services
- Prenatal Care Services

438.206(c)(2) Culturally competent services to all enrollees

MCCs are contractually required in CRA 2.18.3 to participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency and diverse cultural and ethnic backgrounds. Additionally, CRA 2.8.4.3.1 states that health coaching or other interventions for health risk management shall emphasize self-management strategies addressing healthy behaviors, self-monitoring, co-morbidities, cultural beliefs, depression screening, and appropriate communication with providers.

42 CFR 438.207 ASSURANCES OF ADEQUATE CAPACITY AND SERVICES

438.207(b)(1) Offer an appropriate range of preventive, primary care, and specialty services

CRA 2.7.5.1 states, "The Contractor shall provide 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."

CRA 2.7.5.2.1 states, "The Contractor shall provide or arrange for the provision of medically necessary prenatal care to members beginning on the date of their enrollment in the … MCO. This requirement includes pregnant women who are presumptively eligible for TennCare, enrollees who become pregnant, as well as enrollees who are pregnant on the effective date of enrollment in the MCO. The requirement to provide or arrange for the provision of medically necessary prenatal care shall include assistance in making a timely appointment for a woman who is presumptively eligible and shall be provided as soon as the Contractor becomes aware of the enrollment."

CRA 2.7.6.1.1 requires that the MCOs provide EPSDT services (TENNderCare) to members under age 21. CRA 2.7.6.3.1-2 further requires that the MCO provide periodic comprehensive child health assessments, meaning, "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth." At a minimum, these screens must include periodic and interperiodic screens and be provided at intervals which meet standards set forth in the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care for medical practice and American Academy of Pediatric Dentistry (AAPD) guidelines for dental practice. See the response for 438.207(b)(2) (below) for further standards of care.

438.207(b)(2) Maintain network sufficient in number, mix, and geographic distribution

CRA Attachments III, IV and V outline standards that the MCOs have to meet.
(See Attachment I of this document to see the full set of standards.)

42 CFR 438.208 COORDINATION AND CONTINUITY OF CARE

438.208(b)(1) Each enrollee has an ongoing source of primary care appropriate to his or her needs

CRA Attachment III outlines standards for primary care providers that each MCO has to meet. The requirements for Primary Care Physicians or Extenders are as follows:

- Distance/Time Rural: 30 miles
- Distance/Time Urban: 20 miles

- Patient Load: 2,500 or less for physician; one-half this for a physician extender
- Appointment/Waiting Times: Usual and customary practice, not to exceed three weeks from date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
- Documentation/Tracking requirements:
  - Health plans must have a system in place to document appointment scheduling times.
  - Tracking – Plans must have a system in place to document the exchange of member information if a provider other than the primary care provider (i.e., school-based clinic or health department clinic) provides health care.

438.208(b)(2) All services that the enrollee receives are coordinated with the services the enrollee receives from any other MCO/PIHP

The MCOs are responsible for the management, coordination, and continuity of care for all their TennCare members. They coordinate care among PCPs, specialists, behavioral health providers, and long-term care providers and develop/maintain policies and procedures to address this responsibility. For CHOICES members, these policies and procedures specify the role of the care coordinator/care coordination team in conducting these functions (CRA 2.9.1). Additionally, MCOs coordinate with other state and local departments and agencies to ensure that coordinated care is provided to members (CRA 2.9.16).

438.208(b)(3) Share with other MCOs, PIPHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment to prevent duplication of services

MCOs use their Population Health and CHOICES care coordination programs to support the continuity and coordination of covered physical health, behavioral health, and long-term care services, and to support collaboration between providers (CRA 2.9.9.8).

438.208(b)(4) Protect enrollee privacy when providing care

The MCOs are required to comply with all applicable HIPAA and HITECH requirements including, but not limited to, the following (CRA 2.27.2):

- Compliance with the Privacy Rule, Security Rule, and Notification Rule
- The creation of and adherence to sufficient Privacy and Security Safeguards and Policies
- Timely reporting of violations in the access, use, and disclosure of PHI
- Timely reporting of privacy and/or security incidents

438.208(c)(1) State mechanisms to identify persons with special health care needs

CRA 2.9.16 requires MCOs to coordinate with a variety of agencies to assure that those individuals with special health care needs receive the services they need. These agencies include:

- *Tennessee Department of Mental Health & Substance Abuse Services* and *Tennessee Department of Intellectual & Developmental Disabilities (DIDD)* interface and assure continuity and coordination of specialized services in accordance with federal PASRR requirements.
- *Tennessee Department of Children's Services* addresses the needs of children who are in State custody. The TennCare Select MCO serves the majority of these children in order to have continuity when children move from place to place in the state.
- *Tennessee Department of Health, Children's Special Services Program*
- *Area Agencies on Aging and Disability (AAADs)* collaborate on intake of members new to both TennCare and CHOICES. AAADs also assist CHOICES members in Groups 2 and 3 with the TennCare eligibility redetermination process.

MCOs are responsible for the delivery of medically necessary covered services to school-aged children. They are encouraged to work with school-based providers to manage the care of students with special needs. The State implemented a process, referred to as TENNderCare Connection, to facilitate notification of MCOs when a school-aged child enrolled in TennCare has an Individualized Education Plan (IEP) that identifies a need for medical services. In such cases, the school is responsible for obtaining parental consent to share the IEP with the MCO and for subsequently sending a copy of the parental consent and IEP to the MCO. The school is also responsible for clearly delineating the services

on the IEP that the MCOs are to consider for payment (CRA 2.9.16.7.1). Each MCO has a predictive modeling system that allows it to identify high risk individuals and their needs (CRA 2.8.2.1).
438.208(c)(2) Mechanisms to assess enrollees with special health care needs by appropriate health care professionals
For members determined to need a course of treatment or regular care monitoring, the MCO shall have a mechanism in place to allow members to directly access a specialist as appropriate for the members' condition and identified needs (CRA 2.14.3.3).
438.208(c)(3) If applicable, treatment plans developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee; approved in a timely manner; and in accord with applicable state standards
Not Applicable
438.208(c)(4) Direct Access to specialists for enrollees with special health care needs
The MCOs establish and maintain a network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical and behavioral health needs of its members (adults and children) without excessive travel requirements. TennCare monitors compliance with specialty network standards on an ongoing basis (CRA 2.11.3.2-3).
42 CFR 438.210 COVERAGE AND AUTHORIZATION OF SERVICES
438.210(a)(1) Identify, define, and specify the amount, duration, and scope of each service.
See Attachment II for covered benefits.
438.210(a)(2) Services are furnished in an amount, duration, and scope that is no less than those furnished to beneficiaries under fee-for-service Medicaid.
All covered benefits are provided if medically necessary through a capitated arrangement with the MCCs.
438.210(a)(3)(i) Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
CRA 2.6.3 relates to Medical Necessity Determinations. It states that the MCCs may establish procedures for the determination of medical necessity with the determination being made on a case by case basis and in accordance with the definition of medical necessity defined in TCA 71-5-144 and TennCare rules and regulations. However, this requirement does not limit the MCCs' ability to use medically appropriate cost-effective alternative services in accordance with Section 2.6.5.
438.210(a)(3)(ii) No arbitrary denial or reduction in service solely because of diagnosis, type of illness or condition
CRA Sections 2.6.3.2 and 2.6.3.3 state the MCCs may not employ, and shall not permit others acting on their behalf to employ, utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her medical history. The MCCs must not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.
438.210(a)(3)(iii) Each MCO/PIHP may place appropriate limits on a service, such as medical necessity.
CRA Sections 2.6.3.2 and 2.6.3.3 state the MCCs may not employ, and shall not permit others acting on their behalf to employ, utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her medical history. The MCCs must not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.
42 CFR 438.210(a)(4) Specify what constitutes "medically necessary services".
CRA 2.6.3 relates to Medical Necessity Determinations. It states that the MCCs may establish procedures for the determination of medical necessity with the determination being made on a case-by-case basis and in accordance with the definition of medical necessity defined in TCA 71-5-1944 and TennCare rules and regulations governing medical necessity, which are delineated at 1200-13-16. Specifically, to be medically necessary, the benefit must meet each of the following criteria:

- It must be recommended by a licensed physician who is treating the enrollee or other licensed healthcare provider practicing within the scope of his or her license who is treating the enrollee;
- It must be required in order to diagnose or treat an enrollee's medical condition;
- It must be safe and effective;
- It must not be experimental or investigational; and
- It must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition.

438.210(b)(1) Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services.

438.210(b)(2)(i) Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions.

CRA Section 2.14.1.9 states that MCOs must use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorization and decision making. They must also have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any Amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional that has appropriate clinical expertise in treating the member's condition or disease or, in the case of long-term care services, a long-term care professional that has appropriate expertise in providing long-term care services.

CRA Section 2.14.2.1 states that MCOs must have in place, and follow, written policies and procedures for processing requests for initial and continuing prior authorizations of services and have in effect mechanisms to ensure consistent application of review criteria for prior authorization decisions. The policies and procedures shall provide for consultation with the requesting provider when appropriate. If prior authorization of a service is granted by the MCO and the service is provided, payment for the prior authorized service shall not be denied based on the lack of medical necessity, assuming that the member is eligible on the date of service, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances which were described at the time the prior authorization was granted.

CRA 2.14.5.1 states that MCOs must have in place an authorization process for covered long-term services and cost effective alternative services that is separate from but integrated with the prior authorization process for covered physical and behavioral health services.

438.210(b)(3) Any decision to deny or reduce services is made by an appropriate health care professional.

CRA Section 2.14.1.9 states that MCOs must use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorizations and decision making. They must also have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease or, in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services.

438.210(c) Each MCO/PIHP must notify the requesting provider, and give the enrollee written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

438.210(d) Provide for the authorization decisions and notices as set forth in 438.210(d).

438.210(e) Compensation to individuals or entities that conduct utilization management activities does not provide incentives to deny, limit, or discontinue medically necessary services.

CRA 2.14.7, Notice of Adverse Action Requirement, requires MCOs to:

- Clearly document and communicate the reasons for each denial of a prior authorization request in a

manner sufficient for the provider and member to understand the denial and decide about requesting reconsideration of or appealing the decision;
- Comply with all member notice provisions in TennCare rules and regulations; and
- Issue appropriate notice prior to any contractor-initiated decision to reduce or terminate CHOICES or non-CHOICES nursing facility services and shall comply with all federal court orders, and federal and state laws and regulations, regarding members' transfer or discharge from nursing facilities.

Structure and Operations Standards

CMS Requirement: This section should include a discussion of the standards that the state has established in the MCO/PIHP contracts for structure and operations, as required by 42 CFR, Part 438, subpart D. These standards should relate to the overall goals and objectives listed in the quality strategy's introduction. States may either reference the structure and operations provisions from the state's managed care contracts, or provide a summary description of such provisions. CMS recommends states minimize reference to contract language in the quality strategy. However, if the state chooses the latter option, the summary description must be sufficiently detailed to offer a clear picture of the specific contract provisions and be written in language that may be understood by stakeholders who are interested in providing input as part of the public comment process.

STATE STRUCTURE & OPERATIONS STANDARDS AS REQUIRED BY 42 CFR, PART 438, SUBPART D
42 CFR 438.214 Provider Selection
438.214(a) Written Policies for Selection and Retention of Providers.
CRA Section 2.11.1.3.3 states the MCO must have in place written policies and procedures for the selection and retention of providers. These policies and procedures must not discriminate against particular providers that service high risk populations or specialize in conditions that require costly treatment.
438.214(b)(1) Uniform credentialing and recredentialing that each MCO/PIHP must follow.
CRA 2.11.8.1 - Credentialing of Contract Providers: • The MCO must utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action. • The MCO must completely process credentialing applications from all types of providers (physical health, behavioral health, and long-term care providers) within 30 calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. "Completely process" means that the MCO shall approve and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not used by the MCO. • The MCO must ensure all providers submitted to it by the delegated credentialing agent are loaded to its provider files and into its claims processing system within 30 days of receipt. *CRA 2.11.8.2 - Credentialing of Non-Contract Providers* • The MCO must utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing of licensed independent providers with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the MCO selects and directs its members to see a specific provider or group of providers. • The MCO must completely process credentialing applications within 30 calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed contract/agreement if applicable. "Completely process" means that the MCO shall review, approve, and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not used by the MCO.

- The MCO must notify TennCare when it 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.

CRA 2.11.8.3 - Credentialing of Behavioral Health Entities

- The MCO must ensure each behavioral health provider's service delivery site meets all applicable requirements of law and has the necessary and current license/certification/accreditation/designation approval per state requirements.
- When individuals providing behavioral health treatment services are not required to be licensed or certified, it is the responsibility of the MCO to ensure, based on applicable state licensure rules and/or program standards, that they are appropriately educated, trained, qualified, and competent to perform their job responsibilities.

CRA 2.11.8.4 - Credentialing of Long-Term Care Providers

- The MCO must develop and implement a process for credentialing and recredentialing long-term care providers. The process must, as applicable, meet the minimum NCQA requirements. In addition, the MCO must ensure that all long-term care providers, including those credentialed/ recredentialed in accordance with NCQA standards, meet applicable State requirements, as specified by TennCare in State Rule, in this agreement, or in policies or protocols.
- The MCO must develop policies that specify by HCBS provider type the credentialing process, the recredentialing process including frequency, and ongoing provider monitoring activities.
- Ongoing CHOICES HCBS providers must be recredentialed at least annually.
- All other CHOICES HCBS providers (e.g. pest control and assistive technology) must be recredentialed, at a minimum, every three years.
- At a minimum, credentialing of LTC providers must include the collection of required documents, including disclosure statements, and verification that the provider:
  - Has a valid license or certification for contracted services;
  - Is not excluded from participation in the Medicare or Medicaid programs;
  - Has a National Provider Identifier (NPI) Number, where applicable, and has obtained a Medicaid provider number from TennCare;
  - Has policies and processes in place to conduct, in accordance with Federal and State law and rule and TennCare policy, criminal background checks, which must include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, and List of Excluded Individuals/Entities, on all prospective employees who will deliver CHOICES HCBS and to document these in the worker's employment record; and
  - Has a process in place to provide and document initial and ongoing education to its employees who will provide services to CHOICES members.
- Recredentialing of HCBS providers must include verification of continued licensure and/or certification (as applicable) and compliance with policies and procedures identified during credentialing, including background checks and training requirements, critical incident reporting and management, and use of the Electronic Visit Verification (EVV) system.
- For both credentialing and recredentialing process, the MCO must conduct a site visit, unless the provider is located out of state, in which case the site visit may be waived and the reason documented in the provider file.

438.214(c) Provider selection policies and procedures do not discriminate against providers serving high-risk populations or specialize in conditions that require costly treatment.

CRA Section 2.11.1.3.3 requires MCOs to have in place written policies and procedures for the selection and retention of providers. These policies and procedures shall not discriminate against particular providers that service high risk populations or specialize in conditions that require costly treatment.

438.214(d) MCOs/PIHPs may not employ or contract with providers excluded from Federal Health Care Programs.

CRA 2.20.1.5 states, "The contractor, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR 1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive TennCare funds…..shall screen their owners and employees against the federal exclusion databases."

CRA 2.20.3.6 states, "The contractor shall have provisions in its Compliance Plan regarding conducting monthly comparison of their provider files, including atypical providers, against both the Excluded Parties List System (EPLS) and the HHS-OIG List of Excluded Individuals/Entities (LEIE) and provide a report of the result of comparison to TENNCARE each month. The contractor shall establish an electronic database to capture identifiable information on the owners, agents and managing employees listed on providers' Disclosure forms."

CRA 2.20.3.7 states, "The contractor shall have provisions in its Compliance Plan regarding performing a monthly check for exclusions of their owners, agents and managing employees. The contractor shall establish an electronic database to capture identifiable information on its owners, agents and managing employees and perform monthly exclusion checking. The contractor shall provide the State Agency with such database and a monthly report of the exclusion check."

42 CFR 438.218 Enrollee Information

438.218 Incorporate the requirements of 438.10

CRA 2.17 incorporates the responses to CFR 438.10. Primary language is identified by the enrollment contractor at the time of each person's application for TennCare services. If the primary language is omitted from the enrollment files received by the MCO, the MCO staff then collects the information during new member calls. Requirements for the MCOs are as follows:

- Must submit all materials that will be distributed to members to TennCare for prior approval. This includes, but is not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, and system generated letters. Modifications to existing materials must also receive prior approval.
- All member materials must be worded at a sixth grade reading level and must be clearly legible. They must also be available in alternative formats for persons with special needs at no expense to the member. Formats may include Braille, large print, and audio, depending on the needs of the member.
- All vital documents must be translated and available in Spanish. Within 90 calendar days of notification from TennCare, all vital documents must be translated and available to each Limited English Proficiency (LEP) group identified by TennCare that constitutes 5% of the TennCare population or 1,000 enrollees, whichever is less.
- All written member materials must notify enrollees that oral interpretation is available for any language at no expense to them and how to access those services.
- The MCO must provide written notice to members of any changes in policies or procedures described in written materials previously sent to members. They must provide written notice at least 30 days before the effective date of a request.
- The contractor must use the approved Glossary of Required Spanish Terms in the Spanish translation of all member materials.
- All educational materials must be reviewed and updated concurrently with the update of the Clinical Practice Guidelines to assure the materials reflect current evidence-based information.
- The MCO must develop a member handbook based on a template provided by TennCare and update it periodically (at least annually). It must be distributed within 30 calendar days of receipt of notice of enrollment in the MCO or prior to enrollees' enrollment effective date and at least annually thereafter. Members must receive a revised member handbook whenever material changes are made.

CRA 2.17.4.7 requires that each member handbook include the following:

- Table of Contents.
- Explanation of how members will be notified of member-specific information such as effective date of enrollment, PCP assignment, and care coordinator assignment for CHOICES members.
- Explanation of how members can request to change PCPs.
- Description of services provided including benefit limits, the consequences of reaching a benefit limit, non-covered services, and use of non-contract providers, including that members are not entitled to a fair hearing about non-covered services and that members shall use contract providers except in specified circumstances.
- Explanation that prior authorization is required for some services, including non-emergency services provided by a non-contract provider, and that service authorization is required for all long-term care services; that 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.
- Descriptions of the Medicaid Benefits, Standard Benefits, and the covered long-term care services for CHOICES members, by CHOICES group.
- Description of TennCare cost sharing or patient liability responsibilities including an explanation that providers and/or the CONTRACTOR may utilize whatever legal actions are available to collect these amounts. Further, the information shall specify the instances in which a member may be billed for services, and shall indicate that the member may not be billed for covered services except for the amounts of the specified TennCare cost sharing or patient liability responsibilities and explain the member's right to appeal in the event that they are billed for amounts other than their TennCare cost sharing or patient liability responsibilities. The information shall also identify the potential consequences if the member does not pay his/her patient liability, including loss of the member's current nursing facility provider, disenrollment from CHOICES, and, to the extent the member's eligibility depends on receipt of long-term care services, loss of eligibility for TennCare.
- Information about preventive services for adults and children, including TENNderCare; a listing of covered preventive services; and notice that preventive services are at no cost and without cost sharing responsibilities.
- Procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to non-contract providers. The handbook shall advise members that if they need a service that is not available from a contract provider, they will be referred to a non-contract provider and any copayment requirements would be the same as if this provider were a contract provider.
- Information on the CHOICES program, including a description of the CHOICES groups; eligibility for CHOICES; enrollment in CHOICES, including whom to contact at the MCO regarding enrollment in CHOICES; enrollment targets for Group 2 and Group 3 (excluding Interim Group 3), including reserve capacity and administration of waiting lists; and CHOICES benefits, including benefit limits, the individual cost neutrality cap for Group 2, and the expenditure cap for Group 3.
- Information on care coordination for CHOICES members, including but not limited to the role of the care coordinator, level of care assessment and reassessment, needs assessment and reassessment, and care planning, including the development of a plan of care for members in CHOICES Groups 2 and 3.
- Information on the right of CHOICES members to request an objective review by the State of their needs assessment and/or care planning processes and how to request such a review.
- Information regarding consumer direction of eligible CHOICES HCBS, including but not limited to the roles and responsibilities of the member or the member's representative, the services that can be directed, the member's right to participate in or voluntarily withdraw from consumer direction at any time, the role of and services provided by the FEA, and a statement that voluntary or

involuntary withdrawal from consumer direction will not affect a member's eligibility for CHOICES.

- Explanation of emergency services and procedures on how to obtain emergency services both in and out of the contractor's service area, including but not limited to an explanation of post-stabilization services, the use of 911, locations of emergency settings, and locations for post-stabilization services.
- Information on how to access the primary care provider on a 24 hour basis as well as the 24 hour nurse line. The handbook may encourage members to contact the PCP or 24 hour nurse line when they have questions as to whether they should go to the emergency room.
- Information on how to access a care coordinator, including the ability to access a care coordinator after regular business hours through the 24 hour nurse triage/advice line.
- Notice of the right to file a discrimination complaint as provided for by applicable federal and state civil rights laws, including but not limited to Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and Titles II and III of the Americans with Disabilities Act of 1990, as well as a complaint form on which to do so. The notice must be considered a Vital Document and shall be available at a minimum in the English and Spanish languages.
- Information about the Long-Term Care Ombudsman Program.
- Information about the CHOICES consumer advocate, including but not limited to the role of the consumer advocate in the CHOICES program and how to contact the consumer advocate for assistance.
- Information about how to report suspected abuse, neglect, and exploitation of members who are adults (see TCA 71-6-101 *et seq*.) and suspected brutality, abuse, or neglect of members who are children (see TCA 37-1-401 *et seq*. and TCA 37-1-601 *et seq*.), including the phone numbers to call to report suspected abuse/neglect.
- Complaint and appeal procedures.
- Notice that in addition to the member's right to file an appeal directly to TennCare for adverse actions taken by the MCO, the member shall have the right to request reassessment of eligibility related decisions directly to TennCare.
- Written policies on member rights and responsibilities, pursuant to 42 CFR 438.100 and NCQA's Standards and Guidelines for the Accreditation of MCOs.
- Written information concerning advance directives as described in 42 CFR 489 Subpart I and in accordance with 42 CFR 422.128.
- Notice that enrollment in the contractor's MCO invalidates any prior authorization for services granted by another MCO but not utilized by the member prior to the member's enrollment into the contractor's MCO and notice of continuation of care when entering the contractor's MCO as described in Section 2.9.2 of this Agreement.
- Notice to the member that it is his or her responsibility to notify the MCO, TennCare, and DHS (or for SSI eligibles, SSA) each and every time the member moves to a new address and that failure to notify DHS (or for SSI eligibles, SSA) could result in the member not receiving important eligibility and/or benefit information.
- Notice that a new member may request to change MCOs at any time during the 45 calendar day period immediately following their initial enrollment in an MCO, subject to the capacity of the selected MCO to accept additional members and any restrictions limiting enrollment levels established by TennCare. This notice must include instructions on how to contact TennCare to request a change.
- Notice that the member may change MCOs at the next choice period and shall have a 45 calendar day period immediately following the enrollment, as requested during said choice period, in a new MCO to request to change MCOs, subject to the capacity of the selected MCO to accept additional enrollees and any restrictions limiting enrollment levels established by TennCare. This notice shall include instructions on how to contact TennCare to request a change.
- Notice that the member has the right to ask TennCare to change MCOs based on hardship, the circumstances which constitute hardship, explanation of the member's right to file an appeal if such

request is not granted, and how to do so.

- Notice of the enrollee's right to terminate participation in the TennCare program at any time with instructions to contact TennCare for termination forms and additional information on termination.
- TennCare and MCO member services toll-free telephone numbers, including the TennCare hotline, the MCO's member services information line, and the MCO's 24/7 nurse triage/advice line with a statement that the member may contact the MCO or TennCare regarding questions about the TennCare program, including CHOICES, as well as the service/information that may be obtained from each line.
- Information 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.
- Information educating members of their rights and necessary steps to amend their data in accordance with HIPAA regulations and state law.
- Directions on how to request and obtain information regarding the "structure and operation of the MCO" and "physician incentive plans."
- Information that the member has the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- Information that the member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Information on appropriate prescription drug usage.
- Any additional information required in accordance with NCQA's Standards and Guidelines for the Accreditation of MCOs.

Provider Directory requirements, listed in CRA 2.17.8, are as follows:

- The MCO must distribute information regarding general provider directories to new members within 30 calendar days of receipt of notification of enrollment in the MCO or prior to the member's enrollment effective date. Such information must include how to access the provider directory, including the right to request a hard copy and to contact the member services line to inquire regarding a provider's participation in the network. Members receiving a hard copy of the provider directory must be advised that the network may have changed since the directory was printed and told how to access current information regarding participating providers.
- The MCO must provide information regarding the CHOICES provider directory to each CHOICES member as part of the face-to-face visit (for members enrolled through the SPOE) or face-to-face intake visit (for current members) as applicable, but not more than 30 days from notice of CHOICES enrollment. Such information shall include how to access the CHOICES provider directory, including the right to request a hard copy and to contact the member services line to inquire regarding a provider's participation in the network. Members receiving a hard copy of the CHOICES provider directory shall be advised that the network may have changed since the directory was printed, and how to access current information regarding the MCO's participating providers.
- The MCO is also responsible for maintaining updated provider information in an online searchable electronic general provider directory and an online searchable electronic CHOICES provider directory. A PDF copy of the hard copy version will not meet this requirement. The online searchable version of the general provider directory and the CHOICES provider directory shall be updated on a daily basis during the business week. In addition, the MCO must make available upon request, in hard copy format, a complete and updated general provider directory to all members and an updated CHOICES provider directory to CHOICES members. The hard copy of the general provider directory and the CHOICES provider directory shall be updated at least on an annual basis. Members receiving a hard copy and/or accessing a PDF version of the hard copy on the MCO's website of the general provider directory or the CHOICES provider directory must be advised that the network may have changed since the directory was printed and told how to access current information regarding participating providers, including the searchable electronic version of the general provider directory and the CHOICES provider directory as well as the member services line.

- Provider directories (including both the general provider directory and the CHOICES provider directory), and any revisions thereto, must be submitted to TennCare for written approval prior to distribution to enrollees. The text of the directory must be in the format prescribed by TennCare. In addition, the provider information used to populate the provider directory must be submitted as a TXT file or such format as otherwise approved in writing by TennCare and be produced using the same extract process as the actual provider directory.
- The MCO must develop and maintain a general provider directory, which shall be made available to all members. The provider directory must be posted on the MCC website and provided in hard copy upon request of the member. Members must be advised in writing regarding how to access the provider directory, including the right to request a hard copy and to contact the member services line to inquire regarding a provider's participation in the network. Members receiving a hard copy of the provider directory must be advised that the network may have changed since the directory was printed and told how to access current information regarding participating providers. The online version of the provider directory shall be updated on a daily basis. The general provider directory must include the following: names, locations, telephone numbers, office hours, and non-English languages spoken by contract PCPs and specialists; identification of providers accepting new patients; identification of whether or not a provider performs TENNderCare screens; hospital listings, including locations of emergency settings and post-stabilization services, with the name, location, and telephone number of each facility/setting; and a prominent notice that CHOICES members should refer to the CHOICES provider directory for information on long-term care providers.

42 CFR 438.224 Confidentiality

438.224 Individually identifiable health information is disclosed in accordance with Federal privacy requirements.

Individually identifiable health information is used and disclosed in accordance with HIPAA privacy requirements (CRA 2.23.2.1).

42 CFR 438. 226 Enrollment and Disenrollment

438.226 Each MCO/PIHP complies with the enrollment and disenrollment requirements and limitations in 438.56

CRA Section 2.5.3 states that the MCO must not request disenrollment of an enrollee for any reason, and TennCare shall not disenroll members for any of the following reasons:

- Adverse changes in the enrollee's health;
- Pre-existing medical or behavioral health conditions;
- High cost medical or behavioral health bills;
- Failure or refusal to pay applicable TennCare cost sharing responsibilities, except when this results in loss of eligibility for TennCare;
- Enrollee's utilization of medical or behavioral health services;
- Enrollee's diminished mental capacity; or
- Enrollee's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees).

42 CFR 438.228 Grievance Systems

438.228(a) Grievance system meets the requirements of Part 438, subpart F

438.228(b) If applicable, random State reviews of notice of action designation to ensure notification of enrollees in a timely manner

CRA Section 2.19.3 outlines all requirements related to appeals as stated below:

- The MCO must have a contact person who is knowledgeable of appeal procedures and shall direct all appeals, whether the appeal is verbal or the member chooses to file in writing, to TennCare. Should a member choose to appeal in writing, the member shall be instructed to file via mail or fax to the designated TennCare P.O. Box or fax number for medical appeals.

- The MCO must have sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting a TennCare member. The MCO must notify TennCare of the names of appointed staff members and their phone numbers. Staff must be knowledgeable about applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing appeal procedures, as they become effective.
- The MCO must educate its staff concerning the importance of the appeals procedure, the rights of the member, and the time frames in which action must be taken by the MCO regarding the handling and disposition of an appeal.
- The MCO must identify the appropriate internal individual or body having decision-making authority as part of the appeal procedure.
- The MCO must have the ability to take telephone appeals and accommodate persons with disabilities during the appeals process. Appeal forms shall be available at each service site and by contacting the MCO. However, members shall not be required to use a TennCare-approved appeal form in order to file an appeal.
- Upon request, the MCO must provide members a TennCare approved appeal form(s).
- The MCO must provide reasonable assistance to all appellants during the appeal process.
- At any point in the appeal process, TennCare has the authority to remove a member from the MCO when it is determined that such removal is in the best interest of the member and TennCare.
- The MCO must require providers to display notices of members' right to appeal adverse actions affecting services in public areas of each facility in accordance with TennCare rules and regulations. The MCO must ensure that providers have correct and adequate supply of public notices.
- Neither the MCO nor TennCare shall prohibit or discourage any individual from testifying on behalf of a member.
- The MCO must ensure compliance with all notice requirements and notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective.
- TennCare may develop additional appeal process guidelines or rules, including requirements as to content and timing of notices to members, which must be followed by the MCO. However, the MCO must not be precluded from challenging any judicial requirements, and to the extent judicial requirements that are the basis of such additional guidelines or rules are stayed, reversed, or otherwise rendered inapplicable, the MCO must not be required to comply with such guidelines or rules during any period of such inapplicability.
- The MCO must provide general and targeted education to providers regarding expedited appeals (described in TennCare rules and regulations), including when an expedited appeal is appropriate, and procedures for providing written certification thereof.
- The MCO must require providers to provide written certification regarding whether a member's appeal is an emergency upon request by a member prior to filing such appeal, or upon reconsideration of such appeal by the MCO when requested by TennCare.
- The MCO must provide notice to contract providers regarding provider responsibility in the appeal process, including but not limited to, the provision of medical records and/or documentation.
- The MCO must urge providers who feel they cannot order a drug on the TennCare Preferred Drug List to seek prior authorization in advance, as well as to take the initiative to seek prior authorization or change or cancel the prescription when contacted by a member or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.).
- Member eligibility and eligibility-related grievances and appeals (including but not limited to long-term care eligibility and enrollment), including termination of eligibility, effective dates of coverage, and the determination of premium, copayment, and patient liability responsibilities shall be directed to TennCare.

42 CFR 438.230 Subcontractual Relationships and Delegation
438.230(a) Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities
In accordance with contractual requirements, MCOs must monitor all delegated functions to ensure that they are in compliance with all regulations (CRA 2.26.1).
438.230(b)(1) Before any delegation, each MCO/PIHP must evaluate prospective subcontractor's ability to perform.
All MCOs must evaluate prospective subcontractors' ability to perform the activities to be delegated in accordance with contractual requirements (CRA 2.26.1.1).
438.230(b)(2) Written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
MCOs must require that all delegated agreements be in writing and specify the activities and report responsibilities delegated to the subcontractor. Contracts require that delegation may be revoked or sanctions applied if the subcontractor's performance is inadequate (CRA 2.26.1.2).
438.230(b)(3) Monitoring of subcontractor performance on an ongoing basis
MCOs must monitor all subcontractors on an ongoing basis and subject them to formal review, on at least an annual basis, consistent with NCQA standards and state MCO laws and regulations (CRA 2.26.1.4).
438.230(b)(4) Corrective action for identified deficiencies or areas for improvement
MCOs must identify deficiencies or areas for improvement and require subcontractors to take corrective action as necessary (CRA 2.26.1.5).

Measurement and Improvement Standards

CMS requirement: This section should include a discussion of the standards that the state has established in the MCO/PIHP contracts for measurement and improvement, as required by 42 CFR, Part 438, Subpart D. These standards should relate to the overall objectives listed in the quality strategy's introduction. States may either reference the measurement and improvement provisions from the state's managed care contracts, or provide a summary description of such provisions. CMS recommends states minimize reference to contract language in the quality strategy. However, if the state chooses the latter option, the summary description must be sufficiently detailed to offer a clear picture of the specific contract provisions and be written in language that may be understood by stakeholders who are interested in providing input as part of the public comment process.

STATE MEASUREMENT & IMPROVEMENT STANDARDS AS REQUIRED BY 42 CFR, PART 438, SUBPART D
42 CFR 438.236 Practice Guidelines
438.236(b) Practice guidelines: 1) are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 2) consider the needs of enrollees; 3) are adopted in consultation with contracting health care professionals; and 4) are reviewed and updated periodically, as appropriate.
CRA Section 2.15.4 states that the MCO must utilize evidence-based clinical practice guidelines in its Population Health Programs. Wherever possible, MCOs utilize nationally recognized clinical practice guidelines. On occasion, tools for standardized specifications for care to assist practitioners and patient decisions about appropriate care for specific clinical circumstances are developed through a formal process and are based on authoritative sources that include clinical literature and expert consensus. The guidelines must be reviewed and revised whenever the guidelines change and at least every two years. The MCO is required to maintain an archive of its clinical practice guidelines for a period of five years.

Such archive must contain each clinical guideline as originally issued so that the actual guidelines for prior years are retained for program integrity purposes. NCQA standard QI 9, Element A requires that guidelines be distributed to appropriate practitioners. All MCOs are required to be NCQA accredited. As part of the accreditation survey, files are reviewed to assure that the NCQA requirements for clinical practice guidelines are met.

It should be noted that TennCare defines evidenced-based practice as a clinical intervention that has demonstrated positive outcomes in several research studies to assist consumers in achieving their desired goals of health and wellness. Implied in that definition is that the evidence-based guidelines will incorporate the enrollee's needs and interests as part of the development of evidence-based guidelines.

438.236(c) Dissemination of practice guidelines to all providers, and upon request, to enrollees

All MCOs are required to be NCQA accredited. As part of the accreditation survey, files are reviewed to assure that the NCQA requirements for clinical practice guidelines are met.

42 CFR 438.240 Quality Assessment and Performance Improvement Program

438.240(a) Each MCO and PIHP must have an ongoing quality assessment and improvement program.

CRA Section 2.15 addresses the Quality Assessment and Performance Improvement standards for the MCOs. They must:

- Receive and maintain accreditation from NCQA.
- Have a written program that clearly defines its quality structures and processes and assigns responsibility to appropriate individuals.
- Use NCQA standards as a guide and include a plan for improving patient safety.
- Address physical health, behavioral health, and long-term care services.
- Be accountable to the MCC Board of Directors and executive management team.
- Have substantial involvement of a designated physician and designated behavioral health practitioner.
- Have a Quality Improvement (QI) Committee that oversees the QI functions.
- Have an annual work plan.
- Evaluate the program annually and update as appropriate.
- Make all information available to providers and members.
- Make performance data available to providers and members.
- Use results of activities to improve the quality of physical health, behavioral health, and long-term care service delivery with appropriate input from providers and members.
- Take appropriate action to address service delivery, provider, and other QI issues as they are identified.
- Participate in workgroups hosted by TennCare and agree to establish and implement policies and procedures, including billing and reimbursement, in order to address specific quality concerns.
- Collect data on race and ethnicity.
- Include QM/QI activities to improve healthcare disparities identified through data collection.
- Have a QM/QI committee which must include medical, behavioral health, and long-term care staff as well as contract providers, including medical, behavioral, and long-term care. This committee analyzes and evaluates results, recommends policy decisions, and ensures participation of providers. It must also review and approve the QM/QI program description, annual evaluation, and associated work plan prior to submission to TennCare.

438.240(b)(1) and 438.240(d) Each MCO and PIHP must conduct PIPs and measure and report to the state its performance. List out PIPs in the quality strategy.

CRA 2.15.3 – Performance Improvement Projects (PIPs) – requires that each MCO must perform at least two clinical and three non-clinical PIPs. The two clinical PIPs must include one in the area of behavioral health that is relevant to bipolar disorder, major depression, or schizophrenia and one in the area of either child health or perinatal (prenatal/postpartum) health.

One of the three non-clinical PIPs must be in the area of long-term care. The MCOs must use existing processes, methodologies, and protocols, including the CMS protocols.

List of PIPs conducted in 2014 (Some topics were conducted by more than one MCO):

- Follow-up Care for Children Prescribed ADHD Medication
- Member Response to Smoking Cessation
- Increasing LDL Screening in CHOICES Members with Cardiovascular Conditions
- Prenatal and Postpartum Care – will target member and provider interventions improve eligible member access to prenatal care and postpartum care
- Appropriate Testing for Children with Pharyngitis
- Cultural Assessment Data Collection
- CHOICES Culture of Integration Survey
- SF-12 Survey
- Cultural Assessment Data Collection
- Depression Among Group 2 CHOICES members
- CHOICES Re-Credentialing: Does targeted provider outreach and enhanced internal processes for HCBS providers lead to improved compliance with the re-credentialing process?
- Improving Diabetes Monitoring for People with Diabetes and Schizophrenia
- Decreasing Member Reported Balance Billing Incidents
- Improving Screening Rates for Adolescents Ages 12 to 21
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) HEDIS
- Improving Screening Rates for Children Ages Birth to 15 months

438.240(b)(2) and 438.240(c) Each MCO and PIHP must measure and report performance measurement data as specified by the State. List out performance measures in the quality strategy

CRA 2.15.6 states that MCOs must complete all HEDIS measures designated by NCQA as relevant to Medicaid. Due to a Dental carve-out, the dental measures are excluded. Measure results are reported separately for each Grand Region of the state. MCOs must use the Hybrid methodology (i.e., gathered from administrative and medical record data) as the data collection method for any Medicaid HEDIS measure containing Hybrid specifications as identified by NCQA. The MCOs must contract with an NCQA certified HEDIS auditor to validate the processes of the MCO in accordance with NCQA requirements. Audited HEDIS results are submitted both to TennCare and to the EQRO, who then provides a written report to TennCare. See Attachment III for a list of all HEDIS measures.

438.240(b)(3) Each MCO and PIHP must have mechanisms to detect both underutilization and overutilization of services.

CRA Section 2.14, Utilization Management (UM), requires MCOs to provide for methods of assuring the appropriateness of inpatient care. Such methodologies must be based on individualized determinations of medical necessity in accordance with UM policies and procedures and, at a minimum, must include:

- Pre-admission certification process for non-emergency admissions;
- A concurrent review program to monitor and review continued inpatient hospitalization, length of stay, or diagnostic ancillary services regarding their appropriateness and medical necessity.
- Admission review for urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine if the admission is medically necessary and if the requested length of stay for the admission is reasonable based upon an individualized determination of medical necessity. Such reviews must not result in delays in the provision of medically necessary urgent or emergency care.
- Restrictions against requiring pre-admission certification for admissions for the normal delivery of children; and
- Prospective review of same day surgery procedures.

MCOs must review ED utilization data, at a minimum, every six months to identify members with utilization exceeding the threshold defined by TennCare as ten or more visits in the defined six month period (CRA 2.14.1.16.1).

MCOs must have in place, and follow, written policies and procedures for processing requests for initial and continuing prior authorizations of services and have in effect mechanisms to ensure consistent application of review criteria for prior authorization decisions (CRA 2.14.2.1).

Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease or, in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services (CRA 2.14.1.9).

MCOs must not place maximum limits on the length of stay for members requiring hospitalization and/or surgery. MCOs may not employ, and shall not permit others acting on their behalf to employ, utilization control guidelines or other quantitative coverage limits, unless supported by an individualized determination of medical necessity based upon the needs of each member and his/her medical history (CRA 2.14.1.10).

MCOs must have mechanisms in place to ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of the diagnosis, type of illness, or condition (CRA 2.14.1.11).

438.240(b)(4) Each MCO and PIHP must have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

MCOs are contractually required to have in place a written Quality Management/Quality Improve program that describes all of the mechanisms that they have in place for assessing the quality and appropriateness of care for all enrollees, including those with special health care needs (CRA 2.15).

438.240(e) Annual review by the State of each quality assessment and improvement program. If the state requires that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program, indicate this in the quality strategy.

The MCO quality assessment and improvement programs are reviewed in two different ways. The first is an annual review, by Quality Oversight staff, of the QI/UM program descriptions and annual evaluations, as well as the work plans submitted for the following year. After review of these documents, they will be approved by TennCare or denied with a Corrective Action Plan requested. The second review is done annually by the EQRO and includes the following:

- Policies and procedures ensuring coordination between physical, behavioral health, and long-term care (LTC) services by including the following key elements:
  - Screening for behavioral health needs
  - Referral to physical health, behavioral health, and LTC providers
  - Screening for LTC needs
  - Confidentiality
  - Exchange of information
  - Assessment
  - Treatment plan development
  - Collaboration
  - Case management (CM) and population health (PH)
  - Provider training
  - Monitoring implementation and outcomes
  - Encourages PCPs and other providers to use state-approved behavioral health screening tool
- Processes in place to assure that members discharged from psychiatric inpatient hospitals and psychiatric residential treatment facilities are evaluated for mental health CM services and provided with appropriate behavioral health follow-up services.
- 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.
- Processes to assure that each Population Health program includes the development of program descriptions that serve as the outline for all activities and interventions in the program. Condition

monitoring, patient adherence to the program, consideration of other co-morbidities and condition related lifestyle issues are addressed.

- Processes to assure that PH program descriptions address how the CHOICES care-coordinator will receive notification of the member's participation, information collected about the member, and educational materials given to the member.
- Processes to identify CHOICES member needs when they are in transition between MCOs. Must assures that a comprehensive needs assessment is immediately conducted, the plan of care is updated, and the changes in services are implemented within 10 days of the MCO becoming aware of the change in needs.
- Processes for assuring that members transitioning from a nursing facility to a community based residential alternative or to live with a relative or other caretaker, the care coordinator makes contact with the member within the first 24 hours of transition and visits the member in his/her new residence within seven days of transition.
- Processes to assure the MCO conducts a CHOICES 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 eligibility.

In addition to the reviews mentioned above, NCQA reviews QI/UM standards every three years as part of the MCO Accreditation process.

42 CFR 438.242 Health Information Systems

438.242(a) Each MCO and PIHP must maintain a health information system that can collect, analyze, integrate, and report data and provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.

By contract, each MCO must maintain all information related to interactions with enrollees and providers, including complaints and appeals. Each MCO is also required by contract to maintain all information and/or encounter information for providers with whom the MCO has a capitated arrangement both current and historical. Each MCO is also required to maintain all records and information related to member health status and outcomes.

438.242(b)(1) Each MCO and PIHP must collect data on enrollee and provider characteristics and on services furnished to enrollees.

By contract, each MCO is required to maintain all member enrollment and other information, both current and historical. By contract, each MCO is required to maintain all claims information and/or encounter information and all authorization and care coordination both current and historical.

438.242(b)(2) Each MCO and PIHP must ensure data received is accurate and complete.

By contract, each MCO is responsible for ensuring that the level of care is accurate and complete and reflects the member's current medical and functional status based on information gathered and/or claims and encounters submitted.

SECTION IV: IMPROVEMENT AND INTERVENTIONS

CMS Requirement: Describe, based on the results of assessment activities, how the state will attempt to improve the quality of care delivered by MCOs and PIHPs through interventions such as, but not limited to:

- ***Cross state agency collaborative***
- ***Pay-for-performance or value-based purchasing initiatives***
- ***Accreditation requirements***
- ***Grants***
- ***Disease management programs***
- ***Changes in benefits for enrollees***
- ***Provider network expansion***

Describe how the state's planned interventions tie to each specific goal and objective of the quality strategy.

PLANNED INTERVENTIONS' ALIGNMENT WITH QUALITY STRATEGY GOALS AND OBJECTIVES		
GOAL	**OBJECTIVE**	**INTERVENTION**
ACCESS TO CARE	Adult's access to preventive/ ambulatory health services	Distribution of Member Materials: MCOs distribute a large number of educational and informational materials to their membership, including but not limited to member handbooks, newsletters, fact sheets, and brochures. Each MCO is required to receive prior written approval from TennCare of all materials that are distributed to members, whether developed by the MCOs or their contractors. TennCare staff reviews the submitted materials for both clinical and programmatic content and either approves or denies them within 15 calendar days from the date of submission. QO staff works closely with the MCOs regarding continual quality improvement of materials developed.
	Children & adolescents' access to primary care	MCC EPSDT (TENNderCare) Collaborative: The Division of Quality Oversight will continue to host ad hoc MCC EPSDT (TENNderCare) collaborative meetings that include representatives from all MCOs, the Dental Benefits Manager, and the Department of Health. This group addresses ways of reaching out to TennCare enrollees who are under the age of 21 as well as to their families.
	Children and adults visit doctor/clinic when first seeking care as opposed to hospital/ED	Strategic Planning: Annually, the Division of Quality Oversight staff, in collaboration with Qsource and the Division of Healthcare Informatics, reviews and analyzes all data coming in to the Division of Quality Oversight through MCC reporting and other areas. At that time, and in subsequent meetings, decisions are made about areas of performance that need additional emphasis. It has been determined that additional strategies will be developed to address excessive ED utilization as one of the priority initiatives for 2014. The target population is the top five ED utilizers from each MCO by region. The medical records of these individuals will be reviewed by Quality Oversight staff to determine if appropriate interventions were conducted by the MCOs. After reviewing these records, appropriate next steps will be determined.

		Opportunities for improvement include: • Appropriate use of other resources, e.g., medical home, nurse triage line, and urgent care facilities; • Initiation of a TennCare/MCO collaborative workgroup to share best practices; • Overall reduction of non-acute/non-accident ED usage; • Engaging members and their family members; • Education; and • Health care cost efficiency.
QUALITY OF CARE	Adolescent well-care visits	<u>Teen Newsletter:</u> As described above, the MCC EPSDT (TENNderCare) Collaborative focuses its efforts on improving health care access, education, and services for enrollees. An extremely hard population to reach is the adolescent population. For this reason, the Collaborative specifically targets this age group through a quarterly MCO teen newsletter that includes adolescent-specific articles that address physical, behavioral, and dental health.
	Timeliness of Prenatal Care	<u>Cross State Agency Collaborative</u>: The Division of Quality Oversight will continue to host collaborative meetings addressing maternity issues with prenatal and postpartum care. This group includes representatives from all MCOs and the Tennessee Department of Health as well as TennCare. The group has previously developed a number of interventions related to tobacco use and pregnancy, provider referral to MCO maternity programs, information for referrals for substance abuse, Neonatal Abstinence Syndrome flyers, and provider information about performing and billing postpartum depression screening. A large initiative for the past year was conducting the first ever collaborative Women's Health Provider conference. All three MCOs provided funds for this event and all three MCO Medical Directors participated in the event's panel discussion. They are now planning upcoming activities including developing a provider tool kit addressing preconception health, training outreach workers to talk about preconception health, and provider information about availability of breast pumps.
		<u>DOH Perinatal Advisory Committee</u>: The Quality Oversight Clinical Quality Review Manager participates on the Department of Health's Perinatal Advisory Committee. The committee continues to meet quarterly to address Neonatal Abstinence Syndrome, Postneonatal Follow-up, Baby and Me Tobacco Free, Safe Sleep, Breastfeeding, and the Tennessee Infant Mortality Reduction Strategic Plan. Educational Objectives in Medicine for Perinatal Social Workers and Educational Objectives for Nurses are under revision for 2014 approval.
	Breast and Cervical Cancer Screening	<u>Breast and Cervical Cancer Screening Program</u>: The Department of Health's Breast and Cervical Screening Program provides breast and cervical cancer screening to eligible women and diagnostic follow up tests for those with suspicious results. Women diagnosed with breast or cervical cancer or pre-cancerous conditions for these cancers are enrolled for treatment coverage through TennCare. The mission of the program is to reach and serve lower income uninsured or underinsured women for these basic preventive health screening exams. "Cancer screening saves lives."

		DOH Collaborative Work Group: TennCare staff participate in the Cervical Cancer Free Tennessee (CCFTN) Initiative, led by the Tennessee Department of Health, by serving on the Cervical Cancer Elimination Committee and the Cervical Cancer Executive Committee. This initiative has as its focus the elimination of cervical cancer by 2040. Objectives include provider awareness, access to care, and targeted consumer education through social marketing. The workgroup meets every two months. CCFTN initiatives include: • Local, regional, and statewide "Ask Me" campaign with 3-inch buttons and "CAN WE TALK" posters; • PowerPoint and pamphlets developed for statewide distribution; • Targeted outreach in counties with high cervical cancer rates,; • Outreach to Amish communities; • Adding Tennessee to the website www.cervicalcancerfreeamerica.org; • National and local TV coverage; • Tops and Bottoms Program for breast and cervical cancer awareness statewide training; • TennCare MCO HEDIS results serving as the baseline for the measures; • Inclusion in TennCare Quality Oversight Strategic Planning Meetings; • "Teal for Two" cervical cancer awareness training in five Tennessee regions; • Letter from Commissioner to providers urging them to recommend vaccines including HPV; • Discussion with the Tennessee American Academy of Pediatrics to develop a professional HPV training package for physicians; • "Tips and Time-savers for Talking with Parents about HPV Vaccine" fact sheet developed and available at http://www2.aap.org/immunization/illnesses/hpv/hpv.html; and • The Office of Minority Health's development of culturally relevant educational messages that will improve programs and increase breast cancer screening and mammograms.
	Child Health	Body Mass Index (BMI) Focus Study: From a statistically valid random sample, this focus study is conducted to determine compliance with the following measures: height, weight, BMI percentile or value (depending upon age), Counseling for Nutrition, and Counseling for Physical Activity. The analysis includes calculations and rates of the overall and critical component-specific documentation rates for the whole population and stratified by MCO, age group, grand region, and provider type. A BMI Medical Record Review Summary Form is used to summarize deficiencies in provider documentation and provide opportunities for provider education and quality improvement. Based upon a review of the findings, corrective action, together with follow-up, may be indicated.
SATISFACTION	Consumer Satisfaction	CAHPS Survey: Annually, each MCO must conduct a CAHPS survey by entering into a contract with a vendor that is certified by NCQA to perform CAHPS surveys. The vendor must conduct the adult survey, the child survey, and the survey for children with chronic conditions. Survey results must be reported to TennCare separately for each required CAHPS survey and must be reported by grand region.

	Complaint Process	Quality of Care Complaint Process: The Division of Quality Oversight receives enrollee complaints that are sent directly to TennCare. These complaints are addressed in a variety of ways – through calls to the person submitting the complaint, correspondence with the MCOs, or referrals to other agencies. The Division of Quality Oversight receives Home Health Agency (HHA) critical incident reports, unrelated to CHOICES, that are sent directly to TennCare from the MCOs. The incidents are investigated and addressed in a variety of ways – action taken by agency or other agency, action taken by MCO, corrective action as indicated, and follow-up actions. Critical incidents related to the LTSS population are reported to the TennCare LTSS Division.
IMPROVE HEALTH CARE	Hb1A1c Testing and Controlling High Blood Pressure	MCO Diabetes Collaborative: TennCare's Population Health staff facilitates the MCO Population Health Collaborative, which consists of representatives from the three MCOs, Department of Health, University of Tennessee Extension program, American Diabetes Association, and TennCare staff. The group has broadened its concentration from diabetes only to include obesity, heart attack, and stroke. This past year, the collaborative supported several initiatives focused on reaching TennCare members and providers, including: • Million Hearts, a national initiative launched by Health and Human Services to reduce heart attacks and strokes across the United States; • Creation of educational resources for providers to promote completion of annual diabetic retinal eye exams; • Partnership with the UT Extension Walk Across Tennessee program to encourage physical activity and healthy lifestyles; and • Continued work with both the Tennessee Department of Health's Diabetes Program and the University of Tennessee Extension's Stanford Diabetes education initiative. The group is currently working on identifying ways to address the prevalence of diabetes, obesity and hypertension in the Latino community.
	F/U after hospitalization for mental illness	MCO Monitoring: The contracted MCOs are required to submit a *Post-Discharge Services* quarterly report that shows the length of time between psychiatric hospital discharge and first subsequent mental health service that qualifies as a post-discharge service. These services may include MD services, non-MD services, substance abuse outpatient services, psychosocial rehabilitation services, and mental health case management services. TennCare reviews the reports and determines if the MCO meets the performance measure benchmark listed in the Contractor Risk Agreement. A service that qualifies as a post-discharge service must be received by a member within seven calendar days of discharge. For the reporting period of calendar year 2014, 59% of a MCO's post-discharge services must meet the standard in order to be considered compliant with the performance measure. When an MCO falls under the performance measure, TennCare first issues a Corrective Action Plan (CAP) to alert the MCO to address the issue with contracted providers. The response to the CAP also helps TennCare learn more about MCO initiatives to improve compliance. At this time, no MCOs are under a CAP for the *Post-Discharge Services* report.

		Children and Youth Continuum Work Group: The TennCare Division of Behavioral Health Operations participates in the Department of Mental Health and Substance Abuse Services' (TDMHSAS) Children and Youth (C & Y) Crisis Continuum Workgroup. The group includes representatives from all MCOs, the Department of Children's Services, Youth Villages (statewide C & Y crisis provider), and the Council on Children's Mental Health. The workgroup is addressing the need for the development of a Crisis Stabilization Unit for children and youth under the age of 18. Over the past year, TennCare has developed draft planning documents and visited potential physical plant sites. TennCare is working with TDMHSAS leadership to move this initiative forward.
	EPSDT (TENNderCare) screening	Community Outreach: MCOs are contractually required to submit an Annual Community Outreach Plan and to conduct 150 EPSDT (TENNderCare) Community Outreach events throughout the state, including 45 events conducted in rural and suburban counties. The CRA specifies that the results of the contractor's or State's CMS 416 and HEDIS reports, as well as county demographics, shall be utilized in determining counties for targeted activities and in developing strategies for specific populations, particularly members who have limited English proficiency, low literacy levels, behavioral health needs, special health care needs, or who are pregnant. In their plans, the MCOs identify the methodologies they use to target their outreach activities, including some activities targeted at disparate populations. Currently, all of the MCOs have Spanish-speaking bilingual outreach staff at community outreach events targeting the Hispanic TennCare population to promote the importance of preventive health care and to educate members about how to access their benefits and improve their health outcomes by properly utilizing available health care resources.
	Antidepressant medication management	Children's Special Workgroups: The TennCare Division of Behavioral Health Operations participates in regular workgroup meetings with the Department of Children's Services addressing the issues affecting children in foster care. This workgroup includes representatives from all MCOs and the Department of Mental Health and Substance Abuse Services. These meetings focus on the use of psychotropic medications, coordination of treatment, and identification of data that can be shared between agencies that will increase the quality of care. The workgroup continues to review the data on an annual basis and discuss relevant issues.
	F/U care for children prescribed ADHD medication	

<table>
<tr><th colspan="3">LTSS-CHOICES</th></tr>
<tr><td rowspan="1">LEVEL OF CARE</td><td>Pre-admission evaluation</td><td rowspan="6"><u>CHOICES Monitoring</u>:
CHOICES Audits are conducted twice a year, with not all measures being evaluated both times, to evaluate CHOICES Assurances. Specific measures monitored include the number and percentage of:
• CHOICES Group 2 members who had an approved CHOICES Pre-Admission Evaluation prior to enrollment in CHOICES and receipt of Medicaid-reimbursed HCBS.
• CHOICES Group 2 member records reviewed with an appropriately completed and signed freedom of choice form that specifies choice was offered between institutional services and HCBS.
• CHOICES Group 2 member records reviewed whose plans of care were reviewed/updated prior to the member's annual review date.
• CHOICES HCBS providers reviewed for whom the MCO provides documentation that the provider meets minimum qualifications established by the State and was credentialed by the MCO in accordance with NCQA guidelines prior to enrollment in CHOICES and delivery of HCBS.
• CHOICES Group 2 member records reviewed which document that the member/authorized representative (as applicable) received education/information at least annually about how to identify and report instances of abuse, neglect and exploitation.
• Critical incident records reviewed in which the incident was reported within timeframes specified in the Contractor Risk Agreement.
• CHOICES Group 2 member records reviewed in which HCBS were denied, reduced, suspended, or terminated as evidenced in the Plan of Care and consequently, the member was informed of and afforded the right to request a Fair Hearing when services were denied, reduced, suspended, or terminated as determined by the presence of a Grier consent decree notice.</td></tr>
<tr><td rowspan="3">SERVICE PLAN</td><td>Freedom of choice</td></tr>
<tr><td>Completion of Assessment</td></tr>
<tr><td>Plan of care updated</td></tr>
<tr><td>PROVIDERS</td><td>Documentation of minimum qualifications</td></tr>
<tr><td rowspan="3">HEALTH & WELFARE</td><td>Education/information</td></tr>
<tr><td>Critical incidents</td></tr>
<tr><td>Right to fair hearing when services denied, reduced, suspended or terminated</td></tr>
</table>

Other Interventions Affecting All Goals and Objectives

Pay-for-performance or value-based purchasing initiatives:

TennCare has been providing Quality incentives, based on improvement to specific HEDIS measures, to the MCOs for several years. In the past, these incentives were the same for each MCO rather than MCO specific. Over the next three years, these incentives will be changed to MCO specific incentives, addressing areas where each MCO needs specific improvement. Because of the timeframes for data collection, the actual payment for MCO specific incentives will take effect in 2015. The following MCO specific measures have been selected for P4P July 2015 based on 2013 HEDIS rates in accordance with the greatest need for improvement:

- Immunizations, Combo 2
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening – Total
- Appropriate Treatment for Children with URI

- Controlling High Blood Pressure
- HbA1c Testing
- LDL-C Control (<100 ml/dl)
- Antidepressant Med management effective Acute and Continuance Phase Rx
- Follow-up Care for Children Prescribed ADHD Medication Initiation and Continuing Phase
- Follow-up After Hospitalization for Mental Illness 7 day and 30 day
- Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medications and Strategies
- HbA1c Poor Control (>9%) (REVERSE MEASURE)
- Timeliness of Prenatal Care
- Postpartum Care
- Frequency of Ongoing Prenatal Care >81%
- Well-Child visits in 1st 15 Mo of Life, 6 or more Visits
- Adolescent Well Care Visits

Quality Improvement Collaborative Meetings:

Qsource facilitates three meetings a year that are attended by TennCare and MCCs. Each meeting is organized around a specific quality improvement topic and features keynote presentations, panel discussion, and breakout session. Qsource also arranges for continuing education opportunities to be offered at all of the health plan meetings.

Quality Awards:

Annually, the Division of Quality Oversight presents awards to MCCs and MCCs' staff based on performance, best practices, and outstanding initiatives. The awards are used as a benchmarking tool for MCCs recognizing program design and effectiveness.

Grants:

TennCare implemented its Money Follows the Person (MFP) Rebalancing Demonstration Grant program in October 2011. A unique incentive payment structure rewards MCOs who are successful in achieving the state's transition, rebalancing, and related benchmarks established under the program. In addition to helping significant numbers of individuals transition from institutions to qualified residences in the community, the State has utilized rebalancing funds to increase housing capacity across the state, creating more affordable and accessible housing for individuals served in Medicaid programs. There are additional initiatives to increase the capacity and professionalism of the direct support work force serving seniors and adults with disabilities. Improved access to housing and a better trained, more committed workforce increases quality of care and improves personal health outcomes for people served.

In 2013, TennCare was awarded a grant from the Robert Wood Johnson Foundation's State Quality and Value Strategies Program to fund technical assistance in the state's Quality Improvement in Long-Term Services and Supports (QuILTSS) value-based purchasing initiative. As part of the QuILTSS initiative, TennCare will develop a new payment approach based in part on a quality framework, including a core set of quality domains and quality performance measures that will be collected to measure the quality of services provided by LTSS providers, both those in nursing facilities and in home and community based services (HCBS). The data will be used in the calculation of payments in order to properly align incentives, enhance the customer experience of care, support better health and improved health outcomes for persons receiving LTSS, and improve quality performance over time.

Asthma Advisory Committee:
The Director of Population Health is a member of the Department of Health's Asthma Advisory Committee. This committee meets quarterly and is responsible for developing and monitoring the State Asthma Plan.

Clinical Practice Guidelines:
MCOs are contractually required to utilize evidence-based clinical practice guidelines in their Population Health Programs that have been formally adopted by the MCO's QM/QI committee or other clinical committees. The guidelines must include a requirement to conduct a mental health and substance abuse screening and must be reviewed and revised whenever the guidelines change and at least every two years. The MCOs are required to maintain an archive of its clinical practice guidelines for a period of five years.

HEDIS Measures:
Annually, each MCO must submit all HEDIS measures designated by NCQA as relevant to Medicaid. The only exclusion from the complete Medicaid HEDIS data set shall be dental measures and must use the hybrid methodology for any measure containing Hybrid Specifications as identified by NCQA. The results must be reported annually for each grand region in which the Contractor operates. They must contract with an NCQA-certified HEDIS auditor to validate their processes in accordance with NCQA requirements.

Each DNSP that has signed a MIPPA agreement with TennCare also submits HEDIS and CAHPS measures designated for DSNPs to both TennCare and Qsource, who then aggregates the data and provides a written report.

Performance Improvement Projects:
Requirements for the MCOs to conduct Performance Improvement Projects relevant to the enrollee population will be continued. The two clinical PIPs must include one in the area of behavioral health that is relevant to one of the Population Health programs for bipolar disorder, major depression, or schizophrenia and one in the area of either child health or perinatal (prenatal/postpartum) health. Two of the three non-clinical PIPs must be in the area of long-term services and supports. CMS protocols must be utilized.

Strategic Planning:
Annually, the Division of Quality Oversight staff, in collaboration with Qsource and the Division of HealthCare Informatics, review and analyze all data coming in to the Division of Quality Oversight through MCC reporting and other areas. At that time, and in subsequent meetings, decisions are made about areas of performance that need additional emphasis. In early 2014, Quality Oversight chose to develop additional improvement strategies addressing two major issues: 1) excessive ED utilization and 2) heart attacks/strokes.

Emergency Department Utilization –
Quality Oversight initiated an internal Emergency Department Utilization Workgroup in January 2014. The workgroup meets regularly at least once a month and developed a Driver Diagram with Primary Drivers (e.g., timely access to care, misaligned incentives, lack of engagement, etc.), Secondary Drivers (e.g., lack of 24/7 access to PCPs, mixed messages to members, behavioral health issues, etc.), and Ideas for Process Changes (e.g., incentivizing PCPs to extend office hours, integrated physical and behavioral health models, educational outreach, etc.). Quality Oversight staff will review the medical records of the top five ED utilizers from each MCO by region in order to determine if appropriate

interventions were conducted by the MCOs. After reviewing these records, appropriate next steps will be determined.

Heart Attacks and Strokes –

The Million Hearts Campaign, a national initiative to prevent one million heart attacks and strokes by 2017, was identified as a program that is closely aligned with improving outcomes in this area. Recognizing that MCO participation would be critical to the success of this endeavor, TennCare's Division of Quality Oversight created a Million Hearts award to measure the MCOs' performance in relation to their completed activities and interventions. TennCare and the MCOs are focusing on reaching members/citizens as well as contracted providers to build awareness of the campaign and its focus areas. There are also future plans for the MCOs to address operational/system changes targeted on the campaign.

There has been great reception and participation in the campaign by the MCOs and within TennCare. In this first year, the MCOs came up with a number of innovative ideas, such as providing Million Hearts literature and giveaways (e.g., red heart-shaped stress relievers, pens, and bracelets) to attendees at community events, involving health plan staff in the Measure Up/Pressure Down® National Day of Action; Educating Member Education Specialists on the importance of decreasing sodium intake; and placing the Million Hearts website hot link on the provider page of the MCO website. Continued support of this initiative is expected to improve the health of members/citizens, increase provider awareness of the ABCS and align provider payment with Million Hearts measures.

Disease Management (DM)/Population Health:

In December 2011, Quality Oversight staff began leading discussions with the MCOs about moving from disease management to a more comprehensive Population Health model. Discussion continued throughout 2012. Up until this point a traditional disease management model was utilized, addressing only those members who already have a distinct disease process. Beginning in January 2013, a phased in implementation of the new model began with full implementation occurring in July of 2013. The newly designed model was a collaborative effort across all MCOs and reflects a consensus of all participants.

Advantages of the Population Health model include:

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

This program will be continued in order to address the health of all enrollees and will be evaluated carefully. The group has developed both process and outcome measures related to the new model, but are currently in the process of refining them to assure the best possible data collection.

Under the new Population Health model, the entire TennCare population for each MCO is stratified into the following seven programs, with specific minimum interventions required for each:

1. *Wellness* - To include behavioral and physical Health Promotion, and Preventive services.
2. *Low to Moderate risk Maternity* - Formerly Opt out low to moderate DM maternity program.
3. *"Opt Out" Health Risk Management* - Includes members in the low or moderate risk categories with one of the current DM conditions; members in high risk category with multiple conditions who

did not "Opt in" to the high risk Chronic Care management program; and members who may not have a chronic disease but need help with any health risk they might have, such as tobacco use or weight management. This must include, at a minimum, obesity and tobacco cessation programs.

4. *Care Coordination* - Helps members navigate and coordinate health care services available to them. A care plan may or may not be developed.
5. *"Opt In" Chronic Care Management* - Includes members with complex chronic conditions that fall within the top 3% of the population and who agree to participate. Formerly optout high risk DM plus other chronic conditions
6. *"Opt In" High Risk Maternity* - Includes members having high risk pregnancy needs and who agree to participate.
7. *"Opt In" Complex Case Management* - Includes members that fall within the top 1% of population but have complex needs outside of chronic conditions . Members may also be identified as potentials for CM by trigger list or referrals.

MCO Provider Agreements:

The Tennessee Department of Commerce and Insurance (TDCI) operates under an inter-agency agreement with the Bureau of TennCare to review all MCOs' provider agreements to ensure the provider agreements meet the uniform requirements set forth in the CRA. When TDCI receives a provider agreement that contains clinical information or other information outside their area of expertise, a copy is sent to the Bureau of TennCare for review and comments. As a means of quality assurance, the Tennessee Comptroller's office is responsible for auditing the activities of TDCI.

Compliance with Federal Requirements:

Annually, QSource conducts an Abortion, Sterilization, and Hysterectomy (ASH) audit in the MCO's office to assess documentation compliance with state and federal regulations. When coverage requires the completion of a specific form, the form must be properly completed as described in the form instructions. An Exit Conference is conducted for the purpose of reviewing results of the audit and providing opportunities for education and quality improvement. Based upon a review of the findings, corrective action may be indicated.

Provider Network Expansion:

Amerigroup is in the process of expanding their provider network into the West and East Grand Regions of the state. Currently, their contract is only for Middle Tennessee. Effective 1/1/2015, Amerigroup will be expanding to statewide coverage. UHC and BlueCare both already have a statewide network.

Intermediate Sanctions

42CFR 438.204(e) For MCOs, detail how the state will appropriately use intermediate sanctions that meet the requirements of 42 CFR, Part 438, Subpart I.
CRA 4.20.1.1 Addresses Intermediate Sanctions: • TennCare may impose any or all sanctions upon reasonable determination that the contractor failed to comply with any corrective action plan (CAP) or is otherwise deficient in the performance of its obligations under the Agreement, which shall include, but may not be limited to the following: o Fails substantially to provide medically necessary covered services; o Imposes on members cost sharing responsibilities that are in excess of the cost sharing permitted by TennCare; o Acts to discriminate among enrollees on the basis of health status or need for health care services;

- Misrepresents or falsifies information that it furnishes to CMS or to the State;
- Misrepresents or falsifies information furnished to a member, potential member, or provider;
- Fails to comply with the requirements for physician incentive plans as listed in 42 CFR 438.6(h);
- Has distributed directly, or indirectly through any agent or independent contractor, marketing or member materials that have not been approved by the State or that contain false or materially misleading information; and
- Has violated any of the other applicable requirements of Sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.

- TennCare shall only impose those sanctions it determines to be appropriate for the deficiencies identified. However, TennCare may impose intermediate sanctions on the contractor simultaneously with the development and implementation of a corrective action plan if the deficiencies are severe and/or numerous. Intermediate sanctions may include:
  - Liquidated damages;
  - Suspension of enrollment in the contractor's MCO;
  - Disenrollment of members;
  - Limitation of contractor's service area;
  - Civil money penalties as described in 42 CFR 438.704;
  - Appointment of temporary management for an MCO as provided 42 CFR 438.706
  - Suspension of all new enrollment, including default enrollment, after the sanction's effective date;
  - Suspension of payment for members enrolled after the sanction's effective date and until CMS or the State is satisfied that the reason for the sanction no longer exists and is not likely to recur; or
  - Additional sanctions allowed under federal law or state statue or regulation that address areas of non-compliance;
  - Suspension of payment for members enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for the sanction no longer exists and is not likely to recur; or
  - Additional sanctions allowed under federal law or state statute or regulation that address areas of non-compliance.

Specify the state's methodology for using intermediate sanctions as a vehicle for addressing identified quality of care problems.

Each Division of TennCare is responsible for recommending sanctions on MCO if any of the following are identified. The Division of Managed Care Operations reviews all recommendations for sanctions and has the final responsibility for either approving or disapproving them. Once sanctions are approved, the MCO involved in notified that the sanctions will be imposed. Liquidated damages may be assessed for a variety of quality of care issues, including:

- Failure to perform specific responsibilities or requirements that result in a significant threat to patient care or to the continued viability of the TennCare program;
- Failure to perform specific responsibilities or requirements that pose threats to TennCare integrity, but which do not necessarily imperil patient care;
- Failure to perform specific responsibilities or requirements that result in threats to the smooth and efficient operation of the TennCare Program
- Failure to meet performance standards

Deficiencies may be identified through review of MCO reports, audits, or failure to meet other contractual obligations.

Health Information Technology

42 CFR 438.204(f) Detail how the state's information system supports initial and ongoing operation and review of the state's quality strategy. Describe any innovative health information technology (HIT) initiatives that will support the objectives of the state's quality strategy and ensure the state is progressing toward its stated goals.
Tennessee's Quality Strategy represents a different route for meeting the goals and priorities outlined by ONC for expanding statewide e-Prescribing, sharing electronic structured lab results from labs, and supporting patient care transitions with electronic care summaries. These basic HIE building blocks will support numerous care improvements for patients, including better treatment and diagnosis, improved chronic care coordination, and reductions in medication errors and unnecessary repeat testing, as well as protecting enrollee privacy by utilizing electronic health records. In addition to promoting Electronic Health Records, and in accordance with the HITECH Act of 2009, a Business Associate's (BA) disclosure, handling, and use of PHI must comply with HIPAA Security Rule and HIPAA Privacy Rule mandates. Under the HITECH Act, any HIPAA business associate that serves a health care provider or institution is now subject to audits by the Office for Civil Rights (OCR) within the Department of Health and Human Services and can be held accountable for a data breach and penalized for noncompliance. With these new regulations in mind, TennCare's HIPAA business associate agreement explicitly spells out how a BA will report and respond to a data breach, including data breaches that are caused by a business associate's subcontractors. In addition, TennCare's HIPAA business associate agreement requires a BA to demonstrate how it will respond to an OCR investigation. CRA Section 2.12.9.55 requires that the provider safeguard enrollee information according to applicable state and federal laws and regulations including, but not limited, to HIPAA and Medicaid laws, rules and regulations.

SECTION V: Delivery System Reforms

CMS requirement: This section should be completed by states that have recently implemented or are planning to implement delivery system reforms. Examples of such delivery system reforms include, but are not limited to, the incorporation of the following services and/or populations into a managed care delivery system: aged, blind, and disabled population; long-term services and supports; dental services, behavioral health; substance abuse services; children with special healthcare needs; foster care children; or dual eligibles.

While there are no current plans for delivery system reforms in terms of the examples listed above, Governor Bill Haslam launched the Tennessee Health Care Innovation Initiative, a statewide initiative to transition its healthcare payment and delivery system to better reward patient-centered, high quality, high-value health care outcomes for all Tennesseans. The Initiative is led by the Division of Healthcare Finance and Administration (the division of state government that includes TennCare) but includes a broad coalition of stakeholders, including the Benefits Administration for state employees and the largest private insurers in Tennessee, with close involvement from many leading healthcare providers.

Describe the reasons for incorporating this population/service into managed care. Include a definition of this population and methods of identifying enrollees in this population.
N/A
List any performance measures applicable to this population/service, as well as the reasons for collecting these performance measures.
N/A
List any performance improvement projects that are tailored to this population/service. This should include a description of the interventions associated with the performance improvement projects.
N/A
Address any assurances required in the state's Special Terms and Conditions (STCs), if applicable.
N/A

SECTION VI: CONCLUSIONS AND OPPORTUNITIES

Identify any successes that the state considers to be best or promising practices.
The TennCare MCOs have successfully transitioned from Disease Management to Population Health (PH). All 1.2 million TennCare enrollees are now stratified into three PH levels across the care continuum based on their health risk rather than disease. This approach allows for both proactive and reactive interventions and supports staying healthy as well as managing a chronic illness. An effective process is now in place for seamless coordination of a dual member surrounding an inpatient admission through TennCare's MIPPA Dual Care Coordination Project. Beginning in January of 2013, staff from TennCare's Long Term Services and Supports Division and the Quality Oversight Division began discussions with five D-SNPs related to coordinating care for dual eligible enrollees. These D-SNPs included two who are associated with currently contracted MCOs and three who had no contractual relationships with TennCare other than through the MIPPA agreements. Also included was one contracted MCO in the process of becoming a D-SNP who has since successfully completed the process and is now a fully-functioning collaborator. A series of planning meetings was held with all MCOs and these D-SNPs, with the ultimate goal of developing procedures that would allow all of the plans to refer to each other in order to meet the needs of the enrollees. The group gained consensus and jointly developed two referral tools that could be electronically sent on a daily basis. The tools include information about inpatient admissions and discharges and indicate needs for referrals for specific services, such as Nursing Facility Diversion and Exhaustion of Benefits. The Health Plans work together to address any issues in real time, and the TennCare staff have continued to have regular phone and face-to-face meetings to improve data collection and reporting processes. During such discussions, it was revealed that members admitted to the hospital for 'Observation' were not always captured, so the processes were revised to ensure inclusion of this important dual population for coordination of care. Quarterly reports are submitted to TennCare for monitoring and support of the process. In addition, these plans submit HEDIS data to TennCare for measures identified for D-SNPs by NCQA. During the 2014 AQS, surveyors noticed several MCO improvements from the previous year, demonstrating a strong commitment to addressing the opportunities identified during the 2013 AQS. One key area was each MCO's continued commitment to participating in the statewide collaborative work groups with TennCare and other MCOs. These collaborations remain important strengths for 2014 and have improved how the MCOs educate and conduct outreach to members and providers by presenting a unified message on topics such as smoking cessation for pregnant members.
Include a discussion of the ongoing challenges the state faces in improving the quality of care for beneficiaries.
Lack of member engagement in chronic condition programs, wellness programs, and even complex case management programs continues to be a barrier to positive outcomes, both nationally and with the TennCare population. Proven programs can be implemented, but fail if members cannot be engaged. TennCare MCOs, as well as national research, have identified several reasons for lack of engagement by the Medicaid population. Lack of correct or current phone numbers is always the first barrier listed. Medicaid members are very mobile; they change phone numbers and discontinue use of cell phones frequently. Health plans have found this to be true even when the attempt is made one day after receiving the number. When using traditional identification methodologies, there is often a significant lag time between diagnosis and engagement attempts. Members are much more receptive to help at the time of diagnosis. Psychosocial issues also affect engagement rates. If a member has a behavioral health problem, lack of housing and food, or low self-worth, engaging them in health issues is difficult. Another concern for those attempting to engage Medicaid members in continuing programs is the fact that many want their immediate needs met and are not receptive to addressing long-term issues. Often initial engagement occurs but retention in a program does not. The last barrier identified is discovering

the right message for the targeted audience. This is extremely difficult and varies tremendously among subpopulations. All TennCare health plans use motivational interviewing techniques in an attempt to engage their members. They are also testing engagement techniques such as social media, face-to-face engagement, focus group approaches, and telephonic strategies.

The transition to ICD-10 has proven to be a challenging endeavor for providers and TennCare MCOs. During the initial transition, providers are anticipated to spend additional time documenting more accurate patient data, clinical processes, and health outcomes. MCOs are establishing the technical capacity to ensure that services will be coded and billed according to the new ICD-10 structure. MCOs will be training staff and providers to ensure that TennCare enrollees continue to receive timely and quality health care.

Reducing Emergency Department utilization continues to be a challenge as individuals seek ED services for treatment of chronic and ongoing complaints. Quality Oversight continues to explore initiatives to reduce unnecessary ED utilization.

The most pressing program challenge for the MIPPA Dual Care Coordination Project is the lack of engagement with hospitals in more effective communication surrounding discharge planning, particularly setting the member's first follow-up medical/behavioral appointment within seven days. Care coordination is happening between the Medicare and Medicaid Plans on the outpatient side of care, but improvement is needed in securing hospital participation.

Include a discussion of challenges or opportunities with data collection systems, such as registries, claims or enrollment reporting systems, pay-for-performance tracking or profiling systems, electronic health record (EHR) information exchange, regional health information technology collaborative, telemedicine initiatives, grants that support state HIT/HER development or enhancement, etc.

Although some information systems present challenges to data collection for quality oversight and analysis, the State of Tennessee has multiple opportunities for the collection of data to track a variety of quality metrics. Tennessee is constantly seeking ways to upgrade data analytic capabilities across state systems as well as its Medicaid Management Information System (MMIS).

State Registries - The state's immunization cancer registries, as well as a specialized traumatic head injury registry are all relational database systems which lend themselves well to data analytics.

Claims (APCD, MMIS, BC/BS, others) - Tennessee has the ability to perform data analytics on several aspects of claims systems within its ecosystem. An All Payers Claims Database system was implemented in the state and is now in the process of a re-launch with multiple enhancements being added to its functionality. The State also maintains an extensive data informatics staff dedicated to data analysis of MMIS data. In addition to this staff, Tennessee's 100% Medicaid managed care system provides additional system capabilities at each of TennCare's four MCOs.

Enrollment Reporting Systems - Tennessee is currently implementing a new eligibility system to provide for additional functionality for enrollment as well as data analytics and reporting.

EHR Information Exchange and Regional Health Information Collaborative - In Tennessee, HIE development/use has experienced many challenges. Taking advantage of a national initiative, the State has launched Direct Project to create the set of standards and services that, with a policy framework, can enable simple, directed, routed and scalable transport over the Internet to be used for secure and meaningful exchange between known participants in support of meaningful use. Direct technology offers providers a simple and secure way to communicate protected health information (e.g., clinical summaries, continuity of care documents, and laboratory results) between care settings, as well as directly with the patient who also owns a Direct address. Patients are able to communicate via Direct in a secure fashion by using personal health records that are Direct-enabled. The most basic implementation of the Direct Project is secure email via an email client or web portal, which works just like regular email but with an added level of security required for point-to point exchange of sensitive

health information. Direct is advantageous for those with an EHR because it helps in meeting the meaningful use requirements for electronic exchange/transport/transfer of electronic health information. As many as four core and seven menu set measures could be met with various implementations of Direct. The state currently has nearly 5,000 DIRECT secure messaging users.

EHR system adoption in the state is currently at 41%, with over 50% of eligible providers having registered for the CMS incentive program to date. A total of 9,161 providers have registered for either the Medicare or Medicaid EHR incentive program as of the end of August, 2013. While the vast majority of these systems are currently early in the implementation phase, the state HIE infrastructure is also evolving to meet the needs of health information exchange.

There are also two public regional HIEs and approximately ten private provider-based exchanges active in the state. The public exchanges have 89 clinics and 25 hospitals connected to date and exchanging data both with aggressive growth plans.

EHR and Meaningful Use – TennCare's Quality Oversight division is responsible for the meaningful use aspect of the EHR incentive program. As such, the Division has four responsibilities:

- Evaluating meaningful use attestations (pre-payment verification)
- Facilitating successful meaningful use
- Collecting MU data
- Analysis and reporting

The prepayment verification procedures have been structured to encourage and enable providers' continued participation in the program even if an attestation is at first incorrect or incomplete. The robust verification procedures also contribute to the success of that participation by correcting mistakes when they are first available for note and identifying areas of common challenge. A key administrative tool in the prepayment verification process is the TennCare attestation portal: the Provider Incentive Payment Program (PIPP) portal. This portal receives attestations, stores the most recent attestation in a given payment year, and allows TennCare staff to approve or return the attestations as they progress through various stages of the portal. Additional functionality in the portal to support administration of the program is constantly being planned and implemented, and such improvements will continue to affect the process, though not the content, of verification procedures. The goal of these improvements is to support electronic submission of Clinical Quality Measures and other measures as technology advances. These improvements will result in greater reliability of submissions, reducing clerical errors.

In payment year 2012, 35% (494) of the 1409 Eligible Professionals attaining Adoption Implementation Utilization (AIU) of their EHR systems in 2011 successfully attested to stage 1 meaningful use. Payment year 2013 preliminary data show the same trend as 2012, with 56% (659) of the 1182 Eligible Professionals who attained AIU in 2012 successfully attesting to stage 1 meaningful use. Another way to look at this data is to include the Eligible Professionals from 2011 who did not attest for meaningful use in 2012. Adding those still eligible participants results in 34% (659) of the 1949 of these Eligible Professionals who successfully attested to stage 1 year 1 meaningful use. Of the 494 Eligible Professionals who successfully demonstrated stage 1 year 1 meaningful use in 2012, 55% (272) went on to successfully demonstrate meaningful use stage 1 year 2 in 2013. The Quality Oversight portal was ready to accept stage 2 meaningful use attestations as of April 1, 2014. At this time, only two Eligible Professionals have attested to stage 2. However, many Eligible Professionals are emailing questions and in preparation for stage 2. Beginning October 1, 2014, the CMS 2014 Final Rule has provided meaningful use flexibility options based upon a provider's inability to fully implement 2014 Edition CEHRT based on issues related to software development/certification delays and related EHR product delays, as well as for providers who have upgraded to 2014 Edition CEHRT, but the software itself is presenting problems with functionality. The flexibility options require the PIPP portal, in which the providers participating in TennCare attest, to be retooled to accept the flexible attestations. The target date for PIPP to accept the flexible meaningful use attestations is December 1, 2014.

Telemedicine Initiatives - Tennessee has telemedicine facilities in over 100 cities across the state. A recent initiative is the STORC program, a telemedicine project developed through the efforts of Regional Obstetrical Consultants. The project is funded by a grant from the Blue Cross Tennessee Health Foundation and is designed to deliver perinatology services to rural areas. Since its initial implementation in 2009, STORC has now grown to include two physician hub sites, six Tennessee sites and four out-of-state sites. Via STORC services, patients are able to go to a local health center or hospital and meet with a mid-level caregiver and sonographer on site, and with a Maternal-Fetal Medicine specialist physician live via telemedicine equipment. A genetic counselor, diabetic counselor, behavioral health counselor, and interpreter can participate online as well. As of 2012, the technology is used to deliver care in other sub-specialties to which patients in rural areas would otherwise have no access. This technology can also be used to provide Continuing Medical Education.

Grants that support State HIT/EHR development or enhancement - The state of Tennessee has received grants from the Office of the National Coordinator (ONC), CMS, and SAMSHSA/MITRE to further HIT and HIE across the state. ONC granted $11.7 million for HIE advancement over a four year period (February 2010 to February 2014). These funds have assisted in upgrading the state's immunization system, electronic lab reporting, a state DIRECT HISP implementation, the statewide roll-out to providers of DIRECT technology, and ePrescribing adoption, as well as operations and oversight of the program. CMS has granted the state a HIT/HIE IAPD grant of $25,551,041.00. $12,184,496 of these funds is intended to fund administration of the CMS Provider Incentive Program and HIE program in Tennessee as well as updates to the State's incentive program registration system. $13,366,543.00 of these funds is intended to fund HIE projects, including providing State HIE Core services, allowing access to clinical data contained in Medicaid claims to both providers and Medicaid recipients, development of regional HIE organizations, and assisting provider practices in attainment of meaningful use.

Tennessee also received an indirect grant from SAMHSA/MITRE to perform a pilot which provided the infrastructure for the Prescription Drug Monitoring Program to accept real-time updates from pharmacies located within the state at the time of dispensing of controlled substances.

Include recommendations that the State has for ongoing Medicaid and CHIP quality improvement activities in the state. Highlight any grants received that support improvement of the quality of care received by managed care enrollees, if applicable.

Population Health Model Evaluation - This year baseline outcomes measures for the recently-implemented Population Health model will be evaluated Process measures, including engagement and retention rates, will be reviewed to identify opportunities for improvement.

Evaluation of Meaningful Use Data - TennCare will continue to evaluate Meaningful Use Data as more becomes available and will subsequently streamline processes.

MCO-Specific Performance Improvement Incentive Measures - TennCare will transition performance improvement incentive payments from measures that are the same for all MCOs to MCO specific measures.

State Innovation Model (SIM) Grants - Tennessee received a SIM Design grant from the Centers for Medicare and Medicaid Innovation in 2013 that was used to develop payment and delivery system reform models (such as episodes of care and Patient Centered Medical Homes) to enhance the quality of care, improve the patient experience of care for members, and reduce costs.

The State, led by the Tennessee Health Care Innovation Initiative, applied in July 2014 for a SIM Testing grant to help accelerate the implementation of payment and delivery system reforms. If the State receives this grant, the following quality improvements will begin or be accelerated for managed care enrollees:

- Episodes of care will improve the quality of acute care received by members.
- Patient Centered Medical Homes will promote better care through care coordination as well as proactive closing of gaps in care.

- Health Homes will promote better quality, integrated physical and behavioral health care for TennCare members with severe and persistent mental illness.
- The grant will support Tennessee's chapter of the American Academy of Pediatrics in implementing a portfolio of quality improvement projects working with Tennessee pediatricians.
- Tennessee will implement quality- and acuity- based payment and delivery system reforms for long term services and supports, including Nursing Facility services and Home and Community Based Services for seniors and adults with physical, intellectual, and developmental disabilities.
- Value-based purchasing for enhanced respiratory care will adjust facilities' rates based on performance on key performance indicators (e.g. infection rates).
- Tennessee is working on developing a comprehensive training program for professionals delivering long term services and supports. Staff training is an important quality measure, and agencies employing better trained staff will be appropriately compensated for the higher quality of care experienced by the individuals they serve.

CRA ATTACHMENT III

GENERAL ACCESS STANDARDS

In general, contractors shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis. At a minimum, this shall include:

- Primary Care Physician or Extender:

  (a) Distance/Time Rural: 30 miles or 30 minutes

  (b) Distance/Time Urban: 20 miles or 30 minutes

  (c) Patient Load: 2,500 or less for physician; one-half this for a physician extender.

  (d) Appointment/Waiting Times: Usual and customary practice (see definition below), not to exceed 3 weeks from date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

  (e) Documentation/Tracking requirements:

  + Documentation - Plans must have a system in place to document appointment scheduling times.

  + Tracking - Plans must have a system in place to document the exchange of member information if a provider, other than the primary care provider (i.e., school-based clinic or health department clinic), provides health care.

- Specialty Care and Emergency Care: Referral appointments to specialists (e.g., specialty physician services, hospice care, home health care, substance abuse treatment, rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contract. Waiting times shall not exceed 45 minutes.

- Hospitals

  (a) Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.

- Long-Term Care Services:

  Transport distance to licensed Adult Day Care providers will be the usual and customary not to exceed 20 miles for TennCare enrollees in urban areas, not to exceed 30 miles for TennCare enrollees in suburban areas and not to exceed 60 miles for TennCare enrollees in rural areas except where community standards and documentation shall apply.

- General Optometry Services:
    (a) Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation shall apply.

    (b) Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

- Lab and X-Ray Services:
    (a) Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community access standards and documentation will apply.

    (b) Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

- All other services not specified here shall meet the usual and customary standards for the community as determined by TENNCARE.

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.

CRA ATTACHMENT IV

SPECIALTY NETWORK STANDARDS

The CONTRACTOR shall adhere to the following specialty network requirements to ensure access and availability to specialists for all members (adults and children) who are not dually eligible for Medicare and TennCare (non-dual members). For the purpose of assessing specialty provider network adequacy, TENNCARE will evaluate the CONTRACTOR's provider network relative to the requirements described below. A provider is considered a "specialist" if he/she has a provider agreement with the CONTRACTOR to provide specialty services to members.

Access to Specialty Care

The CONTRACTOR shall ensure access to specialty providers (specialists) for the provision of covered services. At a minimum, this means that:

(1) The CONTRACTOR shall have provider agreements with providers practicing the following specialties: Allergy, Cardiology, Dermatology, Endocrinology, Otolaryngology, Gastroenterology, General Surgery, Neonatology, Nephrology, Neurology, Neurosurgery, Oncology/Hematology, Ophthalmology, Orthopedics, Psychiatry (adult), Psychiatry (child and adolescent), and Urology; and

(2) The following access standards are met:
   - Travel distance does not exceed 60 miles for at least 75% of non-dual members and
   - Travel distance does not exceed 90 miles for ALL non-dual members

Availability of Specialty Care

The CONTRACTOR shall provide adequate numbers of specialists for the provision of covered services to ensure adequate provider availability for its non-dual members. To account for variances in MCO enrollment size, the guidelines described in this Attachment have been established for determining the number of specialists with whom the CONTRACTOR must have a provider agreement. These are aggregate guidelines and are not age specific. To determine these guidelines the number of providers within each Grand Region was compared to the size of the population in each Grand Region. The CONTRACTOR shall have a sufficient number of provider agreements with each type of specialist in each Grand Region served to ensure that the number of non-dual members per provider does not exceed the following:

Maximum Number of Non-Dual Members per Provider by Specialty

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 & adolescent)	150,000
Urology	30,000

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.

CRA ATTACHMENT V

ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES

The CONTRACTOR shall adhere to the following behavioral health network requirements to ensure access and availability to behavioral health services for all members (adults and children). For the purpose of assessing behavioral health provider network adequacy, TENNCARE will evaluate the CONTRACTOR's provider network relative to the requirements described below. Providers serving adults will be evaluated separately from those serving children.

Access to Behavioral Health Services

The CONTRACTOR shall ensure access to behavioral health providers for the provision of covered services. At a minimum, this means that:

The CONTRACTOR shall have provider agreements with providers of the services listed in the table below and meet the geographic **and** time for admission/appointment requirements.

Service Type	Geographic Access Requirement	Maximum Time for Admission/Appointment
Psychiatric Inpatient Hospital Services	Travel distance does not exceed 90 miles for at least 90% of members	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24 Hour Psychiatric Residential Treatment	The CONTRACTOR shall contract with at least one (1) provider of service in the Grand Region for **ADULT** members --- Travel distance does not exceed 60 miles for at least 75% of **CHILD** members and does not exceed 90 miles for at least 90% of **CHILD** members	Within 30 calendar days
Outpatient Non-MD Services	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; if urgent, within 48 hours

Intensive Outpatient (may include Day Treatment (adult), Intensive Day Treatment (Children & Adolescent) or Partial Hospitalization	Travel distance does not exceed 90 miles for at least 90% of members	Within 10 business days; if urgent, within 48 hours
Inpatient Facility Services (Substance Abuse)	Travel distance does not exceed 90 miles for at least 90% of members	Within 2 calendar days; for detoxification - within 4 hours in an emergency and 24 hours for non-emergency
24 Hour Residential Treatment Services (Substance Abuse)	The CONTRACTOR shall contract with at least one (1) provider of service in the Grand Region for **ADULT** members --- The CONTRACTOR shall contract with at least one (1) provider of service in the Grand Region for **CHILD** members	Within 10 business days
Outpatient Treatment Services (Substance Abuse)	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; for detoxification – within 24 hours
Mental Health Case Management	Not subject to geographic access standards	Within 7 calendar days
Psychosocial Rehabilitation (may includeSupported Employment, Illness Management & Recovery, or Peer Support	Not subject to geographic access standards	Within 10 business days
Supported Housing	Not subject to geographic access standards	Within 30 calendar days
Crisis Services (Mobile)	Not subject to geographic access standards	Face-to-face contact within 1 hour for emergency situations and 4 hours for urgent situations
Crisis Stabilization	Not subject to geographic access standards	Within 4 hours of referral

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action

Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates the existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions

At a minimum, providers for the following service types shall be reported on the Provider Enrollment File:

Service Type	Service Code(s) for use in position 330-331 of the Provider Enrollment File
Psychiatric Inpatient Hospital Services	Adult - 11, 79, 85 Child – A1 or H9
24 Hour Psychiatric Residential Treatment	Adult - 13, 81, 82 Child – A9, H1, or H2
Outpatient MD Services (Psychiatry)	Adult – 19 Child – B5
Outpatient Non-MD Services	Adult – 20 Child – B6
Intensive Outpatient/ Partial Hospitalization	Adult – 21, 23, 62 Child - B7, C2, C3
Inpatient Facility Services (Substance Abuse)	Adult – 15, 17 Child – A3, A5
24 Hour Residential Treatment Services (Substance Abuse)	Adult - 56 Child - F6
Outpatient Treatment Services (Substance Abuse)	Adult – 27 or 28 Child – D3 or D4
Mental Health Case Management	Adult - 31, 66, or 83 Child – C7, D7, G2, G6, or K1
Psychiatric Rehabilitation Services:	
Psychosocial Rehabilitation	42
Supported Employment	44
Peer Support	88
Illness Management & Recovery	91
Supported Housing	32 and 33
Crisis Services (Mobile)	Adult - 37, 38, 39 Child - D8, D9, E1
Crisis Respite	Adult – 40 Child – E2
Crisis Stabilization	Adult 41

2.6.1 CONTRACTOR Covered Benefits

2.6.1.1 The CONTRACTOR shall cover the physical health, behavioral health and long-term care services/benefits outlined below. Additional requirements for behavioral health services are included in Section 2.7.2 and Attachment I.

2.6.1.2 The CONTRACTOR shall integrate the delivery of physical health, behavioral health and long-term care services. This shall include but not be limited to the following:

2.6.1.2.1 The CONTRACTOR shall operate a member services toll-free phone line (see Section 2.18.1) that is used by all members, regardless of whether they are calling about physical health, behavioral health and/or long-term care services. The CONTRACTOR shall not have a separate number for members to call regarding behavioral health and/or long-term care services. The CONTRACTOR may either route the call to another entity or conduct a "warm transfer" to another entity, but the CONTRACTOR shall not require an enrollee to call a separate number regarding behavioral health and/or long-term care services.

2.6.1.2.2 If the CONTRACTOR's nurse triage/nurse advice line is separate from its member services line, the CONTRACTOR shall comply with the requirements in Section 2.6.1.2.2 as applied to the nurse triage/nurse advice line. The number for the nurse triage/nurse advice line shall be the same for all members, regardless of whether they are calling about physical health, behavioral health and/or long-term services, and the CONTRACTOR may either route calls to another entity or conduct "warm transfers," but the CONTRACTOR shall not require an enrollee to call a separate number.

2.6.1.2.3 As required in Sections 2.9.5 and 2.9.6, the CONTRACTOR shall ensure continuity and coordination among physical health, behavioral health, and long-term care services and ensure collaboration among physical health, behavioral health, and long-term care providers. For CHOICES members, the member's care coordinator shall ensure continuity and coordination of physical health, behavioral health, and long-term care services, and facilitate communication and ensure collaboration among physical health, behavioral health, and long-term care providers.

2.6.1.2.4 Each of the CONTRACTOR's Population Health programs (see Section 2.8) shall address the needs of members who have co-morbid physical health and behavioral health conditions.

2.6.1.2.5 As required in Section 2.9.5.2.2, the CONTRACTOR shall provide the appropriate level of Population Health services (see Section 2.8.4 of this Agreement) to non-CHOICES members with co-morbid physical health and behavioral health conditions. These members should have a single case manager that is trained to provide Population Health services to enrollees with co-morbid physical and behavioral

health conditions. If a member with co-morbid physical and behavioral conditions does not have a single case manager, the CONTRACTOR shall ensure, at a minimum, that the member's Population Health Care Manager collaborates on an ongoing basis with both the member and other individuals involved in the member's care. As required in Section 2.9.6.1.9 of this Agreement, the CONTRACTOR shall ensure that upon enrollment into CHOICES, the appropriate level of Population Health activities are integrated with CHOICES care coordination processes and functions, and that the member's assigned care coordinator has primary responsibility for coordination of all the member's physical health, behavioral health and long-term care needs. The member's care coordinator may use resources and staff from the CONTRACTOR's Population Health program, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the member's care coordinator/care coordination team. The CONTRACTOR shall report on its Population Health activities per requirements in Section 2.30.6.1.

2.6.1.2.6 If the CONTRACTOR uses different Systems for physical health services, behavioral health and/or long-term care services, these systems shall be interoperable. In addition, the CONTRACTOR shall have the capability to integrate data from the different systems.

2.6.1.2.7 The CONTRACTOR's administrator/project director (see Section 2.29.1.3.1) shall be the primary contact for TENNCARE regarding all issues, regardless of the type of service, and shall not direct TENNCARE to other entities. The CONTRACTOR's administrator/project director shall coordinate with the CONTRACTOR's senior executive psychiatrist who oversees behavioral health activities (see Section 2.29.1.3.4 of this Agreement) for all behavioral health issues and the senior executive responsible for CHOICES activities (see Section 2.29.1.3.5 of this Agreement) for all issues pertaining to the CHOICES program.

2.6.1.3 CONTRACTOR Physical Health Benefits Chart

SERVICE		BENEFIT LIMIT
Inpatient Hospital Services		**Medicaid/Standard Eligible, Age 21 and older:** As medically necessary. Inpatient rehabilitation hospital facility services are not covered for adults unless determined by the CONTRACTOR to be a cost effective alternative (see Section 2.6.5). **Medicaid/Standard Eligible, Under age 21:** As medically necessary, including rehabilitation hospital facility.
Outpatient Hospital Services		As medically necessary.

SERVICE		BENEFIT LIMIT
Physician Inpatient Services		As medically necessary.
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services		As medically necessary.
TENNderCare Services		**Medicaid/Standard Eligible, Age 21 and older:** Not covered. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary, except that the screenings do not have to be medically necessary. Children may also receive screenings in-between regular checkups if a parent or caregiver believes there is a problem. Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal and state requirements. See Section 2.7.6.
Preventive Care Services		As described in Section 2.7.5.
Lab and X-ray Services		As medically necessary.
Hospice Care		As medically necessary. Shall be provided by a Medicare-certified hospice.
Dental Services		**Dental Services shall be provided by the Dental Benefits Manager.** However, the facility, medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall be covered services provided by the CONTRACTOR when the dental service is covered by the DBM. This requirement only applies to Medicaid/Standard Eligibles Under age 21.
Vision Services		**Medicaid/Standard Eligible, Age 21 and older:** Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), shall be covered as medically necessary. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery. **Medicaid/Standard Eligible, Under age 21:** Preventive, diagnostic, and treatments services (including eyeglasses) are covered as medically necessary in accordance with TENNderCare requirements.

SERVICE		BENEFIT LIMIT
Home Health Care		**Medicaid /Standard Eligible, Age 21 and older:** Covered as medically necessary and in accordance with the definition of Home Health Care at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard). Prior authorization required for home health nurse and home health aide services, as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard). **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with the definition of Home Health Care at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard). Prior authorization required for home health nurse and home health aide services, as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard).
Pharmacy Services		**Pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM), unless otherwise described below.** The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting and to providers providing both home infusion services and the drugs and biologics. The CONTRACTOR shall require that all home infusion claims contain National Drug Code (NDC) coding and unit information to be paid. Services reimbursed by the CONTRACTOR shall not be included in any pharmacy benefit limits established by TENNCARE for pharmacy services (see Section 2.6.2.2).
Durable Medical Equipment (DME)		As medically necessary. Specified DME services shall be covered/non-covered in accordance with TennCare rules and regulations.
Medical Supplies		As medically necessary. Specified medical supplies shall be covered/non-covered in accordance with TennCare rules and regulations.
Emergency Air And Ground Ambulance Transportation		As medically necessary.
Non-emergency Medical Transportation (including Non-Emergency Ambulance Transportation)		Covered non-emergency medical transportation (NEMT) services are necessary non-emergency transportation services provided to convey members to and from TennCare covered services (see definition in Exhibit A to Attachment XI). Non emergency transportation services shall be provided in accordance with federal law and the Bureau of TennCare's rules and policies and procedures. TennCare covered services (see definition in Exhibit A to Attachment XI) include services provided to a member by a non-contract or non-TennCare provider if (a) the service is

SERVICE		BENEFIT LIMIT
		covered by Tennessee's Medicaid State Plan or Section 1115 demonstration waiver, (b) the provider could be a TennCare provider for that service, and (c) the service is covered by a third party resource (see definition in Section 1 of the Agreement). If a member requires assistance, an escort (as defined in TennCare rules and regulations) may accompany the member; however, only one (1) escort is allowed per member (see TennCare rules and regulations). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional payment to a NEMT provider for an escort. Covered NEMT services include having an accompanying adult ride with a member if the member is under age eighteen (18). Except for fixed route and commercial carrier transport, t**he CONTRACTOR shall not make separate or additional payment to a NEMT provider for an adult accompanying a member under age eighteen (18).** The CONTRACTOR is not responsible for providing NEMT to HCBS provided through a 1915(c) waiver program for persons with intellectual disabilities (i.e., mental retardation) and HCBS provided through the CHOICES program. However, as specified in Section 2.11.1.8 in the event the CONTRACTOR is unable to meet the access standard for adult day care (see Attachment III), the CONTRACTOR shall provide and pay for the cost of transportation for the member to the adult day care facility until such time the CONTRACTOR has sufficient provider capacity. Mileage reimbursement, car rental fees, or other reimbursement for use of a private automobile (as defined in Exhibit A to Attachment XI) is not a covered NEMT service. If the member is a child, transportation shall be provided in accordance with TENNderCare requirements (see Section 2.7.6.4.6). Failure to comply with the provisions of this Section may result in liquidated damages.
Renal Dialysis Services		As medically necessary.

SERVICE		BENEFIT LIMIT
Private Duty Nursing		**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary in accordance with the definition of Private Duty Nursing at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard), when prescribed by an attending physician for treatment and services rendered by a Registered Nurse (R.N.) or a licensed practical nurse (L.P.N.) who is not an immediate relative. Private duty nursing services are limited to services that support the use of ventilator equipment or other life sustaining technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. Prior authorization required, as described Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard). **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with the definition of Private Duty Nursing at Rule 1200-13-13-.01 (for TennCare Medicaid) and 1200-13-14-.01 (for TennCare Standard) when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative. Prior authorization required as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard).
Speech Therapy		**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary 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. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TENNderCare requirements.
Occupational Therapy		**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary when provided by a Licensed Occupational Therapist to restore, improve, or stabilize impaired functions. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TENNderCare requirements.
Physical Therapy		**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary when provided by a Licensed Physical Therapist to restore, improve, or stabilize impaired functions. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TENNderCare requirements.

SERVICE		BENEFIT LIMIT
Organ and Tissue Transplant And Donor Organ Procurement		**Medicaid/Standard Eligible, Age 21 and older:** All medically necessary and non-investigational/experimental organ and tissue transplants, as covered by Medicare, are covered. These include, but may not be limited to: Bone marrow/Stem cell; Cornea; Heart; Heart/Lung; Kidney; Kidney/Pancreas; Liver; Lung; Pancreas; and Small bowel/Multi-visceral. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TENNderCare requirements. Experimental or investigational transplants are not covered.
Reconstructive Breast Surgery		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 surgical procedures on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast shall only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.
Chiropractic Services		**Medicaid/Standard Eligible, Age 21 and older:** Not covered unless determined by the CONTRACTOR to be a cost effective alternative (see Section 2.6.5). **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TENNderCare requirements.

2.6.1.4 CONTRACTOR Behavioral Health Benefits Chart

SERVICE		BENEFIT LIMIT
Psychiatric Inpatient Hospital Services (including physician services)		As medically necessary.
24-hour Psychiatric Residential Treatment		**Medicaid/Standard Eligible, Age 21 and older:** As medically necessary. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary.
Outpatient Mental Health Services (including physician services)		As medically necessary.
Inpatient, Residential & Outpatient Substance Abuse Benefits[1]		**Medicaid/Standard Eligible, Age 21 and older:** Limited to ten (10) days detox, $30,000 in medically necessary lifetime benefits unless otherwise described in the 2008 Mental Health Parity Act as determined by TENNCARE. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary.
Mental Health Case Management		As medically necessary.
Psychiatric-Rehabilitation Services		As medically necessary.
Behavioral Health Crisis Services		As necessary.
Lab and X-ray Services		As medically necessary.
Non-emergency Medical Transportation (including Non-Emergency Ambulance Transportation)		Same as for physical health (see Section 2.6.1.3 above).

[1]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.

2.6.1.5 Long-Term Care Benefits for CHOICES Members

2.6.1.5.1 In addition to physical health benefits (see Section 2.6.1.3) and behavioral health benefits (see Section 2.6.1.4), the CONTRACTOR shall provide long-term care services (including CHOICES HCBS and nursing facility care) as described in this Section 2.6.1.5 to members who have been enrolled into CHOICES by TENNCARE, as shown in the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR, effective upon the CHOICES Implementation Date (see Section 1).

2.6.1.5.2 TennCare enrollees will be enrolled by TENNCARE into CHOICES if the following conditions, at a minimum, are met:

2.6.1.5.2.1 TENNCARE or its designee determines the enrollee meets the categorical and financial eligibility criteria for Group 1, 2 or 3;

2.6.1.5.2.2 For Groups 1 and 2, TENNCARE determines that the enrollee meets nursing facility level of care including for Group 2, that the enrollee needs ongoing CHOICES HCBS in order to live safely in the home or community setting and to delay or prevent nursing facility placement;

2.6.1.5.2.3 For Group 2, the CONTRACTOR or, for new TennCare applicants, TENNCARE or its designee, determines that the enrollee's combined CHOICES HCBS, private duty nursing and home health care can be safely provided at a cost less than the cost of nursing facility care for the member;

2.6.1.5.2.4 For Group 3, TENNCARE determines that the enrollee meets the at-risk level of care; and

2.6.1.5.2.5 For Groups 2 and 3, but excluding Interim Group 3, if there is an enrollment target, TENNCARE determines that the enrollment target has not been met or, for Group 2, approves the CONTRACTOR's request to provide CHOICES HCBS as a cost effective alternative (see Section 2.6.5). Enrollees transitioning from a nursing facility to the community will not be subject to the enrollment target for Group 2 but must meet categorical and financial eligibility for Group 2.

2.6.1.5.3 The following long-term care services are available to CHOICES members, per Group, when the services have been determined medically necessary by the CONTRACTOR.

Service and Benefit Limit	**Group 1**	**Group 2**	**Group 3**
Nursing facility care	X	Short-term only (up to 90 days)	Short-term only (up to 90 days)
Community-based residential alternatives		X	
Personal care visits (up to 2		X	X

Service and Benefit Limit	Group 1	Group 2	Group 3
visits per day at intervals of no less than 4 hours between visits)			
Attendant care (up to 1080 hours per calendar year; up to 1400 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)		X	X
Home-delivered meals (up to 1 meal per day)		X	X
Personal Emergency Response Systems (PERS)		X	X
Adult day care (up to 2080 hours per calendar year)		X	X
In-home respite care (up to 216 hours per calendar year)		X	X
In-patient respite care (up to 9 days per calendar year)		X	X
Assistive technology (up to $900 per calendar year)		X	X
Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime)		X	X
Pest control (up to 9 units per calendar year)		X	X

2.6.1.5.3.1 The CONTRACTOR shall review all requests for short-term NF stays and shall authorize and/or reimburse short-term NF stays for Group 2 and Group 3 members only when (1) the member is enrolled in CHOICES Group 2 or 3, as applicable, and receiving HCBS upon admission; (2) the member meets the nursing facility level of care in place at the time of admission; (3) the member's stay in the facility is expected to be less than ninety (90) days; and (4) the member is expected to return to the community upon its conclusion. The CONTRACTOR shall monitor all short-term NF stays for Group 2 and Group 3 members and shall ensure that the member is transitioned from Group 2 or Group 3, as applicable, to Group 1 at any time a) it is determined that the stay will not be short-term or the member will not transition back to the community; and b) prior to exhausting the ninety (90)-day short-term NF benefit covered for CHOICES Group 2 and Group 3 members.

2.6.1.5.3.1.1 The ninety (90) day limit shall be applied on a per admission (and not a per year) basis. A member may receive more than one short-term stay during the year. However, the CONTRACTOR shall be responsible for carefully reviewing any instance in which a member receives multiple short-term stays during the year or across multiple years, including a review of the circumstances which resulted in each nursing facility admission, and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that transition back to CHOICES Group 2 or Group 3 (as applicable) is appropriate.

2.6.1.5.3.1.2 The CONTRACTOR shall monitor, on an ongoing basis, members utilizing the short-term NF benefit, and shall submit to TENNCARE on a monthly basis a member-by-member status for each Group 2 and Group 3 member utilizing the short-term NF stay benefit, including but not limited to the name of each Group 2 and Group 3 member receiving short-term NF services, the NF in which s/he currently resides, the date of admission for short-term stay, the number of days of short-term NF stay utilized for this admission, and the anticipated date of discharge back to the community. For any member exceeding the ninety (90)-day limit on short-term NF stay, the CONTRACTOR shall include explanation regarding why the benefit limit has been exceeded, and specific actions the CONTRACTOR is taking to facilitate discharge to the community or transition to Group 1, as applicable, including the anticipated timeline.

2.6.1.5.4 In addition to the benefit limits described above, in no case shall the CONTRACTOR exceed the member's individual cost neutrality cap (as defined in Section 1 of this Agreement) for CHOICES Group 2 or the expenditure cap for Group 3.

2.6.1.5.4.1 For CHOICES members in Group 2, the services that shall be compared against the member's individual cost neutrality cap include the total cost of CHOICES HCBS and Medicaid reimbursed home health care and private duty nursing. The total cost of CHOICES HCBS includes all covered CHOICES HCBS and other non-covered services that the CONTRACTOR elects to offer as a cost effective alternative to nursing facility care pursuant to Section 2.6.5.2 of this Agreement including, as applicable: CHOICES HCBS in excess of specified CHOICES benefit limits, the one-time transition allowance for Group 2 and NEMT for Groups 2 and 3.

2.6.1.5.4.2 For CHOICES members in Group 3, the total cost of CHOICES HCBS, excluding minor home modifications, shall not exceed the expenditure cap (as defined in Section 1 of this Agreement).

2.6.1.5.5 CHOICES members may, pursuant to Section 2.9.7, choose to participate in consumer direction of eligible CHOICES HCBS and, at a minimum, hire, fire and supervise workers of eligible CHOICES HCBS.

2.6.1.5.6 The CONTRACTOR shall, on an ongoing basis, monitor CHOICES members' receipt and utilization of long-term care services and identify CHOICES members who are

not receiving long-term care services. Pursuant to Section 2.30.11.5, the CONTRACTOR shall, on a monthly basis, notify TENNCARE regarding members that have not received long-term care services for a thirty (30) day period of time. The CONTRACTOR shall be responsible for immediately initiating disenrollment of any member who is not receiving TennCare-reimbursed long-term care services and is not expected to resume receiving long-term care services within the next thirty (30) days, except under extenuating circumstances which must be reported to TennCare on the *CHOICES Utilization Report*. Acceptable circumstances may include, but are not limited to, a member's temporary hospitalization or temporary receipt of Medicare-reimbursed skilled nursing facility care. Such notification and/or disenrollment shall be based not only on receipt and/or payment of claims for long-term care services, but also upon review and investigation by the CONTRACTOR as needed to determine whether the member has received long-term care services, regardless of whether claims for such services have been submitted or paid.

2.6.1.5.7 The CONTRACTOR may submit to TENNCARE a request to no longer provide long-term care services to a member due to concerns regarding the ability to safely and effectively care for the member in the community and/or to ensure the member's health, safety and welfare. Acceptable reasons for this request include but are not limited to the following:

2.6.1.5.7.1 A member in Group 2 for whom the CONTRACTOR has determined that it cannot safely and effectively meet the member's needs at a cost that is less than the member' cost neutrality cap, and the member declines to transition to a nursing facility;

2.6.1.5.7.2 A member in Group 2 or 3 who repeatedly refuses to allow a care coordinator entrance into his/her place of residence (Section 2.9.6);

2.6.1.5.7.3 A member in Group 2 or 3 who refuses to receive critical HCBS as identified through a needs assessment and documented in the member's plan of care; and

2.6.1.5.7.4 A member in Group 1 who fails to pay his/her patient liability and the CONTRACTOR is unable to find a nursing facility willing to provide services to the member (Section 2.6.7.2).

2.6.1.5.7.5 A member in Group 2 or 3 who refuses to pay his/her patient liability and for whom the CONTRACTOR is either: 1) in the case of persons receiving CBRA services, unable to identify another provider willing to provide services to the member; or 2) in the case of persons receiving non-residential HCBS or companion care, the CONTRACTOR is unwilling to continue to serve the member, and the Bureau of TennCare has determined that no other MCO is willing to serve the member.

2.6.1.5.7.6 The CONTRACTOR's request to no longer provide long-term care services to a member shall include documentation as specified by TENNCARE. The State shall make any and all determinations regarding whether the CONTRACTOR may

discontinue providing long-term care services to a member, disenrollment from CHOICES, and, as applicable, termination from TennCare.

2.6.1.5.8 The CONTRACTOR may submit to TENNCARE a request to disenroll from CHOICES a member who is not receiving any Medicaid-reimbursed LTC services based on the CONTRACTOR's inability to reach the member only when the CONTRACTOR has exhausted all reasonable efforts to contact the member, and has documented such efforts in writing, which must be submitted with the disenrollment request. Efforts to contact the member shall include, at a minimum:

2.6.1.5.8.1 Multiple attempts to contact the member, his/her representative or designee (as applicable) by phone. Such attempts must occur over a period of at least two (2) weeks and at different times of the day and evening, including after business hours. The CONTRACTOR shall attempt to contact the member at the phone number provided in the outbound 834 enrollment file, any additional phone numbers the CONTRACTOR has on file, including referral records and case management notes; and phone numbers that may be provided in TENNCARE's TPAES system. The CONTRACTOR shall also contact the member's Primary Care Provider and any contracted LTC providers that have delivered services to the member during the previous six (6) months in order to obtain contact information that can be used to reach the member;

2.6.1.5.8.2 At least one (1) visit to the member's most recently reported place of residence except in circumstances where significant safety concerns prevent the CONTRACTOR from completing the visit, which shall be documented in writing; and

2.6.1.5.8.3 An attempt to contact the member by mail at the member's most recently reported place of residence at least two (2) weeks prior to the request to disenroll.

2.6.2 **TennCare Benefits Provided by TENNCARE**

TennCare shall be responsible for the payment of the following benefits:

2.6.2.1 Dental Services

Except as provided in Section 2.6.1.3 of this Agreement, dental services shall not be provided by the CONTRACTOR but shall be provided by a dental benefits manager (DBM) under contract with TENNCARE. Coverage of dental services is described in TennCare rules and regulations.

2.6.2.2 Pharmacy Services

Except as provided in Section 2.6.1.3 of this Agreement, pharmacy services shall not be provided by the CONTRACTOR but shall be provided by a pharmacy benefits manager (PBM) under contract with TENNCARE. Coverage of pharmacy services is

described in TennCare rules and regulations. TENNCARE does not cover pharmacy services for enrollees who are dually eligible for TennCare and Medicare.

2.6.2.3 ICF/IID Services and Alternatives to ICF/IID Services

For qualified enrollees in accordance with TennCare policies and/or TennCare rules and regulations, TENNCARE covers the costs of long-term care institutional services in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or alternative to an ICF/IID provided through a Home and Community Based Services (HCBS) waiver for persons with intellectual disabilities.

HEDIS 2013 MEASURES

Effectiveness of Care Measures	
Prevention and Screening Measures:	
Adult BMI Assessment (ABA)	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Broken Out by Age:	**BMI Percentile:** 3-11 years
	12-17 years
	Counseling for Nutrition: 3-11 years
	12-17 years
	Counseling for Physical Activity: 3-11 years
	12 -17 years
Childhood Immunization Status (CIS):	DTaP
	IPV
	MMR
	HiB
	HepB
	VZV
	PCV
	HepA
	RV
	Flu
	Combination 2
	Combination 3
	Combination 4
	Combination 5
	Combination 6
	Combination 7
	Combination 8
	Combination 9
	Combination 10
Immunizations for Adolescents (IMA):	Meningococcal
	Tdap/Td
	Combination 1
Human Papillomavirus Vaccine for Female Adolescents (HPV)	
Lead Screening in Children (LSC)	
Breast Cancer Screening (BCS)	
Cervical Cancer Screening (CCS)	
Chlamydia Screening in Women (CHL) – Broken Out by Age :	16-20 years
	21-24 years
Respiratory Conditions:	
Appropriate Testing for Children With Pharyngitis (CWP)	
Appropriate Treatment for Children With Upper Respiratory Infection (URI)	
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	

Effectiveness of Care Measures	
Pharmacotherapy Management of COPD Exacerbation (PCE):	Systemic corticosteroid
	Bronchodilator
Use of Appropriate Medications for People With Asthma (ASM) – Broken Out by Age:	5-11 years
	12-18 years
	19-50 years
	51-64 years
Medication Management for People with Asthma (MMA) – Broken Out by Age:	**Medication Complication 50%:** 5-11 years
	12-18 years
	19-50 years
	51-64 years
	Medication Complication 75%: 5-11 years
	12-18 years
	19-50 years
	51-64 years
Asthma Medical Ratio (AMR) – Broken Out by Age:	5-11 years
	12-18 years
	19-50 years
	51-64 years
Cardiovascular Conditions:	
Cholesterol Management for Patients With Cardiovascular Conditions (CMC):	LDL-C Screening
	LDL-C Control (<100 mg/dL)
Controlling High Blood Pressure (CBP)	
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	
Diabetes:	
Comprehensive Diabetes Care (CDC):	HbA1c Testing
	HbA1c Control (<7.0%)
	HbA1c Control (<8.0%)
	Retinal Eye Exam Performed
	LDL-C Screening
	LDL-C Control (<100 mg/dL)
	Medical Attention for Nephropathy
	Blood Pressure Control (<140/80 mm Hg)
	Blood Pressure Control (<140/90 mm Hg)
Musculoskeletal Conditions:	
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	
Use of Imaging Studies for Low Back Pain (LBP)	
Behavioral Health:	
Antidepressant Medication Management (AMM):	Effective Acute Phase Treatment
	Effective Continuation Phase Treatment
Follow-Up Care for Children Prescribed ADHD Medication (ADD):	Initiation Phase
	Continuation and Maintenance Phase
Follow-Up After Hospitalization for Mental Illness (FUH):	7-day follow-up
	30-day follow-up

Effectiveness of Care Measures	
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	
Medication Management:	
Annual Monitoring for Patients on Persistent Medications (MPM):	ACE Inhibitors or ARBs
	Digoxin
	Diuretics
	Anticonvulsants
Measures Collected Through CAHPS Health Plan Survey:	
Medical Assistance With Smoking and Tobacco Use Cessation (MSC):	Advising Smokers and Tobacco Users to Quit
	Discussing Cessation Medications
	Discussing Cessation Strategies

Effectiveness of Care Measures Where Lower Rates Indicate Better Performance	
Prevention and Screening:	
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	
Diabetes	
Comprehensive Diabetes Care (CDC):	HbA1c Poor Control (>9.0%)

Access/Availability of Care Measures	
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Broken Out by Age:	20-44 years
	45-64 years
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Broken Out by Age:	12-24 months
	25 months-6 years
	7-11 years
	12-19 years
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET) – Broken Out by Age:	**Initiation of AOD Treatment:** 13-17 years
	≥ 18 years
	Engagement of AOD Treatment: 13-17 years
	≥ 18 years
Prenatal and Postpartum Care (PPC):	Timeliness of Prenatal Care
	Postpartum Care
Call Answer Timeliness (CAT)	

Utilization Measures	
Frequency of Ongoing Prenatal Care (FPC):	≥ 81 percent
Well-Child Visits in the First 15 Months of Life (W15):	6 or more visits
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	
Adolescent Well-Care Visits (AWC)	

2013 Consumer Assessment of Health Plans (CAHPS) Survey Topics

2013 CAHPS 5.0H Adult – Customer Satisfaction
1. Getting Needed Care (Always + Usually)
2. Getting Care Quickly (Always + Usually)
3. How Well Doctors Communicate (Always + Usually)
4. Customer Service (Always + Usually)
5. Shared Decision Making (A lot/Yes)
6. Rating of all Health Care (9+10)
7. Rating of Personal Doctor (9+10)
8. Rating of Specialist Seen Most Often (9+10)
9. Rating of Health Plan (9+10)

2013 CAHPS 5.0H Child
1. Getting Needed Care (Always + Usually)
2. Getting Care Quickly (Always + Usually)
3. How Well Doctors Communicate (Always + Usually)
4. Customer Service (Always + Usually)
5. Shared Decision Making (A lot/Yes)
6. Rating of all Health Care (9+10)
7. Rating of Personal Doctor (9+10)
8. Rating of Specialist Seen Most Often (9+10)
9. Rating of Health Plan (9+10)

2013 CAHPS 5.0H Child (Children with Chronic Conditions)
1. Getting Needed Care (Always + Usually)
2. Getting Care Quickly (Always + Usually)
3. How Well Doctors Communicate (Always + Usually)
4. Customer Service (Always + Usually)
5. Shared Decision Making (A lot/Yes)
6. Rating of all Health Care (9+10)
7. Rating of Personal Doctor (9+10)
8. Rating of Specialist Seen Most Often (9+10)
9. Rating of Health Plan (9+10)
10. Access to Specialized Services (Always + Usually)
11. Family-Centered Care: Personal Doctor or Nurse Who Knows Child (Yes)
12. Family-Centered Care: Coordination of Care for Children with Chronic Conditions (Yes)
13. Family-Centered Care: Getting Needed Information (Always + Usually)
14. Access to Prescription Medicines (Always + Usually)