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

October 31, 2012

Ms. Jessica Woodard
TennCare Project Officer
Division of State Demonstrations & Waivers
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: TennCare II, STC #48, Annual Report

Dear Ms. Woodard:

Enclosed please find the Annual Report for Demonstration Year 10 (July 1, 2011, through June 30, 2012). This report is being submitted in accordance with STC #48.

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) 10

(7/1/2011 – 6/30/2012)

Executive Summary

Operating within the context of a slow economic recovery and its attendant effect on the State's budget, the Bureau of TennCare took every opportunity during Demonstration Year 10 to confront complex health care challenges with innovative and cost-effective solutions.

Epitomizing this proactive approach was the Bureau's "TennCare PLUS" proposal to integrate care for individuals enrolled in both Medicare and Medicaid. Recognizing that higher health needs and lower incomes make "dual eligibles" an especially vulnerable population, TennCare crafted a plan to reduce the fragmentation of care that inevitably results when an enrollee has two different forms of health coverage. The principal undertaking envisioned in TennCare PLUS—delivering all of an individual's Medicare and Medicaid benefits through a single managed care organization—is uniquely capable of succeeding in Tennessee, where the entire TennCare population has been enrolled in managed care since 1994.

More than 80 percent of TennCare's population of dual eligibles is enrolled in CHOICES, TennCare's program of Long-Term Services and Supports (LTSS) for individuals who are elderly or physically disabled. The needs of CHOICES enrollees were addressed not solely by the TennCare PLUS proposal, but by a new measure designed to maximize the availability of cost-effective Home and Community Based Services (HCBS) as well. In obtaining CMS's approval of the "Interim CHOICES 3" category, the Bureau ensured that Nursing Facility (NF) services would be preserved for enrollees with the most pronounced health problems, that HCBS would be available for enrollees whose health problems could otherwise require NF placement in the near future, and that the entire system of LTSS could be maintained more sustainably than ever before.

Other initiatives distinguished the year as well. The Bureau's Electronic Health Record Incentive Program continued to be successful, with over $80 million expended on improving health outcomes through improved forms of record-keeping. This leadership in systems issues was also illustrated by TennCare's conversion to a new era of electronic transactions standards—"Version 5010"—months before the implementation deadline established by CMS. In addition, the Standard Spend Down eligibility category opened to new enrollment twice during DY 10, thereby offering medical coverage to a very vulnerable population. The range of covered services were expanded, too, with smoking cessation agents being made available to non-pregnant adults for the first time.

To guarantee that this path of innovation continues, the State submitted an application to renew the TennCare II Demonstration just as DY 10 drew to a close. Detailing the history of the TennCare program, the challenges it has faced, and the goals it intends to accomplish, the application charted a course for the program through June 30, 2016.

TennCare continues to be committed to its mission of maintaining an exemplary system of high quality health care for eligible Tennesseans within a sustainable and predictable budget. An indication that this mission is being fulfilled is the level of satisfaction that enrollees expressed—95 percent, an all-time high—within the annual Beneficiary Survey conducted by the University of Tennessee.

I. Accomplishments

Over the course of DY 10, TennCare maintained its commitment to rebalancing its system of Long-Term Services and Supports, while simultaneously achieving state and national recognition for innovations in such varied fields as provider reimbursement, electronic transactions, and third party liability.

Changes in CHOICES Membership ("Amendment 14"). During DY 10, the Bureau began the next phase of rebalancing CHOICES, TennCare's program of Long-Term Services and Supports (LTSS) for individuals who are elderly or physically disabled. Waiver Amendment 14—submitted to CMS on March 1, 2012—requested permission to open the "Interim CHOICES 3" category. The purpose of this measure was to allow the State to direct Nursing Facility (NF) care to enrollees with the highest acuity of need, while simultaneously preserving a pathway to eligibility for individuals who would have met the State's Level of Care (LOC) criteria in effect prior to July 1, 2012.

Under Amendment 14, Interim CHOICES 3 would be open to new enrollment—with no cap—from July 1, 2012, through December 31, 2013. Members would be eligible for a package of Home and Community Based Services (HCBS), as well as all TennCare-covered physical and behavioral health services. As a result, the State could make appropriate changes to the program, remain in compliance with the "Maintenance of Effort" requirements of the Affordable Care Act, and achieve cost-avoidance of nearly $16 million in Fiscal Year 2012-2013 alone.

CMS notified the Bureau on June 15, 2012, that Amendment 14 had been approved. Exactly two weeks later, TennCare filed emergency rules implementing the provisions of Amendment 14.

Additional information about CHOICES appears in the Attachments to this report. As required by STC #34(e)(iii)(A), the operational procedures regarding reserve slots in CHOICES 2 are presented in Attachment A. Attachment B contains a list of the steps taken by the State to ensure compliance with the HCBS regulations outlined in STC #45(b).

Standard Spend Down. During DY 10, TennCare completed two rounds of enrollment for the Standard Spend Down (SSD) eligibility category and prepared for another round in the first quarter of DY 11.

SSD is available through an amendment to the TennCare Waiver. The program is designed to serve a limited number of persons who are not otherwise eligible for Medicaid but who are aged, blind, disabled, or the caretaker relative of a Medicaid-eligible child and who have enough unreimbursed medical bills to allow them to "spend down" their income to a low level known as the Medically Needy Income Standard (MNIS). The MNIS for a family of three in Tennessee is $317 per month.

One of the distinctive aspects of SSD is that individuals interested in enrolling must request an application by calling a dedicated, toll-free phone line furnished by the Department of Human Services (DHS) during open enrollment periods. Phone calls are accepted until 2,500 individuals request an application.[1] During DY 10, open enrollment periods were held on September 12, 2011, and February 21, 2012, and, in both cases, application targets were fulfilled as expected.

[1] Section XIII, Part III of the STCs outlines the procedures for enrolling individuals in SSD. The number of applications that are taken is determined according to the number of applications DHS can process within federal timeliness standards.

Assuming no change in circumstances, individuals approved for SSD are eligible for TennCare for one year before having to be reverified for continued eligibility. As DY 10 concluded, TennCare and DHS were preparing for the next open enrollment period, scheduled to take place on September 13, 2012.

Expansion of Smoking Cessation Coverage. In response to legislation passed by the Tennessee General Assembly, TennCare expanded coverage of smoking cessation products by making them available to non-pregnant adults, effective July 1, 2011. This benefit—previously covered only for pregnant women and individuals under the age of 21—encompassed both prescription products and prescribed over-the-counter products.

Following consultation with the Pharmacy Advisory Committee, TennCare announced its plans for enhancing the smoking cessation benefit even further. Effective October 1, 2011, the medication Chantix® was reclassified from a "non-preferred agent" to a "preferred agent," and the prior authorization requirement was removed from all items on the list of preferred agents that treat smoking behaviors.

Enhanced Coordination of Pharmacy Benefits and SXC Client Innovation Award. TennCare's Pharmacy Benefits Manager SXC Health Solutions presented its annual Client Innovation Award to TennCare on April 25, 2012. The honor was bestowed on the Bureau in recognition of its successful implementation of SXC's Enhanced Coordination of Benefits (Enhanced COB) program in July 2011. Accepting the award on behalf of TennCare were Director Darin Gordon and Chief Medical Officer Wendy Long.

Enhanced COB enables TennCare to detect other forms of pharmacy insurance that an enrollee may have before a claim is processed. Instead of paying for a medication initially and then pursuing reimbursement from another insurer at a later point (a cycle frequently referred to as "pay and chase"), TennCare improved its method of identifying other forms of coverage before payment is rendered and can now require the pharmacist who filled the prescription to seek compensation from those sources first. Information provided to the pharmacist in response to a submitted claim is much more detailed than in the past and is designed to make redirection easier. Conservative estimates indicate that savings generated by the Enhanced COB program are twice as much as those produced prior to its implementation. As a result, "enhanced third party pharmacy collection" was included in TennCare's budget for State Fiscal Year 2013 as a method of reducing the Bureau's expenditures by $9,634,600 ($7,200,000 of federal funds and $2,434,600 of state funds).

The advantages of Enhanced COB are not limited to cost avoidance alone. When multiple insurers pay for an individual's medications, there is less coordination of care and, consequently, a greater likelihood that hazardous drug interactions or excessive drug quantities may result. By continually directing pharmacists to their patients' primary source of prescription drug coverage, conversely, more effective monitoring of medication regimens may be achieved. Although the impact of Enhanced COB on patient safety is difficult to quantify, the principle of improved coordination among insurers and providers is a central tenet of TennCare's vision of health care.

New Electronic Transactions Standards. On November 26, 2011, TennCare became one of the first Medicaid programs to upgrade the standards governing some of its most important electronic transactions, including claims, payment, and eligibility verification. This undertaking, which took two

years and hundreds of thousands of personnel hours to complete, placed TennCare in compliance with federal requirements several months early.[2]

Because the old standards (sometimes referred to as "Version 4010") had been in place for eight years, an array of confusing, redundant, or unnecessary elements had been identified. The new standards (called "Version 5010") introduced such improvements as:

- Expanded technical fields to accommodate the newest version of International Classification of Diseases (or "ICD") codes
- A significant number of new transaction edits
- A variety of transaction qualifiers

These revisions, as well as a host of others, ensure that data submitted electronically to TennCare is more specific and streamlined and that parties responsible for such transmissions have a better understanding of what to include. Furthermore, faster processing speeds[3] and ongoing cost-savings[4] help to justify the resources TennCare has invested.

Quality Oversight Awards. As part of its quarterly meeting with the Bureau's External Quality Review Organization and Managed Care Contractors (MCCs) on June 12, 2012, TennCare's Division of Quality Oversight presented its second annual awards to the MCCs that demonstrated "excellence in improving healthcare for members as well as innovative and emerging best practices."

Nominations and awards were based on recommendations from TennCare's Quality Oversight staff, TennCare's Medical Director, and the MCCs themselves. While some honors (such as "2012 Highest Annual Quality Survey Score Award" and "2011 Highest NCQA-Ranked TennCare Health Plan Award") recognized MCCs, others (like "Disease Management Collaboration Award" and "CHOICES Care Coordinator of the Year Award") were bestowed on individual MCC staff members. The "Best All Around Award", which acknowledges exceptional performance across a broad spectrum of disciplines, was presented to Amerigroup.

Award for Chief Financial Officer. At its President's Dinner on December 8, 2011, the Tennessee Primary Care Association (TPCA) gave TennCare Chief Financial Officer Casey Dungan the William V. Corr Award of Excellence. This honor recognizes "outstanding leadership resulting in health policy development or innovative program implementation in Tennessee."[5]

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[2] Although January 1, 2012, had originally been established as the deadline for states to upgrade their transactions standards, CMS announced on November 17, 2011, that no enforcement action would be taken until March 31, 2012. See http://www.cms.gov/ICD10/Downloads/CMSStatement5010EnforcementDiscretion111711.pdf (accessed on February 23, 2012).

[3] In some instances, transactions that used to be processed in six one-hundredths of a second can now be processed in six ten-thousandths of a second.

[4] Under the new transactions standards, TennCare has been able to eliminate equipment that had previously been leased at an annual cost of $385,000.

[5] This and additional information about the award is available on TPCA's website at http://www.tnpca.org/displaycommon.cfm?an=1&subarticlenbr=133.

TPCA's stated goal is "maximizing access to health services for all Tennesseans with emphasis on the working poor, the uninsured, TennCare patients, and others most in need."[6] In bestowing the Corr Award on Mr. Dungan, TPCA recognized the work that he had done with the Prospective Payment System workgroup to streamline TennCare's reimbursement policies.

Mr. Dungan's duties as the Bureau's Chief Financial Officer began on October 1, 2011, following terms as a budget analyst and the Deputy CFO. Additional information about Casey appears in Section VI, "Policy and Administrative Issues and Solutions" (under the heading of "New Chief Financial Officer").

Recognition of Executive Staff Members. On March 20, 2012, the March of Dimes and its advocacy partner the Tennessee Initiative for Perinatal Quality Care (TIPQC) honored three members of TennCare's executive staff. At the Healthy Babies Legislative Reception, Director Darin Gordon, Chief Medical Officer Wendy Long, and Medical Director Jeanne James were recognized for their "work to protect women and babies."

The mission of the Tennessee Chapter of the March of Dimes is to "help babies in our community start life in the healthiest way possible,"[7] while TIPQC strives to "improve health outcomes for mothers and infants in Tennessee."[8]

II. Project Status

Despite continued fiscal constraints that forced the State to revisit the possibility of benefit reductions, a renewal of the hospital assessment fee provided a one-year reprieve from program cuts. This development allowed the Bureau to channel its energies into such crucial projects as applying for a renewal of the TennCare Waiver, designing a model of integrated Medicare and Medicaid benefits, and leading medical records technology into the future.

Budget Issues. The State's budget situation has been discussed in each Quarterly Report filed during the Demonstration Year. TennCare, like other public agencies in Tennessee, was asked to reduce spending in order to help the State meet its Constitutional obligation of maintaining a balanced budget. Benefit reductions that had been contemplated during DY 8 and DY 9 (and even proposed to CMS as Waiver Amendments 9 and 12, respectively, before being withdrawn) were revived during DY 10 in the form of Waiver Amendment 15. This proposed amendment included such program modifications as:

- Elimination of physical therapy, speech therapy, and occupational therapy for all adults; and
- Benefit limits on certain hospital services, lab and x-ray services, and health practitioners' office visits for most non-institutionalized adults (with pregnancy-related services remaining exempt from benefit limits).

[6] See TPCA's "Our History" page, located online at http://www.tnpca.org/displaycommon.cfm?an=1&subarticlenbr=38.
[7] See the organization's "Tennessee Programs" page, which is located at http://www.marchofdimes.com/tennessee/programs.html.
[8] TIPQC's full mission statement, as well as more information about the organization, is available online at http://www.tipqc.org/.

Following the Tennessee General Assembly's passage of a one-year extension of the hospital assessment fee, the Bureau of TennCare notified CMS by letter dated April 3, 2012, that the benefit eliminations and reductions proposed in Amendment 15 would not be needed in State Fiscal Year 2013.

Program modifications unrelated to Amendment 15 and scheduled to take effect on July 1, 2012, included opening the "Interim CHOICES Group 3" category and blending CHOICES homemaker and hands-on care services and reimbursement.

Application to Renew the TennCare Waiver. Unlike traditional fee-for-service Medicaid programs, TennCare is a demonstration project. In exchange for a waiver of certain federal statutes and regulations governing Medicaid, TennCare "demonstrates" the principle that a managed care approach to health care can extend coverage to people who would not otherwise be eligible for Medicaid without increasing expenditures or diminishing the quality of care. One limitation imposed on demonstration projects, however, is that they may operate only for finite periods of time (referred to as "approval periods") before having to be renewed.

Although the current approval period for the TennCare Demonstration does not expire until July 1, 2013, federal regulations and the terms of the current waiver require TennCare to submit applications for renewal a full year in advance.[9] Furthermore, in the interest of full transparency, such applications must be preceded by a 30-day public notice and comment period, during which time the details of the request for renewal must be made available for review, and the public must be provided multiple opportunities to provide feedback.[10] Therefore, in addition to publishing a notice in several Tennessee newspapers and in the "Announcements" section of the *Tennessee Administrative Register*, TennCare created a dedicated page on its website. This webpage offered not only an overview of the TennCare Demonstration, but also a copy of the draft renewal application, an email address and telephone number for submitting comments, a link to CMS's own online resources regarding TennCare, and information about two public hearings hosted by the Bureau on May 15 and 22, 2012, to solicit public comments. These measures fulfilled the requirements of CMS's final rule—which had taken effect on April 27, 2012—regarding the revised review and approval process for Section 1115 Demonstration waivers.

The State's application to renew the TennCare Demonstration was submitted to CMS on June 29, 2012.

"TennCare PLUS" Proposal to Integrate Care. On May 17, 2012, TennCare submitted a proposal to the Medicare-Medicaid Coordination Office (MMCO) within CMS. The program outlined within the proposal is called "TennCare PLUS", and the population the program is designed to serve is Full Benefit Dual Eligibles (FBDEs), meaning individuals enrolled in both Medicare and Medicaid.[11] FBDEs represent more than 11 percent of the total TennCare population and approximately 90 percent of TennCare members receiving Long-Term Services and Supports through the Bureau's CHOICES program.

[9] See 42 C.F.R. § 431.412(c) and Paragraph 8 of the Special Terms and Conditions of the TennCare Demonstration Waiver.

[10] The details of the "State public notice process" are located at 42 C.F.R. § 431.408.

[11] The only FBDEs who would be ineligible to participate in TennCare PLUS are those individuals enrolled in TennCare's Program of All-Inclusive Care for the Elderly (PACE), which already offers a fully integrated set of Medicare and Medicaid benefits to eligible individuals in Hamilton County.

One of the principal health care problems that FBDEs face—the problem that TennCare PLUS is intended to address—is the fragmented nature of their coverage. Members of this population have one set of providers and benefits through Medicare and a different set through Medicaid. Medicare and Medicaid are not at all coordinated. Medicare data that could be helpful to states in coordinating care is only available under certain arrangements, but even then its utility is compromised, since it is not real-time data and includes no information about denied claims.

The Bureau's TennCare PLUS proposal seeks to eliminate this lack of coordination by assigning responsibility for each FBDE's Medicare and Medicaid benefits to a single entity: the individual's TennCare managed care organization (MCO). The MCO will deliver a comprehensive package of benefits—including primary care, acute care, prescription drug coverage, and Long-Term Services and Supports—which will be facilitated by care coordination. Savings achieved by Medicaid through this model of integration will be reinvested into the program and, if adequate, would be used to provide a supplemental set of dental, vision, and hearing benefits.

The TennCare PLUS proposal, available online at http://www.tn.gov/tenncare/forms/plusproposal.pdf, reflects not just the vision of the Bureau, but also the feedback provided by a variety of stakeholders in meetings dating back to February 2011, and in public hearings held on May 3 and 8, 2012. If MMCO approves the proposal as submitted, implementation of TennCare PLUS would begin on January 1, 2014. As DY 10 drew to a close, it was expected that negotiation of a Memorandum of Understanding with CMS would begin no earlier than November 2012.

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, as its name suggests, is to provide financial incentives to Medicaid providers[12] to replace outdated, often paper-based approaches to medical record-keeping with an electronic system that meets 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 administrative costs.

Although Tennessee's EHR program was a national pacesetter with regard to planning and the early stages of implementation during DY 9, the momentum of the program accelerated exponentially during DY 10. Highlights from the year included the following:

- Payments to providers who had adopted, implemented, or upgraded to certified EHR technology capable of meeting "meaningful use" standards (referred to variously as "first-year" or "Year 1" payments) neared a cumulative total of $83 million by June 30, 2012.
- Payments to providers who had demonstrated meaningful use of certified EHR technology ("second-year" or "Year 2" payments) began in the concluding quarter of DY 10 and exceeded $500,000 in that three-month period alone.
- On November 4, 2011, the Bureau implemented the Provider Incentive Payment Program (or "PIPP") web portal through which providers could gain information about payments, register

[12] 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).

with CMS, submit and track attestations (affirmations that applicable criteria had been met), file appeals, and communicate with TennCare.

These achievements would not have been possible without the Bureau's multilayered approach to communicating updates and instructions to providers throughout the state. A dedicated webpage (located at http://www.tn.gov/tenncare/ehr_intro.shtml) and newsletters distributed by TennCare's EHR ListServ successfully disseminated information to interested parties, and TennCare staff hosted a variety of in-person and online outreach efforts throughout DY 10 to address the topics with which providers had most difficulty.

John B. **Lawsuit.** No review of the major events of DY 10 would be complete without reference to the progress achieved by the State in a longstanding legal matter referred to as "John B."

The *John B.* lawsuit addresses the adequacy of services provided by TennCare to children under the age of 21. A consent decree filed in the matter in 1998 has been the subject of ongoing litigation since 2000. In 2011, shortly after assuming responsibility for the case, Judge Thomas A. Wiseman, Jr. issued a Case Management Order, which identified current substantial compliance with the requirements of the consent decree as the primary issue to be resolved at trial. The Order also provided a schedule for discovery and set a trial date of October 31, 2011. The trial began as scheduled and lasted exactly one month, concluding on November 30.

On February 14, 2012, almost 14 years to the day after the suit was filed, Judge Wiseman ruled that TennCare had successfully established its compliance with "all the binding provisions of the Consent Decree" and, consequently, that the consent decree was vacated and the case dismissed.[13] In his 38-page Memorandum Opinion, Judge Wiseman not only outlined in extensive detail all of the components of TennCare's early and periodic screening, diagnosis and treatment ("EPSDT") program for children—including outreach efforts, screening, diagnosis and treatment, and monitoring and oversight—but also documented the manner in which the State had achieved "substantial compliance with virtually every operative paragraph of the Consent Decree."[14] In addition, the Plaintiffs and Defendants alike were praised for presenting proof in a manner that was both "highly professional" and "completely devoid of acrimony."[15]

On March 9, 2012, the Plaintiffs filed a Notice of Appeal with the United States Court of Appeals for the Sixth Circuit. The matter was subsequently scheduled to be heard by a three-judge panel on October 4, 2012.

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 #51(b) requires that the State include enrollment reporting by Eligibility Group and by Type for the TennCare population. Table 1 summarizes that information.

[13] John B. v. Emkes. U.S. District Court for the Middle District of Tennessee at Nashville. Order, pages 1-2. February 14, 2012.
[14] John B. v. Emkes. U.S. District Court for the Middle District of Tennessee at Nashville. Memorandum Opinion, page 24. February 14, 2012.
[15] Ibid, page 38.

Table 1
Enrollment Counts for DY 10

State Plan and Demonstration Populations	Total No. of TennCare Enrollees			
	July-Sep 2011	Oct - Dec 2011	Jan - Mar 2012	Apr - Jun 2012
EG1 Disabled, Type 1 State Plan eligibles	129,497	129,555	129,409	127,642
EG1 Disabled and EG9 H-Disabled, Type 2 Demonstration Population	3,865	4,063	4,277	4,345
EG2 Over 65, Type 1 State Plan eligibles	321	308	320	515
EG2 Over 65 and EG10 H-Over 65, Type 2 Demonstration Population	20	25	32	35
EG3 Children, Type 1 State Plan eligibles	667,796	669,975	666,187	664,693
EG4 Adults, Type 1 State Plan eligibles	305,054	305,712	302,808	300,751
EG4 Adults, Type 2 Demonstration Population	0	0	0	0
EG5 Duals, Type 1 State Plan eligibles	150,615	148,268	146,345	143,087
EG6E Expan Adult, Type 3 Demonstration Population	1,098	1,092	1,187	1,086
EG7E Expan Child, Type 3 Demonstration Population	3,078	2,694	2,355	2,163
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	25,914	22,081	18,591	17,332
TOTAL	1,287,258	1,283,773	1,271,511	1,261,649

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.), 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 10, CBER published a summary of the results of the most recent survey entitled "The Impact of TennCare: A Survey of Recipients, 2011." Although the findings of a single survey must be viewed in context of long-term trends, several results from the November 2011 report were noteworthy:

- A higher percentage of respondents (95 percent) expressed satisfaction with care received through TennCare than ever before.
- A higher percentage of respondents (48 percent) classified care provided to their children through TennCare as "excellent" than ever before.
- Both the estimated number of uninsured Tennesseans (604,222) and the estimated percentage of uninsured Tennesseans (9.5 percent) were at their lowest point since 2008.
- Both the estimated number of uninsured Tennessee children (35,743) and the estimated percentage of uninsured Tennessee children (2.4 percent) were at their lowest point in the last 13 years.

In summary, the report notes, "TennCare recipients' experience with medical care remains positive, with the quality of TennCare householder's children's medical care increasing substantially. TennCare continues to receive positive feedback from its recipients, indicating the program is providing health 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/tncare11.pdf.[16]

HEDIS/CAHPS Report. TennCare published the annual report of HEDIS/CAHPS data on December 13, 2011. 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—presented in Attachment E and posted on the TennCare website at http://www.tn.gov/tenncare/forms/hedis11.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 2010 Medicaid National Average. Higher success rates were achieved in all of the following categories:

- Childhood Immunization Status
- Lead Screening in Children
- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection
- Children and Adolescents' Access to Primary Care Practitioners
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Adolescent Well-Care Visits

Improvement was also observed in the following categories related to women's health:

- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening
- Timeliness of Prenatal Care

[16] In compliance with STC #49, the Bureau submitted the Beneficiary Survey to CMS on September 30, 2011.

HEDIS 2011 was the second 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 2010 were achieved in such categories as Follow-Up Care for Children Prescribed ADHD Medication, Follow-Up After Hospitalization for Mental Illness, and Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.

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 FY 2010, FY 2011, and FY 2012 are presented in Table 2.

Table 2
Key Indicators Tracked by TennCare FYs 2010-2012

METRIC	FY 2010	FY 2011	FY 2012
Member Months (FTE)	**1,204,088**	**1,206,067**	**1,226,313**
COST INDICATORS			
PMPM – Physician	**$100.88**	**$110.07**	**$114.44**
PMPM – Facilities	**$101.29**	**$102.28**	**$104.98**
PMPM – Rx (before rebate)	**$50.45**	**$52.88**	**$56.41**
UTILIZATION MEASURES			
Hospital Days/1000	**489**	**483**	**475**
Hospital Admissions/1000	**126**	**121**	**121**
ER Visits/1000	**858**	**847**	**844**
Prescriptions/1000	**10,461**	**10,670**	**10,576**

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's performance measures for the 2010-2013 period may be grouped into six 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 eligibles 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 each of the Quarterly Reports) during DY 10.

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 Quality Improvement Strategy comprising Attachment F.

Objective 6: Assure that 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 2013, 100 percent of the TennCare MCCs 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 2010, 80 percent of MCCs demonstrated compliance in at least 10 out of 12 months.
    - 2012 Measure—In Calendar Year 2011, 80 percent of MCCs demonstrated compliance in at least 10 out of 12 months.
- Performance Measure 6.2—By 2013, the MCCs will report a compliance rate of 95 percent for all contractual claims payment accuracy reports. *Note: MCCs 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 2010, the MCCs reported a compliance rate of 91.5 percent.
    - 2012 Measure—In Fiscal Year 2012, the MCCs reported a compliance rate of 98.4 percent.

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

VI. Policy and Administrative Issues and Solutions

Maximizing Disproportionate Share Hospital Funding (Waiver Amendment 16). On June 15, 2012, CMS notified the Bureau that Amendment 16 to the TennCare Demonstration had been approved. The purpose of Amendment 16 was to enable TennCare to take full advantage of the Medicaid Disproportionate Share Hospital (DSH) allotment appropriated to the State by Congress for Federal Fiscal Year 2012.

Prior to Amendment 16, certain payments made to hospitals by TennCare were subject to an annual cap of $540 million. This cap was developed on the basis of the amount of DSH funding appropriated by Congress when the current Demonstration extension was approved in 2007. It would not have been possible for the State to make use of the entire new DSH allotment appropriated by Congress and remain within the cap.

Therefore, the State proposed in Amendment 16 to reconfigure the current Special Terms and Conditions of the Demonstration so that the State would always have the capacity to make use of any DSH allotments made by Congress to Tennessee.

New Chief Financial Officer. For five years, Scott Pierce served as TennCare's Assistant Commissioner and Chief Financial Officer. His decision to accept the position of Chief Executive Officer at Volunteer State Health Plan (VSHP) did not, however, leave a vacuum of leadership within the Bureau. Instead, Deputy Chief Financial Officer Casey Dungan filled the vacated post beginning on October 1, 2011.

Mr. Dungan, who began working with TennCare in September 2006, has a bachelor's degree from Duke University and a master's degree in Public Administration (with a concentration in Public Budgeting and Finance) from the University of Georgia. His career with the State began in August 2000 with the Department of Finance and Administration's Division of Budget. Following a period of service from 2003 to 2006 in the City of Nashville's Office of Management and Budget, Mr. Dungan joined TennCare as a budget analyst. His role quickly expanded, however, to include the management of Managed Care Contractor (MCC) reimbursement, which consists not only of paying MCCs for the delivery of medical, behavioral health, pharmacy, and dental services, but also of preparing reports on MCC expenditures. Finally, in his capacity as Deputy Chief Financial Officer, Casey worked closely with the CFOs of TennCare's MCCs, as well as with the third party actuaries that establish the rates at which MCCs are reimbursed.

New Pharmacy Leadership. On May 14, 2012, Bryan Leibowitz and Michael Polson joined the team responsible for managing TennCare's Pharmacy Division.

Dr. Leibowitz, who succeeds Nicole Woods as the Bureau's Director of Pharmacy, earned a Doctorate of Pharmacy degree from the Ernest Mario School of Pharmacy at Rutgers University. The range of his experience as a pharmacist—more than a decade spent in such varied disciplines as home infusion/specialty, hospital, retail, and pharmacy benefit management—uniquely qualifies Dr. Leibowitz to oversee the complexities of a program that accounted for more than $826 million of TennCare's budget in State Fiscal Year 2012.

Dr. Polson joins the Pharmacy Division as its Clinical Director. The chief function of this role is to ensure that TennCare's pharmacy benefit is clinically appropriate based on the latest guidelines and medical research. Dr. Polson's educational achievements—a bachelor's degree in mathematical sciences, a master's degree in statistics, and a Doctorate of Pharmacy—in conjunction with his previous work experience at TennCare (within the Health Care Informatics Division) make him ideally suited for the position.

Providing optimal pharmaceutical care to TennCare enrollees within a fiscally responsible framework is the priority that both individuals have established in their tenure with the Bureau thus far.

TennCare Call Center. On July 1, 2011, Tennessee Community Services Agency (TNCSA) assumed responsibility for the staffing and operation of TennCare's call center. The program initially consisted of 16 operators and a supervisor, but, by the conclusion of DY 10, 8 additional operators had been added to assist with the heavy demands placed on the call center (an average monthly call volume in DY 10 of 24,283). Services furnished by the center to providers, enrollees, and the general public include:

- Answering questions about applying for TennCare

- Verification of enrollee eligibility for providers who inquire
- Registration of provider complaints against managed care contractors (MCCs)
- Responding to inquiries about the Electronic Health Records (EHR) program
- Status updates for claims payment and provider applications
- Referrals to Operation Warm Homes Tennessee

Additional information about TNCSA is available online at http://www.tncsa.com.

Fraud Prevention Webpage. In November 2011, TennCare's Division of Audit and Program Integrity updated the "TennCare Fraud" page of the Bureau's website. The refurbished site—located online at http://www.tn.gov/tenncare/fraud.shtml—provides links to the websites of all State agencies that combat TennCare fraud, including the Office of Inspector General, the Tennessee Bureau of Investigation, and the Office of the Attorney General. Additionally, the webpage offers user-friendly definitions and examples of "member fraud" and "provider fraud," as well as a toll-free number for reporting either. The ultimate aim of the "TennCare Fraud" page is to educate the public on a subject of central importance to the program and to furnish the tools for citizens to help solve the problem.

Long-Term Services and Supports Webpage. In January 2012, TennCare's Division of Long-Term Services and Supports (LTSS) took a similar step, unveiling its own updated webpage at http://www.tn.gov/tenncare/longtermcare.shtml. The site offers a wealth of information, including:

- An overview of the meaning and function of long-term services and supports
- Descriptions of all LTSS programs, including CHOICES, the "Money Follows the Person" (or "MFP") grant, services for individuals with intellectual disabilities, and the Program of All-inclusive Care for the Elderly (or "PACE")
- Instructions for applying for LTSS programs
- Links to the websites of State agencies and managed care organizations that have a role in delivering long-term care to TennCare enrollees
- Contact information for TennCare's LTSS Division

As TennCare continues its efforts to rebalance Long-Term Services and Supports, the upgraded webpage is expected to serve an important function in delivering updates and furnishing resources to the public.

ATTACHMENT A

OPERATIONAL PROCEDURES REGARDING RESERVE SLOTS IN CHOICES GROUP 2

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

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://www.tn.gov/sos/rules/1200/1200-13/1200-13-01.20120629.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/tenncare/forms/middletnmco.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://www.tn.gov/sos/rules/1200/1200-13/1200-13-01.20120629.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, development of the plan of care and

Regulation	Topic	Actions
		service initiation for potential and new CHOICES members. 2. Provider Agreements between the managed care organizations and network providers include critical incident reporting requirements. 3. 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 and may elect to receive services in a NF. 4. 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 5. 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. 6. 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 facilitate 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://www.state.tn.us/sos/rules/1200/1200-08/1200-08.htm 4. TennCare Rules 1200-13-01-.08(2) 5. 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://www.tn.gov/sos/rules/1240/1240-03/1240-03-03.20101029.pdf. 6. TennCare Rule 1200-13-01-.08 further defines the post-eligibility treatment of income and is available at http://www.tn.gov/sos/rules/1200/1200-13/1200-13-01.20110923.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 10

STC	Topic	Actions
#3	Changes in Medicaid and CHIP Law, Regulation, and Policy	On April 27, 2012, CMS's final rule regarding the revised review and approval process for Section 1115 Demonstration waivers took effect. Guidance was published in State Health Officer Letter #12-001. TennCare followed this rule and this guidance in preparing the application to renew the TennCare II Demonstration (addressed at greater length below for STC 8).
#6 **#7**	Changes Subject to the Amendment Process Amendment Process	The State submitted amendments to the Demonstration to CMS as follows: • December 15, 2011—Waiver Amendment 13 (concerning the enrollment target for CHOICES 2). This Amendment was withdrawn and consolidated with Amendment 14 on March 1, 2012. • March 1, 2012—Waiver Amendment 14 (concerning Interim CHOICES 3 and the enrollment target for CHOICES 2). • March 1, 2012—Waiver Amendment 15 (concerning benefit reductions that would be required if the hospital assessment fee were not renewed). Following the Tennessee General Assembly's extension of the assessment fee, Amendment 15 was withdrawn on April 3, 2012. • April 13, 2012—Waiver Amendment 16 (concerning Disproportionate Share Hospital funding). On June 15, 2012, following weeks of negotiations (including conference calls, formal questions and answers, and draft approval materials), CMS approved Waiver Amendments 14 and 16. The State sent courtesy copies of proposed State Plan Amendments (SPAs) to the CMS Project Officer as follows: • July 13, 2011—SPA 11-005 (PBM National Network) • August 31, 2011—SPAs 11-009 (Freestanding Birth Centers) and 11-010 (Opioid Detoxification Drugs, Sedative Hypnotic Drugs, and Smoking Cessation Products) • September 30, 2011—SPA 11-011 (Provider-Preventable Conditions) • November 7, 2011—SPA 11-012 (Recovery Audit Contractor) • November 18, 2011—SPA 11-013 (Reimbursement of Specialty Pharmacies) • December 15, 2011—SPA 11-015 (Rate Reduction for ICFs/IID (ICFs/MR at the time)) • December 22, 2011—SPA 11-014 (PACE Payment Methodology and Personal Needs Allowance) • March 30, 2012—SPA 12-001 (Provider Screening and

STC	Topic	Actions
		Enrollment) On March 14, 2012, the State sent the CMS Project Officer a request to amend certain CHOICES benefits in Attachment D of the TennCare Waiver; and, on May 8, 2012, CMS approved the request.
#8	Extension of the Demonstration	As DY 10 concluded, the State submitted an application to extend the TennCare II Demonstration from July 1, 2013, through June 30, 2016. To ensure that stakeholders were aware of the application and had an opportunity to provide input prior to submission, TennCare notified the public in a variety of in-person, print, and electronic forums. Significant events in the application process included: • April 11, 2012—Discussion in meeting of the State's Medical Care Advisory Committee • April 24, 2012—Presentation during statewide stakeholder conference call • May 4, 2012—Submission of abbreviated public notice to newspapers of widest circulation in the eight Tennessee cities with 50,000 or more citizens • May 7, 2012—Opening of public notice and comment period with launch of extension-specific website; publication of abbreviated public notice in the *Tennessee Administrative Register* • May 8, 2012—Notification to TennCare Facebook friends and Twitter followers; presentation during meeting of state advocacy organizations • May 9, 2012—Email notification to state agencies and advocacy organizations • May 10, 2012—Notification to members of the Tennessee General Assembly • May 15, 2012—First public hearing to accept comments • May 22, 2012—Second public hearing to accept comments • June 29, 2012—Submission of formal application to extend the TennCare II Demonstration to CMS
#15	Public Notice	Public notice concerning Waiver Amendments was provided in Tennessee newspapers as follows: • Waiver Amendment 13—December 2011 • Waiver Amendment 14—January and February 2012 • Waiver Amendment 15—January and February 2012 • Waiver Amendment 16—March 2012 Public notice concerning the State's application to extend the

STC	Topic	Actions
		TennCare II Demonstration is addressed in STC 8 above.
#17	Eligibility	Waiver Amendment 14 (concerning Interim CHOICES 3 and the enrollment target for CHOICES 2) was submitted to CMS on March 1, 2012, and was approved by CMS on June 15, 2012.
#21	Adult Non-State Plan Demonstration Population Categories	Open enrollment periods for the Standard Spend Down program were held on September 12, 2011, and February 21, 2012.
#25	Medicaid Eligibility Quality Control (MEQC)	The State submitted its MEQC report for October 2009 – September 2010 on July 27, 2011. The State's MEQC pilot plan for October 2011 – September 2012 was submitted to CMS on August 29, 2011.
#31	Cost-Effective Alternatives (CEAs)	TennCare's "Cost-Effective Alternatives" policy, BEN 08-001, was updated on April 5, 2012, to add Buprenorphine above 8 mg per day as a cost-effective alternative to hospitalization. Policy BEN 08-001 is located on TennCare's website at http://www.tn.gov/tenncare/forms/ben08001.pdf. STC 31 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 terms and conditions—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 Risk Contracts require and contain capitation payment rates that have been reviewed and certified by Actuaries and determined to be actuarially sound.
#34	Operations of the TennCare CHOICES Program	On August 31, 2011, the State notified the CMS Project Officer that there was a need, because of the continuing increase in the number of people applying for CHOICES and electing to receive

STC	Topic	Actions
		HCBS, to increase the CHOICES 2 enrollment target to 11,000, the number approved by CMS for DY 10. CMS notified the State on the same day that the revised target could take effect no earlier than September 30, 2011. Waiver Amendment 14 (concerning Interim CHOICES 3 and the enrollment target for CHOICES 2) was submitted to CMS on March 1, 2012, and was approved by CMS on June 15, 2012. On March 14, 2012, the State sent the CMS Project Officer a request to amend certain CHOICES benefits in Attachment D of the TennCare Waiver; and, on May 8, 2012, CMS approved the request. On June 27, 2012, the State sent CMS the operational procedures for determining individuals "at risk" of institutionalization. The State reported enrollment statistics for each CHOICES group, any applicable enrollment targets, and the reserve capacity for CHOICES 2 in each Quarterly Report. The operational procedures regarding reserve slots in CHOICES Group 2 are presented in Attachment A.
#35 **#36** **#37**	Cost Sharing Co-Payments Aggregate Annual Cost-Sharing Cap	Negotiations between CMS and the State over the State's cost-sharing implementation plan continued—and ultimately concluded—during DY 10. On July 28, 2011, the State sent the CMS Project Officer a summary of previous discussions concerning the "retroactive aggregate cap", as well as a plan the State had submitted on December 17, 2009, proposing use of the "shoebox" method for computing costs incurred toward the aggregate cap. On September 1, 2011, the State sent the CMS Project Officer two sets of information: • Examples of the number of services an individual would have to use to reach the cost-sharing cap during a quarter. • A copy of an MCO contract requirement (#2.18.4.7) that MCOs must maintain a 24/7 nurse assistance line to help enrollees identify providers and schedule appointments. On February 21, 2012, the CMS Project Officer sent the State draft approval materials for the State's cost-sharing implementation plan; and, on March 6, 2012, the State notified CMS of its acceptance of the terms of the approval. On April 18, 2012, CMS issued a formal approval of the State's cost-

STC	Topic	Actions
		sharing implementation plan, implementation of which is scheduled to take place on January 1, 2013.
#41	Plan Enrollment and Disenrollment	One provision of Waiver Amendment 14 (which was submitted to CMS on March 1, 2012, and was approved by CMS on June 15, 2012) added the following additional factor that would not be considered a hardship enabling a member to change MCOs (after the 45-day period): "The enrollee's Primary Care Provider (PCP) is no longer in the MCO's network, the enrollee wants to continue to see the current PCP, and has refused alternative PCP or provider choices offered by the MCO."
#45	Additional Reporting Requirements	The State submitted contract amendments to CMS as follows: • August 31, 2011—Generic versions of proposed contract amendments for the MCOs and TennCare Select. • November 22, 2011—Generic versions of Amendment 7 to the East/West TN Contractor Risk Agreement (CRA), Amendment 10 to the Middle TN CRA, and Amendment 27 to the TennCare Select Contract. • December 29, 2011—Signed versions of the amendments submitted on November 22, 2011. • January 31, 2012—Amendment 8 to the East/West TN CRA and Amendment 11 to the Middle TN CRA. • May 10, 2012—Amendment 9 to the East/West TN CRA, Amendment 12 to the Middle TN CRA, and Amendment 28 to the TennCare Select contract. Electronic files containing TennCare CHOICES data were submitted to CMS on August 31, 2011, and on June 28, 2012. Information regarding data and trends of the designated CHOICES data elements was reported in the Quarterly Reports as required. The steps taken by the State to ensure compliance with HCBS regulations are presented in Attachment B.
#46	Monthly Calls	Monthly calls were held in 2011 on July 28, August 30, September 29, November 1, and December 15; and in 2012 on February 23, March 22, April 26, May 24, and July 5. Discussion topics included the cost-sharing implementation plan, opening the Interim CHOICES 3 category, and extending the TennCare II Demonstration.
#47	Quarterly Progress Reports	The State submitted quarterly progress reports on August 31, 2011, November 30, 2011, February 29, 2012, and May 31, 2012.
#48	Annual Report	The State submitted a draft Annual Report on October 31, 2011.

STC	Topic	Actions
		CMS has not commented on the draft Annual Report. The title XXI annual State report concerning Medicaid Expansion children was included with the annual report submitted by CoverKids to CMS on February 28, 2012. (CMS extended the due date of this report from December 31, 2011, to March 1, 2012.)
#49	Beneficiary Survey	The State submitted a report of the survey's results to CMS on September 30, 2011.
#51	Enrollment Reporting	Enrollment information was reported to CMS in each Quarterly Report with one exception: data was withheld from the report covering the January-March 2012 quarter, so that the methodology used to calculate enrollment could be reviewed with CMS. This material was scheduled to be submitted to CMS in the first quarter of DY 11.
#52	Quarterly Expenditure Reports	Quarterly expenditure reports have been submitted to CMS as required.
#53	Reporting Expenditures in the Demonstration	Expenditure Reports have been submitted to CMS as required.
#54	Reporting Member Months	Member months were reported to CMS in each Quarterly Report with one exception: data was withheld from the report covering the January-March 2012 quarter, so that the methodology used to calculate Member Months could be reviewed. This material was scheduled to be submitted to CMS in the first quarter of DY 11.
#55	Assignment of Expenditures and Member Months to Eligibility Groups	Expenditures and member months were reported in the Quarterly Reports as required, with the exception noted above for STC #54.
#56	Standard Funding Process	The State submitted the CMS-64 and CMS-37 expenditure reports in accordance with this STC.
#57	Extent of Federal Financial Participation for the Demonstration	Lists of current hospitals receiving pool payments were included in each Quarterly Report. The State submitted Waiver Amendment 16 to CMS on April 13, 2012. The purpose of Amendment 16 was to allow the State to draw down the full Disproportionate Share Hospital (DSH) allotment authorized by Congress. CMS approved Amendment 16 by letter dated June 15, 2012. The State sent CMS the final Meharry Medical Center uncompensated cost report for the period ended June 30, 2011, on

STC	Topic	Actions
		January 26, 2012. The State reported actual certified public expenditures as part of the CMS-64 report as required by this STC.
#63	Eligibility Groups Subject to the Budget Neutrality Cap	Eligibility Group (EG) information was submitted in each Quarterly Report with one exception: data was withheld from the report covering the January-March 2012 quarter, so that the methodology used for EG assignments could be reviewed. This material was scheduled to be submitted to CMS in the first quarter of DY 11.
#64	Budget Neutrality Ceiling	Budget neutrality information was submitted in each Quarterly Report with one exception: data was withheld from the report covering the January-March 2012 quarter, so that the methodology used for EG assignments could be reviewed. This material was scheduled to be submitted to CMS in the first quarter of DY 11.
#71	Interim Evaluation Reports	The State included an Interim Evaluation Report (Part VI, Pages 43-49) in its application to extend the TennCare II Demonstration (addressed at greater length above for STC 8).
Section XIII, Part III	Enrollment in TennCare Standard Spend Down	Open enrollment periods for the Standard Spend Down program were held on September 12, 2011, and February 21, 2012.
Section XIV	Schedule of State Deliverables During the Demonstration Extension	The State submitted revised versions of the Operational Protocol to CMS on October 19, 2011, and October 21, 2011.

ATTACHMENT D

THE IMPACT OF TENNCARE: A SURVEY OF RECIPIENTS 2011

THE IMPACT OF TENNCARE

A Survey of Recipients, 2011

Prepared by
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Research Associate, CBER
and
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November 2011

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The Impact of TennCare: A Survey of Recipients, 2011

Method

The Center for Business and Economic Research 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 in order to ascertain their insurance status and use of medical facilities. Given the necessity of obtaining accurate estimates for subpopulations, a target sample size of 5,000 was agreed upon. The survey instrument was prepared in cooperation with personnel from the Bureau of TennCare.

The survey was conducted by telephone between May and July 2011. The survey was conducted with both a Computer Assisted Telephone Interviewing System, utilizing a random digit dialing based sample, and a cell phone sample. This is the first time a dual frame sampling technique has been used since this survey began in 1993. The additional cell phone sampling allowed the surveyors to reach a segment of the population that would have not been reachable in prior years, the segment that depends solely on cell phone use. 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. The University of Tennessee Social Work Office of Research and Public Service administered the survey. When Spanish-speaking households were reached, a translator would call the households at a later time to conduct the survey.

Approximately 59 percent of those contacted through the random digit dialing technique and 44 percent of those contacted through the cell phone sample 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 of the uninsured, 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. In prior years, the sample has been adjusted by household income using the 2000 Census. Since 2010, the sample has been adjusted by household income and head of household age using the 3-year American Community Survey (ACS)[2].

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, comparisons are made to findings from the earlier surveys.

[1] In the random digit dialing sample, there were 4,829 completed surveys and 3,418 refusals. In the cell phone sample, there were 195 completed surveys and 253 refusals.

[2] The American Community Survey (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 a part of the United States Census Bureau.

FIGURE 1: Head of Household Age and Household Income

Age-Householders	Proportion in 2011 Survey (Percent)	Proportion in ACS* (Percent)	Deviation (Percent)
Under 25	1.5	5.1	3.6
25-44	22.4	35.5	13.1
45-64	53.5	38.4	-15.1
65+	22.7	21.1	-1.6

Household Income Level	Proportion in 2011 Survey (Percent)	Proportion in ACS* (Percent)	Deviation (Percent)
<10000	9.0	9.5	0.5
10,000-14999	9.0	6.9	-2.1
15,000-19,999	8.4	6.6	-1.8
20,000-29,999	12.4	12.4	0.0
30,000-39,999	11.5	11.7	0.2
40,000-49,999	10.2	10.0	-0.2
50,000-59,999	8.5	8.6	0.1
60,000-99,999	17.6	20.6	3.0
100,000+	13.4	13.8	0.4

*Census Bureau, 2007-2009 American Community Survey 3-year Estimates

Estimates for Insurance Status

Estimates for the number of Tennesseans who are uninsured are presented below (Table 1). The estimated 604,222 uninsured represent 9.5 percent of the 2011 population (6,236,524[3]). This is the lowest total uninsured since the 2008 estimate. The uninsured rate for children is 2.4 percent, a decrease from last year's rate of 3.9 percent. The rate for adults remained the same as the 2010 rate of 12.0 percent (Table 1a). The slight decrease in the total uninsured rate is attributable to the not-so-slight decrease in the uninsured rate of children, a result possibly driven by increased TennCare and CoverKids enrollments as well as sampling changes.

TABLE 1: Statewide Estimates of Uninsured Populations (1993–2011)

	1993	1994	1995	1996	1997	1998	1999
State Total	452,232	298,653	303,785	333,268	319,079	335,612	387,584
Percent	8.9	5.7	5.8	6.3	6.1	6.2	7.2

	2000	2001	2002	2003	2004	2005	2006
State Total	372,776	353,736	348,753	371,724	387,975	482,353	649,479
Percent	6.5	6.2	6.1	6.4	6.6	8.1	10.7

	2007	2008	2009	2010	2011
State Total	608,234	566,633	616,967	618,445	604,222
Percent	10.0	9.3	10.0	9.9	9.5

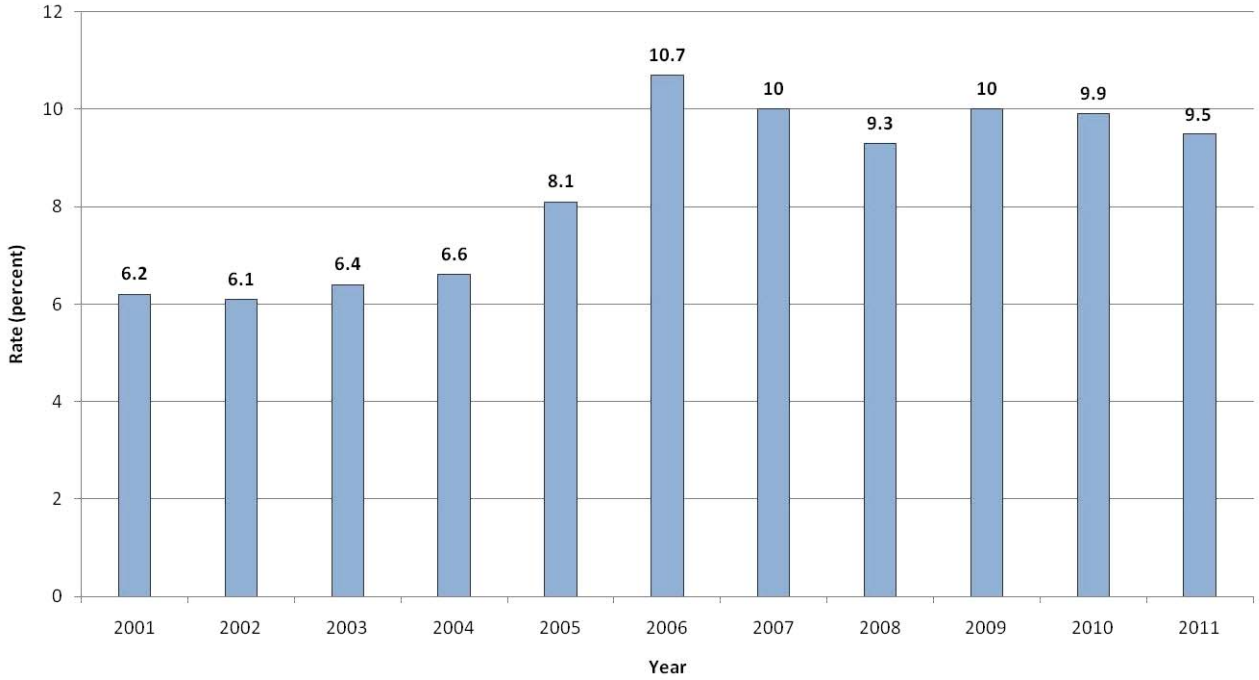
TABLE 1a: Uninsured Tennesseans by Age (1999–2011)

	1999	2000	2001	2002	2003	2004	2005
Under 18 Total	56,332	56,691	56,141	54,552	46,999	67,772	72,387
Under 18 Percent	4.2	4.1	4.0	3.9	3.3	4.9	5.0
18+ Total	331,252	316,053	297,595	297,779	324,725	320,203	409,965
18+ Percent	8.2	7.4	6.9	6.9	7.4	7.2	9.1

	2006	2007	2008	2009	2010	2011
Under 18 Total	82,484	70,096	72,258	54,759	57,912	35,743
Under 18 Percent	5.7	4.8	4.9	3.7	3.9	2.4
18+ Total	566,955	538,138	494,375	562,208	560,532	568,479
18+ Percent	12.1	11.7	10.6	11.9	12.0	12.0

[3] United States Census Bureau, 2007-2009 American Community Survey. In prior years (1993-2009), population figures were found using the "Interim State Population Projections," also part of the United States Census Bureau.

FIGURE 2: Rate of Uninsured Populations (2001-2011)



Reasons for Failure to Obtain Medical Insurance

The underlying reported reason for a lack of insurance has changed little over the period since TennCare was implemented in 1994, though the percentages have shifted somewhat. The major reason that people report remaining uninsured is their perception that they cannot afford insurance (Table 2). In 2011, 88 percent indicate that this is a major reason for not having insurance, a decrease from 2010's 91 percent. It is the fifth highest number since TennCare's inception, though it has been slightly decreasing since 2008. 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 it a major reason (Table 3). The exception to this rule is that 92 percent in the highest income bracket consider cost a major barrier to having insurance, a dramatic increase from any earlier year. The $40,000 bracket experienced a decrease from 92 percent claiming affordability as a major barrier to not having insurance to 80 percent[4]. The lowest two income brackets both claim affordability as less of a barrier to having insurance this year than last year. While financial pressures continue to limit people from obtaining coverage, 11 percent indicate that they just did not get around to securing it, and 8 percent indicate that a major reason is that they do not need insurance.

TABLE 2: Reasons for Not Having Insurance (1997–2011) (Percent)

Reason	Can't Afford			Didn't Get to It			Don't 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

[4] While both the $40,000 and $50,000 brackets experienced large percentage point changes in the number of people claiming "cannot afford" as a major reason for no insurance, the sample sizes are small and merit little statistical significance. Only those who report not having insurance and earn income in the $40,000 and $50,000 brackets and above are included in this calculation.

TABLE 3: "Cannot Afford" Major Reason for No Insurance: by Income (1998–2011) (Percent)

Major Reason	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Less $10,000	79	75	76	82	82	86	97	90	92	93	97	96	96	89
$10,000 - $14,499	86	76	84	84	90	84	88	82	96	95	97	96	95	90
$15,000 - $19,999	80	75	84	89	77	93	92	91	87	93	88	93	88	90
$20,000 - $29,999	73	69	80	74	70	83	87	81	90	89	96	92	94	89
$30,000 - $39,999	78	64	80	82	72	84	84	78	76	90	88	90	87	83
$40,000 - $49,999	63	73	45	69	62	82	70	64	84	88	93	92	92	80
$50,000+	46	39	47	46	36	67	47	67	68	76	81	80	76	92

Evaluations of Medical Care and Insurance Coverage

The quality of medical care ratings for TennCare remain high, with over 70 percent of heads of households rating their care "good" or "excellent" and 87 percent rating their children's care "good" or "excellent." Tennesseans' overall perception of the quality of care they and their children have been receiving has been relatively stable in recent years but is up considerably since 1995. Overall perception of children's healthcare remained stable from 2010 to 2011, with 89 percent giving children's medical care a "good" or "excellent" rating in 2011. Ratings of medical care quality for the TennCare head of household population gradually increased from TennCare's inception in 1994 to 2005; in 2011, the perceived medical care quality for TennCare heads of households topped the 2009 high with 30 percent rating it "excellent;" 71 percent rate their quality as "good" or "excellent," while 19 percent rate their quality as "fair." Perceptions of quality of medical care for their children remain high in 2011, with only 13 percent rating the quality of care as "fair" or "poor" and 48 percent rating the quality as "excellent," leading to favorable ratings. Ratings for quality of children's medical care are similar for the TennCare and total populations.

TABLE 4: Quality of Medical Care Received by Heads of Households (1997–2011) (Percent)

All Heads of Households	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Excellent	22	23	21	22	22	25	25	26	29	28	28	28	32	32	31
Good	51	52	50	50	48	51	50	50	48	48	47	46	46	46	46
Fair	22	22	22	21	23	19	19	18	17	18	18	18	16	16	15
Poor	5	3	7	7	7	5	6	6	6	7	7	8	6	6	7
Medicaid/ TennCare	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Excellent	19	18	18	18	20	21	21	23	28	21	23	24	29	24	30
Good	47	42	47	43	41	46	45	47	40	43	44	43	47	41	41
Fair	26	31	25	27	28	24	25	23	26	27	27	25	18	29	19
Poor	8	9	10	12	11	9	9	7	6	10	6	8	6	6	10

TABLE 5: Quality of Medical Care Received by Children of Heads of Households (1997–2011) (Percent)

All Heads of Households	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Excellent	30	30	30	33	30	34	36	36	38	39	35	34	39	46	44
Good	50	51	51	48	50	51	48	48	49	47	48	51	49	43	45
Fair	15	15	15	15	16	12	13	12	9	11	12	11	9	9	9
Poor	5	4	4	4	4	4	3	4	4	3	4	4	3	3	2
Medicaid/ TennCare	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Excellent	27	27	29	25	24	28	32	31	34	39	30	32	41	43	48
Good	48	49	49	47	50	48	45	47	49	38	49	49	48	45	39
Fair	19	18	18	20	19	17	17	16	12	17	19	14	8	6	11
Poor	6	7	4	8	7	7	6	5	5	6	2	6	3	6	2

Satisfaction with Quality of Care Received from TennCare

TennCare recipients continue to show high levels of satisfaction with quality of care received from TennCare (Table 6), and the 95 percent expressing satisfaction (responding "somewhat satisfied" or "very satisfied") represents the highest level of satisfaction since TennCare's inception. The previous high, in 2010, was 94 percent. This new level exceeds the satisfaction reported by Medicaid recipients in 1993 by 13 percentage points and is considerably higher than when TennCare began in 1994.

TABLE 6: Percent Indicating Satisfaction with TennCare (1993–2011) (Percent)

1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
82	61	75	82	81	83	81	78	79	85	83	90

2005	2006	2007	2008	2009	2010	2011
93	87	90	89	92	94	95

Behavior Relevant to Medical Care

Each respondent was asked a series of questions regarding his or her behavior when seeking medical care (Table 7). The proportion of TennCare heads of households initially seeking care at hospital emergency rooms in 2011 is slightly higher than it was in 2010, increasing from 7 percent to 8 percent. This is the highest it has been since 2004. An even larger increase in hospital visits as initial medical care sought exists when TennCare households seek care for their children, an increase from 3 percent in 2010 to 9 percent in 2011 (Table 8). This is the highest share initially seeking care for their children at hospitals since 1994. The share of TennCare adults initially seeking care at a doctor's office is 80 percent, while it is 83 percent for all heads of households. The increase in TennCare recipients' visits to the doctor's office, a 3 percentage point increase from 2010, resulted in a decrease in initial clinic visits. While the share of TennCare households initially seeking medical care at a doctor's office for their children has also increased in 2011, from 82 percent in 2010 to 84 percent in 2011, the share seeking initial care from clinics dropped from 15 percent to 7 percent.

TABLE 7: Head of Household: Medical Facilities Used When Medical Care Initially Sought (1997–2011) (Percent)

All Heads of Households	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Doctor's Office	81	81	81	83	81	84	85	85	83	83	83	83	83	82	83
Clinic	12	12	12	11	12	10	9	9	11	11	11	11	12	12	12
Hospital	6	6	6	5	6	5	5	5	5	5	4	4	4	4	4
Other	2	1	1	1	2	1	1	1	1	1	2	2	2	2	2
Medicaid/ TennCare	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Doctor's Office	74	74	78	76	78	77	80	77	78	76	79	80	83	77	80
Clinic	17	19	15	17	14	15	12	14	14	15	15	13	12	15	11
Hospital	7	6	6	6	7	7	7	8	7	7	4	6	4	7	8
Other	1	1	1	1	2	1	1	1	1	1	2	<1	1	<1	2

TABLE 8: Children: Medical Facilities Used When Medical Care Initially Sought (1997–2011) (Percent)

All Heads of Households	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Doctor's Office	81	83	81	84	81	85	85	85	86	87	88	88	86	87	88
Clinic	13	13	12	12	14	10	9	11	10	10	9	10	10	11	9
Hospital	5	4	6	3	4	4	5	3	3	3	2	2	3	2	2
Other	1	1	1	1	1	2	1	1	1	<1	1	<1	<1	<1	<1
Medicaid/ TennCare	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Doctor's Office	75	76	79	76	77	77	80	78	79	82	83	83	85	82	84
Clinic	17	18	15	17	16	17	12	16	13	12	14	14	15	15	7
Hospital	7	5	5	6	7	5	7	6	8	6	3	3	0	3	9
Other	1	1	1	1	1	1	1	0	0	1	0	<1	0	0	0

A similar change has occurred over the past decade in the frequency of visits to physicians. TennCare recipients continue to see physicians on a more frequent basis than the average Tennessee household. Seventy-eight percent of TennCare heads of households see a physician at least every few months (Table 9), while 71 percent of TennCare children visit physicians at that same frequency (Table 10). This represents a slight increase in visits for children, where 67 percent reported they visited a doctor at least every few months in 2010; the figure decreased from 82 percent of adults in 2010 to 78 percent in 2011. Only 48 percent of adults saw a physician this often prior to TennCare's inception in 1994. The increase in visits is much less pronounced for children than for TennCare adults.

TABLE 9: Frequency of Visits to Doctor for Head of Household (1997–2011) (Percent)

All Heads of Households	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Weekly	2	2	2	2	3	2	3	3	2	2	2	3	2	2	2
Monthly	10	11	12	11	13	11	11	11	11	12	13	12	12	11	11
Every Few Months	39	39	41	39	41	41	42	44	46	44	46	46	49	45	44
Yearly	27	27	25	27	25	27	27	26	26	25	23	22	22	24	25
Rarely	22	21	20	21	19	19	17	16	15	18	16	17	15	18	17
Medicaid/ TennCare	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Weekly	4	4	5	5	7	6	8	7	6	7	8	7	6	6	6
Monthly	24	21	25	26	24	24	29	28	30	30	33	33	30	29	26
Every Few Months	39	44	45	41	44	44	42	46	46	45	45	47	51	47	46
Yearly	14	14	13	13	12	14	10	9	11	8	6	8	7	7	10
Rarely	19	19	12	15	13	13	12	10	7	10	8	4	6	12	11

TABLE 10: Frequency of Visits to Doctor for Children (1997–2011) (Percent)

All Heads of Households	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Weekly	2	2	2	2	2	2	2	1	2	1	2	2	1	2	1
Monthly	12	11	11	11	11	11	12	10	11	10	11	9	9	9	10
Every Few Months	52	55	54	52	52	51	52	53	53	52	50	50	51	51	50
Yearly	23	22	24	24	24	23	26	26	23	28	27	29	31	29	31
Rarely	12	10	9	11	11	13	8	10	11	10	10	10	8	9	8
Medicaid/ TennCare	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Weekly	3	3	4	3	3	2	4	3	2	2	4	1	1	3	1
Monthly	15	12	14	16	14	17	17	14	21	16	14	16	18	13	15
Every Few Months	54	57	56	53	56	56	53	53	49	51	54	55	50	51	55
Yearly	16	19	18	18	16	17	17	22	17	23	16	21	27	24	25
Rarely	12	9	8	10	11	9	8	9	11	8	11	7	4	10	4

Appointments

The time required to obtain an appointment is comparable to the 2010 findings, with more reporting a wait of a week or less and fewer reporting two weeks or more. The percent of TennCare recipients obtaining a doctor's appointment on the same day that the request is made or the next day increased to 40 percent in 2011, an increase from 39 percent in 2010. The proportion of TennCare heads of household being able to obtain an appointment within one week increased to 70 percent. The number reporting having to wait longer than three weeks is 16 percent (Table 11). TennCare recipients are waiting 58 minutes on average to see their physicians once they reach the office (Table 12). This is a decrease from the 2010 time of 65 minutes, and is on par with previous wait times in the TennCare era, excluding the high in 2006.

TABLE 11: Time between Attempt to Make Appointment and First Availability of Appointment: TennCare Heads of Household (1997–2011) (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?	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Same day	29	26	23	22	19	22	20	20	21	22	22	21	18	20	21
Next day	17	21	18	19	15	18	16	17	17	27	20	17	23	19	19
1 week	28	27	27	31	31	29	29	33	31	22	30	27	25	29	30
2 weeks	11	10	12	11	12	9	11	11	10	10	8	10	9	11	10
3 weeks	5	4	5	4	5	5	5	3	5	4	4	4	4	4	4
Over 3 weeks	11	11	15	15	18	18	18	15	16	16	15	22	20	17	16

TABLE 12: Wait for Appointments: TennCare Heads of Household (1997–2011) (Minutes)

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Number of minutes wait past scheduled appointment time?	52	49	52	64	61	64	50	63	57	80	57	50	52	65	58
Number of minutes to travel to physician's office?	21	21	22	24	23	23	22	27	32	30	21	25	24	31	23

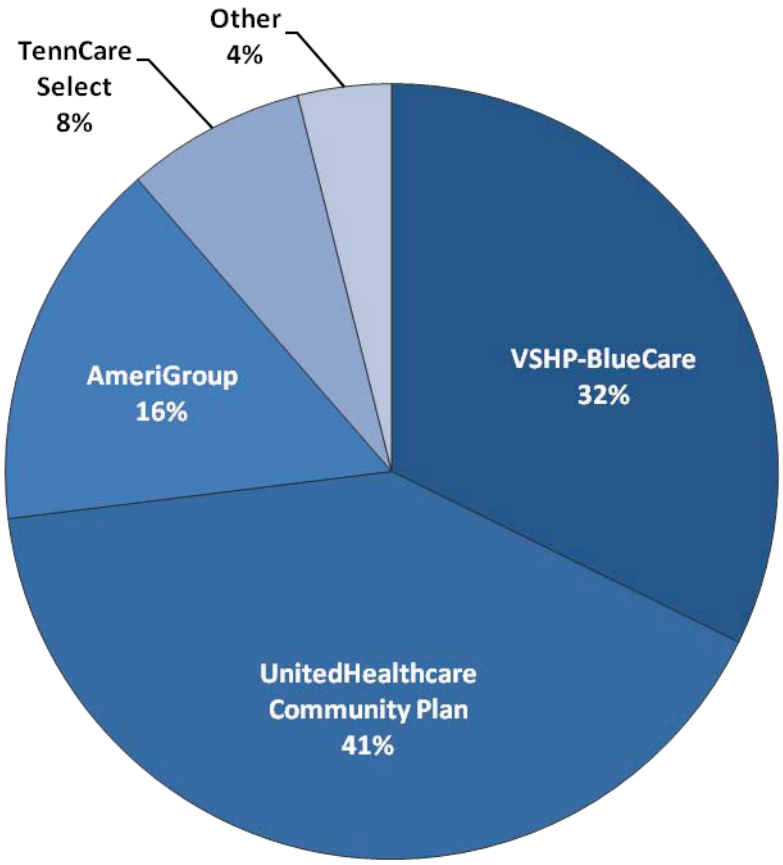
TennCare Plans

The largest number of TennCare recipients (41 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 (32 percent). AmeriGroup accounts for another 16 percent, while 8 percent are represented by TennCare Select. Four percent report being represented by other plans (Table 13).

TABLE 13: Reported Company Managing TennCare Plan (1998–2011) (Percent)

What company manages your TennCare plan?	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Blue Cross / Blue Shield	48	50	50	50	40	42	39	36	31	35	37			
VSHP - BlueCare												41	36	32
UnitedHealthcare Community Plan (formerly AmeriChoice)												26	37	41
AmeriGroup												8	10	16
Health Net	8	2	1											
John Deere (Heritage)	3	4	5	4	7	7	6	9	6	7	4	1		
TLC (Memphis Managed Care)	4	4	3	5	12	12	13	13	11	7	9	2		
Phoenix (Advantage Care)	6	13	8											
Preferred Health Partner	6	7	7	4	8	12	10	10	11	8	6	2		
Prudential (Prudential)	1	1	1											
Access Med Plus	18	20	22	23	5	3	1	1		2	3	<1		
Total Health Plus (THP)	1	0	0											
Vanderbilt Health Plan	0	0	1	1	0	1	1	1	1	<1				
Omnicare (Affordable)	3	4	2	2	7	6		6	9	7	5	2		
Xantus Health Plan			9	8	9	10				<1				
Universal Care				2	9	4	1		1	1	1			
Better Health Plans				1	3	4	2	2	3	1	1	<1		
TennCare Select							21	21	18	6	7	10	8	8
Premier Behavioral							1		1		<1			
Tennessee Behavioral							1			<1				
VHP Community Care									1		<1			
Windsor Health Plan of TN, Inc.										<1	<1			
Other	2	1	1				4	1	6	22	27	7	7	4

FIGURE 3: Reported Company Managing TennCare Plan (2011)



In 2011, reported receipt of information from MCOs (enrollment card, grievance form, a list of rights and responsibilities, information on filing grievances, and name of provider assigned) decreased. Sixty-one percent recall receiving an enrollment card, down from last year's 74 percent (Table 14), while 5 percent of respondents indicated that they changed plans. Respondents reported receiving both a list of rights and responsibilities and the name of the assigned MCO in less proportion than in 2010. The preferred method for receiving information about TennCare remains through the mail, with 78 percent reporting this is the best way they obtain TennCare information (Table 15).

TABLE 14: Households Receiving TennCare Information from Plans (1998–2011) (Percent)

Please indicate whether or not you or anyone in your household has received each of the following regarding TennCare	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
An enrollment card	77	76	74	65	70	65	74	70	73	78	78	77	74	61
A grievance form	41	39	33	32	34	35	33	24	42	44	40	40	39	28
Information on filing grievances	43	44	36	46	39	40	40	26	41	46	41	41	43	29
A list of rights and responsibilities	73	70	66	63	70	70	75	71	78	77	73	75	74	68
Name of MCO to whom assigned				72	79	76	81	79	82	81	79	79	79	76

TABLE 15: Best Way to Get Information about TennCare (2002–2011) (Percent)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Mail	67	75	73	75	75	72	73	71	72	78
Doctor	7	5	5	6	8	8	5	6	5	5
Phone	11	10	9	9	5	8	11	10	11	5
Handbook	8	6	4	4	3	6	6	7	5	6
Drug Store	1	0	1	1	2	1	1	1	<1	<1
Friends	2	0	1	0	1	1	<1	1	1	2
TV	0	1	1	1	1	0	1	<1	<1	<1
Paper	0	0	0	0	0	0	<1	1	<1	0
Other	4	3	3	4	5	4	3	3	4	4

Conclusion

The survey reveals that from the perspective of the recipients, the TennCare program continues to work as expected. Since the beginning of TennCare, its recipients have continued to see physicians more often, visit emergency rooms less for routine care, and are able to see a physician without excessive travel or waiting time. Tennessee's 9.5 percent rate of uninsured in 2011 is a slight decrease from 9.9 percent in 2010 and is the second lowest since 2005. Still, the rate is much higher than those experienced before 2006. The total uninsured population is approximately 604,222, including about 35,743 children, a decrease from last year's number of 57,912 uninsured children.

In 2011, recipients expressed the highest overall satisfaction with TennCare since its existence, with a 1 percentage point increase over the proportion expressing satisfaction in 2010. The satisfaction rate remains dramatically higher (34 percentage points) than the rate in the program's first year. Additionally, TennCare recipients' experience with medical care remains positive, with the quality of TennCare householder's children's medical care increasing substantially. TennCare continues to receive positive feedback from its recipients, indicating the program is providing health care in a satisfactory manner and up to the expectations of those it serves.

ATTACHMENT E

2011 HEDIS/CAHPS REPORT: A COMPARATIVE ANALYSIS OF AUDITED RESULTS FROM TENNCARE MANAGED CARE ORGANIZATIONS

Comparative Analysis of Audited Results from TennCare MCOs

August 2011

2011 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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Acknowledgements/Copyrights

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

Amerigroup ..... Amerigroup Community Care, Inc. d.b.a. Amerigroup in all three of Tennessee's Grand Regions

AMI ..... Acute Myocardial Infarction

AMM ..... Antidepressant Medication Management

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

BlueCare-East ..... Volunteer State Health Plan, Inc. d.b.a. BlueCare-East in the Tennessee East Grand Region

BlueCare-West ..... Volunteer State Health Plan, Inc. d.b.a. BlueCare-West in the Tennessee West Grand Region

BMI ..... Body Mass Index
BP ..... Blood Pressure
C&M ..... Continuation and Maintenance
CAB ..... Call Abandonment
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 4.0H Adult Version
CPC ..... CAHPS Health Plan Survey 4.0H Child Version
COPD ..... Chronic Obstructive Pulmonary Disease
CWP ..... Appropriate Testing for Children with Pharyngitis
CY ..... Calendar Year
d.b.a. ..... doing business as
DMARD ..... Disease-Modifying Anti-Rheumatic Drug
DT ..... Diphtheria and Tetanus Vaccination
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
HTN ..... Hypertension
IAD ..... Identification of Alcohol and Other Drug Services

IET ..... Initiation and Engagement of AOD Dependence Treatment
IMA ..... Immunizations for Adolescents
IP ..... Inpatient
IPU ..... 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
MMR ..... Measles, Mumps and Rubella Vaccination
MPM ..... Annual Monitoring for Patients on Persistent Medications
MPT ..... Mental Health Utilization
MSC ..... Medical Assistance with Smoking and Tobacco Use Cessation
NA ..... Not Applicable
NCQA ..... National Committee for Quality Assurance
NR ..... Not Reported
OB/GYN ..... Obstetrician/Gynecologist
Pap ..... Papanicolaou Test
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
PMPM/PMPY ..... Per Member Per Month/Year
PPC ..... Prenatal and Postpartum Care
RV ..... Rotavirus
SPR ..... Use of Spirometry Testing in the Assessment and Diagnosis of COPD
Strep ..... Streptococcus
Td ..... Tetanus, Diphtheria Toxoids Vaccine
Tdap ..... Tetanus, Diphtheria Toxoids and Acellular Pertussis Vaccine
TennCare ..... Tennessee Department of Finance and Administration, Bureau of TennCare
TennCare*Select* ..... Volunteer State Health Plan, Inc. d.b.a. TennCare*Select* in all three of Tennessee's Grand Regions
UnitedHealthcare-East ..... UnitedHealthcare Plan of the River Valley, Inc. d.b.a. AmeriChoice-East in the Tennessee East Grand Region

UnitedHealthcare-Middle .....UnitedHealthcare Plan of the River Valley, Inc. d.b.a. AmeriChoice-Middle in the Tennessee Middle Grand Region

UnitedHealthcare-West .....UnitedHealthcare Plan of the River Valley, Inc. d.b.a. AmeriChoice-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) in Tennessee are required to report a full Healthcare Effectiveness Data and Information Set (HEDIS) as a part of the state's accreditation mandates. 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 tracking over time, as well as comparisons to national averages/benchmarks and across the state's MCOs. 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 2011 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 across the state's MCOs with color-coding for national and state benchmark comparison where available/applicable. **Appendix A** contains a comprehensive table of HEDIS 2011 plan-specific results and national benchmarks for HEDIS 2010 Use of Services Measures.

Background

HEDIS Measures–Domains of Care

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 employed ensure the integrity of measure reporting and help purchasers make more reliable, 'apples-to-apples' comparisons between health plans. HEDIS measures are subject to an 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 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 2011 results, CY2010 was the review period. Similarly, the comparative data presented in this report from the HEDIS 2010 Medicaid Means and Percentiles reflect data procured during CY2009.

For HEDIS 2011, there were a total of 75 measures (Commercial, Medicare and Medicaid) across eight domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Satisfaction with the Experience of Care (**CAHPS Survey Results**)
- Use of Services
- Cost of Care
- Health Plan Descriptive Information
- Health Plan Stability
- Informed Healthcare Choices (no measures in this domain)

The following brief descriptions of selected HEDIS measures were extracted from NCQA's *HEDIS 2011 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, Satisfaction with the Experience of Care (**CAHPS Survey Results**), and Use of Services.

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

For 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 Use of Services measures are included in **Appendix A**.

Prevention and Screening

Adult BMI Assessment (ABA)

The percentage of members 18-74 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 the measurement year.

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

The percentage of members 3-17 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 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two 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 their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates. HepA, RV, flu, and Combinations four through ten were added in HEDIS 2010. 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 Influenza
- Combination 7: DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA and RV
- Combination 8: DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA and Influenza
- Combination 9: DTaP, IPV, MMR, HiB, HepB, VZV, PCV, RV and Influenza
- Combination 10: DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV and Influenza

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

Lead Screening in Children (LSC)
The percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.

Breast Cancer Screening (BCS)
The percentage of women 40-69 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 21-64 years of age who received one or more Papanicolaou (Pap) tests to screen for cervical cancer during the measurement year or the two years prior to the measurement year.

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

Respiratory Conditions

Appropriate Testing for Children with Pharyngitis (CWP)
The percentage of children 2-18 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 3 months to 18 years of age who were given a diagnosis of upper respiratory infection (URI) 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 18-64 years of age with a diagnosis of acute bronchitis who 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 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. It is possible for the denominator to include multiple events for the same individual.

Use of Appropriate Medications for People with Asthma (ASM)

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

Cardiovascular Conditions

Cholesterol Management for Patients with Cardiovascular Conditions (CMC)

The percentage of members 18-75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) from January 1-November 1 of 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:

- Low density lipoprotein-cholesterol (LDL-C) screening performed during the measurement year
- LDL-C controlled (<100 mg/dL) for the most recent LDL-C screening

Controlling High Blood Pressure (CBP)

The percentage of members 18-85 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 18-75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing during the measurement year
- HbA1c poor control (>9.0%) for the most recent HbA1c test during the measurement year[1]
- HbA1c control (<7.0%) for the most recent HbA1c test during the measurement year
- HbA1c control (<8.0%) for the most recent HbA1c test during the measurement year
- An eye exam (retinal or dilated) for diabetic retinal disease performed in the measurement year or a negative retinal exam (no evidence of retinopathy) in the year prior to the measurement year
- LDL-C screening performed during the measurement year
- LDL-C controlled (<100 mg/dL) for the most recent LDL-C screening during the measurement year
- Medical attention for nephropathy which includes a nephropathy screening test or evidence of nephropathy during the measurement year
- Blood pressure control (<130/80 mm Hg) for the most recent reading during the measurement year
- Blood pressure control (<140/90 mm Hg) for the most recent reading during the measurement year

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).

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, CT scan) within 28 days of the diagnosis. This measure is 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).

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 were 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:

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

- *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 recommended or discussed

Behavioral Health

Antidepressant Medication Management (AMM)

The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression, 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. One of these visits must have been within the Intake Period and within 30 days of the earliest ambulatory prescription dispensed for ADHD medication, at which time the member must have been 6-12 years of age with a Negative Medication History. Two rates are reported:

- *Initiation Phase* – The percentage of members who had one follow-up visit with practitioner prescribing authority during the 30-day Initiation Phase
- *Continuation and Maintenance (C&M) Phase* – The percentage of members who remained on the medication at least 210 days and who had at least two follow-up visits with a practitioner within 270 days (9 months) of the end of the Initiation Phase, in addition to the Initiation Phase visit

Follow-Up After Hospitalization for Mental Illness (FUH)

The percentage of discharges for members 6 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:

- The percentage of members who received follow-up within 7 days of discharge
- The percentage of members who received follow-up within 30 days of discharge

Medication Management

Annual Monitoring for Patients on Persistent Medications (MPM)

The percentage of members 18 years of age and older who received at least a 180-treatment day supply 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. 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)

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.

- 20-44 years of age
- 45-64 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 6 years who had a visit with an MCO PCP during the measurement year, and members 7-19 years who had a visit with an MCO PCP during the measurement year or the year prior. The MCO reports four separate percentages:

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

- *Initiation of AOD Treatment* – The percentage who initiate treatment through an impatient AOD admission, outpatient visit, intensive outpatient encounter or patient hospitalization within 14 days of diagnosis
- *Engagement of AOD Treatment* – The percentage of members 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: 13-17; 18 and older; 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 Abandonment (CAB)

The percentage of calls received by the organization's Member Services call centers (during operating hours) during the measurement year that were abandonment by the caller before being answered by a live voice. Lower rates represent better performance.

Call Answer Timeliness (CAT)

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

Use of Services Measures

The Use of Services domain includes measures on which services an MCO provides for its population. It addresses information about how MCOs manage the provisions of care. Typically, these measures are expressed as rates of service, such as per 1,000 member months or years, or as the percentage of members who received a particular service.

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
- 21-40 percent
- 41-60 percent
- 61-80 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 3-6 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 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Satisfaction with the Experience of Care

The CAHPS Health Plan Survey 4.0H Adult Version (CPA) and 4.0H 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:

- 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[2]
- 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 4.0H) 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, 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 2011, Volume 3:*

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

Specifications for Survey Measures. MCO results from the CAHPS 4.0H Adult and the CAHPS 4.0H Child and CCC Surveys were evaluated for this report.

CAHPS Health Plan Survey 4.0H 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
   - Definitely No
   - Somewhat No
   - Somewhat Yes
   - Definitely Yes

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 how often in the last six months the members were able to get care when attempting to do so. The summary rate represents the percentage of members who responded 'Always' or 'Usually.'

Customer Service

The Customer Service composite measures how often members were able to get information and to get help from customer service in the last six months. The summary rate represents the percentage of members who responded 'Always' or 'Usually.'

Getting Care Quickly

The Getting Care Quickly composite measures how often the members received care or advice in a reasonable time, including office waiting room experiences. The summary rate represents the percentage of members who responded 'Always' or 'Usually.'

How Well Doctors Communicate

The How Well Doctors Communicate composite measures how often providers listen, explain, and spend enough time with and show respect for what members have to say. The summary rate represents the percentage of members who responded 'Always' or 'Usually.'

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 'Definitely Yes.'

Additional Questions

There are four additional questions with responses scaled 0-10 in the CAHPS 4.0H Adult Survey: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan*. Zero represents 'worst possible' and 10 represents 'best possible.' The summary rate represents the percentage of respondents who rated the question 9 or 10.

CAHPS Health Plan Survey 4.0H Child Version: General Population (CPC)

The CPC Survey 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
   - Definitely No
   - Somewhat Yes
   - Somewhat No
   - Definitely Yes

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 how often in the last six months members were able to get care from doctors and specialists when attempting to do so. The summary rate represents the percentage of members who responded 'Always' or 'Usually.'

Customer Service

The Customer Service composite measures how often members were able to get information and to get help from customer service in the last six months. The summary rate represents the percentage of members who responded 'Always' or 'Usually.'

Getting Care Quickly

The Getting Care Quickly composite measures how often the members received care or advice in a reasonable time, including office waiting room experiences. The summary rate represents the percentage of members who responded 'Always' or 'Usually.'

How Well Doctors Communicate

The How Well Doctors Communicate composite measures how often providers listen, explain and spend enough time with and show respect for what members have to say. The summary rate represents the percentage of members who responded 'Always' or 'Usually.'

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 'Definitely Yes.'

Additional Questions

There are four additional questions with responses scaled 0-10 in the CAHPS 4.0H Child Survey: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan*. Zero represents 'worst possible' and 10 represents 'best possible.' The summary rate represents the percentage of respondents who rated the question 9 or 10.

CAHPS Health Plan Survey 4.0H 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 CAHPS 4.0H Child Survey. 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 Prescription Medicines
2. Access to Specialized Services
3. Family-Centered Care: Getting Needed Information
4. Family-Centered Care: Personal Doctor Who Knows Child
5. Coordination of Care

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 Prescription Medicines

The Access to Prescription Medicines composite measures how often members were able to obtain prescription medicine and assistance if they experienced an access problem. The summary rate represents the percentage of members who responded 'Always' or 'Usually.'

Access to Specialized Services

The Access to Specialized Services composite measures how often a member was able to obtain special medical equipment, therapy, and treatment or counseling, and assistance if they experienced an access problem. The summary rate represents the percentage of members who responded 'Always' or 'Usually.'

Family-Centered Care: Getting Needed Information

The Family-Centered Care: Getting Needed Information composite measures how often doctors made it easy to discuss questions or concerns, how often members received the needed information from health providers, and how often healthcare questions were answered by providers. The summary rate represents the percentage of members who responded 'Always' or 'Usually.'

Family-Centered Care: Personal Doctor or Nurse Who Knows Child

The Family-Centered Care: Personal Doctor or Nurse Who Knows Child composite measures whether or not providers discussed the child's feelings, growth and behavior, and if the provider understands how the medical or behavioral conditions affect both the child's and family's day-to-day life. The summary rate represents the percentage of members who responded 'Yes.'

Family-Centered Care: Coordination of Care

The Family-Centered Care: The Coordination of Care composite measures whether or not doctors or other health providers assisted, if needed, in contacting the child'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 members who responded 'Yes.'

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 2011, this included the health plans in all three Grand Regions: Amerigroup Community Care, Inc. (**Amerigroup**); Volunteer State Health Plan, Inc. (**BlueCare-East**, **BlueCare-West** and **TennCare*Select***); and UnitedHealthcare Plan of the River Valley, Inc. (**UnitedHealthcare-East**, **UnitedHealthcare-Middle** and **UnitedHealthcare-West**).

Tables 2-1 (**a** and **b**), **2-2** (**a** and **b**) and **2-3** summarize the weighted average TennCare score for each of the selected HEDIS 2010 and HEDIS 2011 measures as well as the HEDIS 2010 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 2-1** (**a** and **b**), **2-2** (**a** and **b**) and **2-3**, the statewide changes for each measure reported during both HEDIS 2010 and HEDIS 2011 are presented. The column titled 'Change from 2010 to 2011' indicates whether there was an improvement (⬆) or a decline (⬇) in statewide performance for the measure from HEDIS 2010 to HEDIS 2011.

Table 2-1a. HEDIS 2011 State to National Rates: Effectiveness of Care Measures

Measure	Weighted State Rate		2010 Medicaid National Avg.	Change 2010 to 2011
	2010	2011		
Prevention and Screening				
Adult BMI Assessment (ABA)	26.93%	18.95%	34.6%	⬇
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC):				
BMI Percentile: 3-11 years	18.39%	9.00%	30.4%	⬇
12-17 years	19.03%	10.99%	30.1%	⬇
Total	**18.64%**	**9.65%**	**30.3%**	⬇
Counseling for Nutrition: 3-11 years	45.21%	24.22%	43.8%	⬇
12-17 years	39.52%	20.79%	38.1%	⬇
Total	**43.43%**	**23.15%**	**41.9%**	⬇
Counseling for Physical Activity: 3-11 years	29.96%	18.75%	31.8%	⬇
12-17 years	32.98%	18.13%	34.2%	⬇
Total	**30.94%**	**18.58%**	**32.5%**	⬇

Table 2-1a. HEDIS 2011 State to National Rates: Effectiveness of Care Measures				
Measure	Weighted State Rate		2010 Medicaid National Avg.	Change 2010 to 2011
	2010	2011		
Childhood Immunization Status (CIS):				
DTaP/DT	83.73%	80.70%	79.6%	↓
IPV	93.55%	94.84%	89.0%	↑
MMR	92.11%	91.51%	91.2%	↓
HiB	96.83%	91.40%	93.7%	↓
HepB	92.94%	93.83%	89.1%	↑
VZV	92.51%	91.74%	90.6%	↓
PCV	81.92%	82.08%	77.6%	↑
HepA	43.18%	40.57%	35.5%	↓
RV	61.13%	65.68%	49.8%	↑
Influenza	38.80%	38.14%	40.6%	↓
Combination 2	78.17%	74.21%	74.3%	↓
Combination 3	72.71%	70.28%	69.4%	↓
Combination 4	38.55%	36.24%	30.4%	↓
Combination 5	50.67%	52.58%	41.6%	↑
Combination 6	33.22%	32.11%	33.8%	↓
Combination 7	28.18%	28.34%	20.6%	↑
Combination 8	19.66%	18.45%	17.2%	↓
Combination 9	25.14%	26.63%	23.2%	↑
Combination 10	15.29%	15.57%	12.6%	↑
Immunizations for Adolescents (IMA):				
Meningococcal	39.91%	47.58%	47.4%	↑
Tdap/Td	44.52%	53.48%	59.1%	↑
Combination 1	35.02%	43.16%	42.5%	↑
Lead Screening in Children (LSC)	65.72%	70.87%	66.4%	↑
Breast Cancer Screening (BCS)	38.45%	43.79%	52.4%	↑
Cervical Cancer Screening (CCS)	61.30%	67.29%	65.8%	↑
Chlamydia Screening in Women (CHL):				
16-20 year-old women	53.77%	53.93%	54.4%	↑
21-24 year-old women	60.86%	62.10%	61.6%	↑
Total	**56.59%**	**57.19%**	**56.7%**	↑
Respiratory Conditions				
Appropriate Testing for Children with Pharyngitis (CWP)	70.13%	72.05%	62.3%	↑
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	74.94%	74.95%	86.0%	↑

Table 2-1a. HEDIS 2011 State to National Rates: Effectiveness of Care Measures				
Measure	Weighted State Rate		2010 Medicaid National Avg.	Change 2010 to 2011
	2010	2011		
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	33.46%	21.51%	25.6%	↓
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	26.17%	30.68%	28.6%	↑
Pharmacotherapy Management of COPD Exacerbation (PCE):				
Systemic corticosteriod	38.59%	42.54%	61.8%	↑
Bronchodilator	65.78%	73.17%	80.7%	↑
Use of Appropriate Medications for People with Asthma (ASM):				
5-11 years old	94.88%	93.80%	91.8%	↓
12-50 years old	84.49%	83.23%	86.0%	↓
Total	**89.44%**	**88.39%**	**88.6%**	↓
Cardiovascular Conditions				
Cholesterol Management for Patients with Cardiovascular Conditions (CMC):				
LDL-C Screening	80.71%	80.61%	80.7%	↓
LDL-C Controlled (<100 mg/dL)	35.27%	36.01%	41.2%	↑
Controlling High Blood Pressure (CBP)	53.67%	52.96%	55.3%	↓
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	66.67%	72.01%	76.6%	↑
Diabetes				
Comprehensive Diabetes Care (CDC):				
HbA1c Testing	77.93%	78.87%	80.6%	↑
HbA1c Control (<7.0%)	37.02%	34.64%	33.9%	↓
HbA1c Control (<8.0%)	46.05%	44.54%	45.7%	↓
Retinal Eye Exam Performed	35.12%	37.02%	52.7%	↑
LDL-C Screening	73.90%	74.73%	74.2%	↑
LDL-C Controlled (<100 mg/dL)	30.10%	29.22%	33.5%	↓
Medical Attention for Nephropathy	73.91%	73.19%	76.9%	↓
Blood Pressure Control (<130/80 mm Hg)	29.14%	35.56%	32.2%	↑
Blood Pressure Control (<140/90 mm Hg)	56.63%	55.03%	59.8%	↓
Musculoskeletal Conditions				
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	57.11%	57.88%	70.5%	↑
Use of Imaging Studies for Low Back Pain (LBP)	68.19%	67.88%	76.1%	↓
Behavioral Health				
Antidepressant Medication Management (AMM):				
Effective Acute Phase Treatment	50.11%	47.31%	49.6%	↓
Effective Continuation Phase Treatment	32.03%	28.23%	33.0%	↓
Follow-Up Care for Children Prescribed ADHD Medication (ADD):				
Initiation Phase	34.29%	39.11%	36.6%	↑
Continuation and Maintenance Phase	44.15%	47.00%	41.7%	↑

Table 2-1a. HEDIS 2011 State to National Rates: Effectiveness of Care Measures				
Measure	Weighted State Rate		2010 Medicaid National Avg.	Change 2010 to 2011
	2010	2011		
Follow-Up After Hospitalization for Mental Illness (FUH):				
7-day follow-up	37.93%	41.52%	42.9%	↑
30-day follow-up	61.24%	64.79%	60.2%	↑
Medication Management				
Annual Monitoring for Patients on Persistent Medications (MPM):				
ACE Inhibitors or ARBs	89.65%	89.75%	85.9%	↑
Digoxin	92.46%	91.00%	88.9%	↓
Diuretics	89.75%	89.97%	85.4%	↑
Anticonvulsants	75.48%	75.42%	68.7%	↓
Total	**87.60%**	**87.96%**	**83.2%**	↑
Measures Collected Through CAHPS Health Plan Survey				
Medical Assistance with Smoking and Tobacco Use Cessation (MSC):				
Advising Smokers and Tobacco Users to Quit*	75.08%**	71.76%**		↓
Discussing Cessation Medications*	38.02%**	38.13%**		↑
Discussing Cessation Strategies*	34.49%**	35.23%**		↑

** The three MSC rates were not included in Quality Compass in 2010 because the measure was revised; a rolling average was used for the measure's rates; therefore, two years of data is needed (rates will be calculated in 2011).*

*** The denominator was not available; hence, the average is not weighted.*

For the Effectiveness of Care Measure – Comprehensive Diabetes Care: HbA1c Poor Control (> 9.0%) presented in **Table 2-1b**, 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 2-1b. HEDIS 2011 State to National Rates: Effectiveness of Care Measure Where Lower Rates Indicate Better Performance				
Measure	Weighted State Rate		2010 Medicaid National Avg.	Change 2010 to 2011
	2010	2011		
Comprehensive Diabetes Care (CDC):				
HbA1c Poor Control (>9.0%)	45.61%	47.85%	44.9%	↓

Tables 2-2 (**a** and **b**) summarize results for the Access/Availability Domain of Care.

Table 2-2a. HEDIS 2011 State to National Rates: Access/Availability of Care Measures

Measure	Weighted State Rate		2010 Medicaid National Avg.	Change 2010 to 2011
	2010	2011		
Adults' Access to Preventive/Ambulatory Health Services (AAP):				
20-44 year-olds	79.50%	80.28%	80.5%	⬆
45-64 year-olds	79.89%	85.69%	85.3%	⬆
Children and Adolescents' Access to Primary Care Practitioners (CAP):				
12-24 months	97.10%	97.07%	95.2%	⬇
25 months-6 years	89.85%	89.91%	88.3%	⬆
7-11 years	91.43%	92.80%	90.3%	⬆
12-19 years	87.22%	88.63%	87.9%	⬆
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET):				
Initiation of AOD Treatment: 13-17 years	59.32%	63.61%	42.5%	⬆
18 + years	45.36%	53.71%	44.7%	⬆
Total	**46.48%**	**54.45%**	**44.3%**	⬆
Engagement of AOD Treatment: 13-17 years	34.73%	37.37%	17.7%	⬆
18 + years	14.36%	14.93%	11.8%	⬆
Total	**15.99%**	**16.61%**	**12.3%**	⬆
Prenatal and Postpartum Care (PPC):				
Timeliness of Prenatal Care	81.06%	83.12%	83.4%	⬆
Postpartum Care	64.11%	62.50%	64.1%	⬇
Call Answer Timeliness (CAT)	88.03%	91.39%	82.2%	⬆

For the Access/Availability of Care Measure – Call Abandonment (CAB) presented in **Table 2-2b**, 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 2-2b. HEDIS 2011 State to National Rates: Access/Availability of Care Measure Where Lower Rates Indicate Better Performance

Measure	Weighted State Rate		2010 Medicaid National Avg.	Change 2010 to 2011
	2010	2011		
Call Abandonment (CAB)	1.80%	0.78%	3.0%	⬆

Table 2-3 summarizes results for the Use of Services Domain of Care.

Table 2-3. HEDIS 2011 State to National Rates: Use of Services Measures				
Measure	Weighted State Rate		2010 Medicaid National Avg.	Change 2010 to 2011
	2010	2011		
Frequency of Ongoing Prenatal Care (FPC):				
≥ 81 percent	51.82%	61.07%	61.6%	↑
Well-Child Visits in the First 15 Months of Life (W15):				
6 or More Visits	59.72%	55.75%	59.4%	↓
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	70.23%	71.80%	71.6%	↑
Adolescent Well-Care Visits (AWC)	41.14%	46.19%	47.7%	↑

Individual Plan Performance

This section is intended to provide an overview of individual plan performance using appropriate available comparison data. The results highlight those areas where each MCO is performing in relation to the HEDIS 2010 National Medicaid Means and Percentiles for select MCO-reported HEDIS measures. Qsource uses these data to determine overall TennCare plan performance to the highest and lowest percentiles. The 'percentiles' are statistical values that represent the distribution of data. 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 2-5 (**a** and **b**), **2-6** (**a** and **b**) and **2-7** display the plan-specific performance rates for each measure selected from the Effectiveness of Care, Access/Availability of Care and Use of Services domains. **Table 2-4** details the color-coding used in **Tables 2-5** through **2-7** 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 CAHPS 4.0H Adult Survey as noted in **Tables 2-1a .**

Table 2-4. MCO HEDIS 2011 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.
NR	Not Reported	The measure was not reported (NR) by the health plan.
■	No Rating Available	Benchmarking data were not available.

Table 2-5a. HEDIS 2011 Plan-Specific Rates: Effectiveness of Care Measures								
Measure	Amerigroup	BlueCare		TennCare *Select*	UnitedHealthcare			HEDIS 2010 National Medicaid 50th Percentile
		-East	-West		-East	-Middle	-West	
Prevention and Screening								
Adult BMI Assessment (ABA)	4.72%	2.69%	2.59%	1.98%	29.68%	37.96%	45.99%	35.3%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC):								
BMI Percentile: 3-11 years (yrs)	1.31%	0.64%	0.14%	0.73%	23.96%	18.21%	19.50%	27.8%
12-17 yrs	1.04%	0.87%	0.29%	0.87%	22.76%	30.83%	25.58%	27.1%
Total	**1.23%**	**0.72%**	**0.18%**	**0.80%**	**23.60%**	**21.90%**	**21.41%**	**29.3%**
Counseling for Nutrition: 3-11 yrs	1.65%	3.96%	1.04%	4.71%	56.94%	52.23%	52.84%	49.6%
12-17 yrs	1.18%	0.70%	0.76%	2.11%	48.78%	51.67%	52.71%	41.1%
Total	**1.51%**	**2.88%**	**0.95%**	**3.57%**	**54.50%**	**52.07%**	**52.80%**	**46.2%**
Counseling for Physical Activity: 3-11 yrs	0.02%	0.00%	0.00%	0.03%	47.92%	40.55%	45.74%	33.0%
12-17 yrs	0.05%	0.00%	0.04%	0.04%	40.65%	46.67%	50.39%	37.2%
Total	**0.03%**	**0.00%**	**0.01%**	**0.03%**	**45.74%**	**42.34%**	**47.20%**	**35.3%**
Childhood Immunization Status (CIS):								
DTaP/DT	84.10%	79.08%	81.51%	79.32%	78.59%	82.00%	78.10%	81.8%
IPV	94.22%	94.65%	96.35%	91.24%	93.67%	96.59%	93.43%	90.7%
MMR	93.49%	90.51%	91.24%	88.32%	88.32%	94.40%	90.51%	91.7%
HiB	94.22%	91.48%	91.73%	89.05%	88.32%	93.92%	87.10%	95.4%
HepB	93.01%	93.43%	95.86%	90.51%	92.70%	94.65%	93.43%	91.8%
VZV	92.53%	89.29%	92.21%	90.02%	89.78%	94.65%	91.97%	91.3%
PCV	85.78%	79.81%	82.00%	79.08%	81.02%	83.45%	80.54%	79.3%
HepA	43.13%	40.63%	38.20%	37.47%	42.34%	41.61%	37.96%	34.8%
RV	66.99%	65.45%	61.56%	47.69%	67.88%	71.05%	64.48%	49.9%
Influenza	54.46%	42.34%	17.76%	49.15%	37.71%	50.12%	19.46%	40.0%
Combination 2	77.83%	73.24%	75.67%	73.48%	70.32%	76.89%	69.10%	76.6%
Combination 3	74.94%	68.61%	71.29%	69.34%	66.67%	72.99%	65.21%	71.0%
Combination 4	38.31%	35.77%	35.04%	34.06%	35.77%	38.44%	33.82%	29.5%
Combination 5	56.14%	51.09%	50.85%	40.39%	51.82%	59.12%	46.96%	42.0%
Combination 6	46.51%	35.28%	14.84%	40.15%	30.17%	43.07%	16.79%	32.9%
Combination 7	28.67%	28.22%	26.52%	20.92%	30.66%	30.90%	26.52%	19.7%
Combination 8	26.51%	20.68%	8.76%	20.92%	16.30%	24.57%	10.71%	16.0%
Combination 9	37.83%	29.68%	12.41%	24.33%	27.25%	37.47%	11.68%	21.1%
Combination 10	21.69%	18.00%	7.06%	13.14%	16.06%	21.17%	7.79%	11.7%

Table 2-5a. HEDIS 2011 Plan-Specific Rates: Effectiveness of Care Measures								
Measure	Amerigroup	BlueCare		TennCare *Select*	UnitedHealthcare			HEDIS 2010 National Medicaid 50th Percentile
		-East	-West		-East	-Middle	-West	
Immunizations for Adolescents (IMA):								
Meningococcal	48.91%	50.42%	40.20%	46.80%	49.88%	54.99%	41.12%	46.7%
Tdap/Td	53.69%	58.65%	46.11%	51.83%	57.66%	61.56%	42.82%	60.8%
Combination 1	44.26%	45.79%	35.26%	42.31%	46.23%	51.82%	35.77%	42.4%
Lead Screening in Children (LSC)	74.94%	65.86%	71.72%	64.15%	68.86%	74.70%	70.07%	71.6%
Breast Cancer Screening (BCS)	42.71%	48.78%	45.19%	24.81%	41.01%	44.21%	35.31%	52.0%
Cervical Cancer Screening (CCS)	70.66%	66.05%	71.04%	37.97%	67.90%	67.92%	59.71%	67.8%
Chlamydia Screening in Women (CHL):								
16-20 year-old women	50.99%	49.33%	63.29%	50.79%	45.98%	52.79%	60.77%	53.0%
21-24 year-old women	58.74%	56.42%	70.76%	NA	55.89%	60.23%	67.06%	62.4%
Total	**54.07%**	**52.20%**	**66.56%**	**50.77%**	**49.53%**	**56.11%**	**63.43%**	**55.7%**
Respiratory Conditions								
Appropriate Testing for Children with Pharyngitis (CWP)	75.29%	71.69%	72.01%	69.97%	70.02%	73.26%	69.23%	65.5%
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	77.10%	73.11%	74.67%	72.24%	72.42%	75.98%	77.40%	85.8%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	20.51%	19.22%	22.29%	20.65%	21.76%	22.70%	24.86%	23.5%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	25.21%	33.59%	36.59%	NA	32.24%	30.49%	NA	28.0%
Pharmacotherapy Management of COPD Exacerbation (PCE):								
Systemic corticosteroid	42.64%	45.38%	37.50%	NA	47.72%	37.82%	42.86%	63.4%
Bronchodilator	67.47%	76.23%	82.33%	NA	71.12%	74.94%	67.62%	84.1%
Use of Appropriate Medications for People with Asthma (ASM):								
5-11 years old	94.75%	96.01%	90.83%	96.27%	94.83%	93.03%	89.42%	92.2%
12-50 years old	82.38%	86.81%	80.31%	91.23%	83.45%	78.29%	79.42%	86.3%
Total	**88.64%**	**91.16%**	**85.45%**	**93.88%**	**88.83%**	**85.55%**	**84.21%**	**88.6%**
Cardiovascular Conditions								
Cholesterol Management for Patients with Cardiovascular Conditions (CMC):								
LDL-C Screening	78.27%	81.51%	80.78%	NA	78.83%	80.29%	83.94%	80.9%
LDL-C Controlled (<100 mg/dL)	40.42%	41.85%	29.20%	NA	34.79%	32.60%	30.90%	43.2%

Table 2-5a. HEDIS 2011 Plan-Specific Rates: Effectiveness of Care Measures								
Measure	**Amerigroup**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**HEDIS 2010 National Medicaid 50th Percentile**
		-East	**-West**		**-East**	**-Middle**	**-West**	
Controlling High Blood Pressure (CBP)	58.96%	56.61%	57.18%	57.23%	49.39%	48.66%	42.58%	57.1%
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)	71.67%	85.88%	64.52%	NA	61.04%	88.71%	52.17%	77.8%
Diabetes								
Comprehensive Diabetes Care (CDC):								
HbA1c Testing	83.08%	81.04%	80.03%	74.61%	77.58%	75.00%	75.26%	81.1%
HbA1c Control (<7.0%)	37.96%	42.82%	32.36%	38.46%	35.17%	30.10%	23.55%	35.5%
HbA1c Control (<8.0%)	52.09%	54.34%	40.59%	44.04%	43.15%	37.82%	32.05%	46.6%
Retinal Eye Exam Performed	28.98%	46.13%	38.95%	52.85%	34.79%	33.97%	30.38%	54.0%
LDL-C Screening	76.21%	78.20%	74.47%	63.73%	72.85%	73.21%	71.28%	75.4%
LDL-C Controlled (<100 mg/dL)	34.34%	33.65%	26.68%	32.12%	27.15%	26.92%	23.33%	33.6%
Medical Attention for Nephropathy	76.21%	75.83%	73.65%	52.33%	71.39%	69.74%	71.67%	77.7%
Blood Pressure Control (<130/80 mm Hg)	36.68%	40.28%	32.08%	45.60%	39.52%	32.69%	27.69%	32.5%
Blood Pressure Control (<140/90 mm Hg)	58.29%	59.56%	51.39%	62.18%	58.06%	52.56%	46.28%	61.6%
Musculoskeletal Conditions								
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	53.33%	64.90%	59.43%	NA	60.92%	49.39%	54.10%	71.5%
Use of Imaging Studies for Low Back Pain (LBP)	70.71%	66.98%	70.30%	70.37%	64.32%	67.11%	68.22%	76.2%
Behavioral Health								
Antidepressant Medication Management (AMM):								
Effective Acute Phase Treatment	48.63%	46.96%	44.35%	64.38%	50.41%	44.36%	48.73%	48.1%
Effective Continuation Phase Treatment	28.78%	27.39%	25.80%	36.99%	32.04%	26.16%	29.60%	31.0%
Follow-Up Care for Children Prescribed ADHD Medication (ADD):								
Initiation Phase	62.25%	40.42%	34.05%	32.55%	40.84%	33.36%	30.97%	35.7%
Continuation and Maintenance Phase	70.78%	44.57%	45.24%	40.07%	46.69%	41.75%	41.28%	42.1%
Follow-Up After Hospitalization for Mental Illness (FUH):								
7-day follow-up	51.80%	37.75%	23.02%	34.07%	48.09%	53.91%	42.13%	43.5%
30-day follow-up	71.77%	66.01%	50.63%	56.86%	68.52%	74.18%	63.46%	62.6%

Table 2-5a. HEDIS 2011 Plan-Specific Rates: Effectiveness of Care Measures								
Measure	Amerigroup	BlueCare		TennCare *Select*	UnitedHealthcare			HEDIS 2010 National Medicaid 50th Percentile
		-East	-West		-East	-Middle	-West	
Medication Management								
Annual Monitoring for Patients on Persistent Medications (MPM):								
ACE Inhibitors or ARBs	88.00%	90.28%	91.25%	84.09%	90.60%	88.79%	89.21%	86.3%
Digoxin	88.04%	95.50%	94.06%	NA	91.30%	86.49%	90.10%	90.0%
Diuretics	88.56%	91.05%	89.89%	87.06%	90.75%	90.70%	88.01%	86.1%
Anticonvulsants	71.95%	78.46%	74.17%	74.58%	76.59%	75.11%	73.77%	68.6%
Total	**86.30%**	**89.07%**	**88.67%**	**78.16%**	**88.99%**	**87.76%**	**86.63%**	**84.3%**
Measures Collected Through CAHPS Health Plan Survey								
Medical Assistance with Smoking and Tobacco Use Cessation (MSC):								
Advising Smokers and Tobacco Users to Quit*	78.45%	78.92%	69.41%	61.11%	72.48%	75.52%	66.41%	
Discussing Cessation Medications*	40.63%	40.40%	33.33%	37.65%	39.80%	38.68%	36.43%	
Discussing Cessation Strategies*	32.75%	40.92%	40.27%	37.27%	30.90%	33.33%	31.15%	

**The three MSC rates were not included in Quality Compass in 2010 because the measure was revised; a rolling average was used for the measure's rates; therefore, two years of data is needed (rates will be calculated in 2011).*

For the Effectiveness of Care Measure – Comprehensive Diabetes Care: HbA1c Poor Control (> 9.0%) presented in **Table 2-5b**, 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 2-5b. HEDIS 2011 Plan-Specific Rates: Effectiveness of Care Measure Where Lower Rates Indicate Better Performance								
Measure	Amerigroup	BlueCare		TennCare *Select*	UnitedHealthcare			HEDIS 2010 National Medicaid 50th Percentile
		-East	-West		East	Middle	West	
Comprehensive Diabetes Care (CDC):								
HbA1c Poor Control (>9.0%)	39.03%	37.76%	51.72%	48.70%	51.15%	54.23%	60.51%	43.2%

Table 2-6a. HEDIS 2011 Plan-Specific Rates: Access/Availability of Care Measures								
Measure	**Amerigroup**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**HEDIS 2010 National Medicaid 50th Percentile**
		-East	**-West**		**East**	**Middle**	**West**	
Adults' Access to Preventive/Ambulatory Health Services (AAP):								
20-44 year-olds	80.85%	84.58%	79.91%	66.50%	78.32%	83.22%	73.12%	82.9%
45-64 year-olds	84.48%	90.96%	85.02%	51.30%	83.46%	88.98%	78.47%	88.1%
Children and Adolescents' Access to Primary Care Practitioners (CAP):								
12-24 months	97.42%	98.00%	97.21%	94.11%	96.87%	97.63%	95.12%	96.8%
25 months-6 years	90.52%	91.85%	89.71%	91.09%	88.01%	91.01%	86.88%	89.8%
7-11 years	92.19%	93.97%	94.05%	93.01%	90.66%	92.99%	91.41%	91.3%
12-19 years	90.62%	92.13%	87.54%	86.57%	87.99%	89.68%	83.04%	88.9%
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET):								
Initiation of AOD Treatment: 13-17 years	48.86%	59.56%	64.58%	66.00%	68.31%	73.67%	64.37%	41.4%
18 + years	35.64%	46.54%	40.09%	56.05%	64.57%	72.09%	60.51%	43.9%
Total	**36.37%**	**47.53%**	**41.47%**	**61.05%**	**64.82%**	**72.17%**	**60.72%**	**43.9%**
Engagement of AOD Treatment: 13-17 years	37.88%	38.26%	25.52%	36.00%	44.72%	46.98%	23.56%	13.9%
18 + years	15.96%	13.17%	8.04%	21.30%	18.12%	19.52%	10.66%	8.5%
Total	**17.16%**	**15.07%**	**9.03%**	**28.68%**	**19.89%**	**20.92%**	**11.35%**	**10.2%**
Prenatal and Postpartum Care (PPC):								
Timeliness of Prenatal Care	86.01%	95.13%	80.29%	70.83%	83.42%	81.41%	65.21%	86.0%
Postpartum Care	57.51%	75.18%	62.04%	51.04%	57.65%	63.32%	51.34%	65.5%
Call Answer Timeliness (CAT)	93.68%	95.73%	94.65%	94.88%	87.98%	87.98%	87.98%	83.0%

For the Access/Availability of Care Measure – Call Abandonment (CAB) presented in **Table 2-6b**, 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 2-6b. HEDIS 2011 Plan-Specific Rates: Access/Availability of Care Measure Where Lower Rates Indicate Better Performance								
Measure	**Amerigroup**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**HEDIS 2010 National Medicaid 50th Percentile**
		-East	**-West**		**East**	**Middle**	**West**	
Call Abandonment (CAB)	0.49%	0.47%	0.67%	0.46%	1.03%	1.03%	1.03%	2.6%

Table 2-7. HEDIS 2011 Plan-Specific Rates: Use of Services Measures								
Measure	Amerigroup	BlueCare		TennCare *Select*	UnitedHealthcare			HEDIS 2010 National Medicaid 50th Percentile
		-East	-West		East	Middle	West	
Frequency of Ongoing Prenatal Care (FPC):								
≥ 81 percent	63.10%	81.51%	57.91%	44.76%	50.00%	NR	38.20%	64.2%
Well-Child Visits in the First 15 Months of Life (W15):								
6 or More Visits	62.83%	57.97%	39.48%	34.33%	61.30%	67.45%	46.47%	60.1%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	72.02%	70.91%	74.67%	71.51%	71.28%	70.47%	71.49%	71.8%
Adolescent Well-Care Visits (AWC)	47.69%	46.23%	48.66%	47.20%	44.28%	43.80%	45.26%	46.8%

Tables 2-9 through **2-11** display the plan-specific performance rates for the CAHPS survey results. **Table 2-8** details the color-coding and the MCO rating scale, as well as any additional comments, used in **Tables 2-9** through **2-11** 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 2010 National Medicaid Benchmarking data were obtained from AHRQ' website: **www.cahps.ahrq.gov**.

Table 2-8. MCO 2011 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 2-9. 2011 CAHPS 4.0H Adult Medicaid Survey Results								
Amerigroup	BlueCare		TennCare *Select*	UnitedHealthcare			Statewide Average	2010 National Medicaid CAHPS Benchmarking
	-East	-West		-East	-Middle	-West		
1. Getting Needed Care (Always + Usually)								
79.22%	78.97%	78.55%	82.04%	74.50%	76.25%	74.78%	77.76%	76%
2. Customer Service (Always + Usually)								
NA	NA	NA	NA	NA	NA	NA	NA	79%
3. Getting Care Quickly (Always + Usually)								
83.25%	84.12%	82.67%	83.92%	79.07%	81.64%	77.99%	81.81%	79%
4. How Well Doctors Communicate (Always + Usually)								
86.90%	86.44%	86.25%	91.09%	85.46%	84.62%	86.57%	86.76%	88%
5. Shared Decision Making (Definitely Yes)								
54.07%	53.84%	57.31%	59.52%	60.17%	56.44%	52.33%	56.24%	
6. Rating of Personal Doctor (9+10)								
57.82%	63.52%	64.17%	64.47%	59.59%	60.00%	57.58%	61.02%	84%
7. Rating of Specialist Seen Most Often (9+10)								
68.91%	61.50%	58.20%	68.42%	58.58%	64.46%	57.28%	62.48%	84%
8. Rating of All Health Care (9+10)								
51.41%	48.03%	48.93%	50.53%	45.53%	44.88%	46.10%	47.92%	78%
9. Rating of Health Plan (9+10)								
51.71%	61.49%	58.14%	61.63%	52.38%	53.69%	58.52%	56.79%	80%

In **Tables 2-10** and **2-11** the National Medicaid CAHPS Benchmarking data for the 4.0H 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 2-10. 2011 CAHPS 4.0H Child Medicaid Survey Results (General Population)								
Amerigroup	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**Statewide Average**	**2010 National Medicaid CAHPS Benchmarking**
	-East	**-West**		**-East**	**-Middle**	**-West**		
1. Getting Needed Care (Always + Usually)								
85.03%	84.44%	NA	85.71%	87.37%	86.88%	NA	85.89%	77%
2. Customer Service (Always + Usually)								
NA	NA	NA	NA	NA	NA	NA	NA	79%
3. Getting Care Quickly (Always + Usually)								
90.69%	92.75%	87.69%	91.94%	91.08%	89.44%	84.91%	89.79%	86%
4. How Well Doctors Communicate (Always + Usually)								
91.81%	92.67%	91.91%	92.10%	91.50%	94.15%	90.51%	92.09%	91%
5.Shared Decision Making (Definitely Yes)								
68.78%	66.13%	69.69%	71.84%	62.60%	65.61%	57.78%	66.06%	
6. Rating of Personal Doctor (9+10)								
72.81%	72.54%	70.90%	66.94%	66.67%	74.09%	67.02%	70.14%	92%
7. Rating of Specialist Seen Most Often (9+10)								
NA	70.00%	NA	72.16%	73.33%	NA	NA	71.83%	89%
8. Rating of All Health Care (9+10)								
69.36%	67.11%	62.07%	62.69%	61.59%	68.25%	62.12%	64.74%	89%
9. Rating of Health Plan (9+10)								
70.82%	74.04%	72.31%	67.53%	65.05%	73.74%	62.66%	69.45%	89%

Table 2-11. 2011 CAHPS 4.0H Child Medicaid Survey Results (Children with Chronic Conditions)								
Amerigroup	BlueCare		TennCare *Select*	UnitedHealthcare			Statewide Average	2010 National Medicaid CAHPS Benchmarking
	-East	-West		-East	-Middle	-West		
1. Getting Needed Care (Always + Usually)								
85.44%	86.78%	81.22%	85.21%	84.59%	82.44%	81.74%	83.92%	77%
2. Customer Service (Always + Usually)								
NA	NA	NA	80.25%	NA	NA	NA	80.25%	79%
3. Getting Care Quickly (Always + Usually)								
91.77%	94.46%	90.46%	91.44%	92.14%	91.17%	89.99%	91.63%	86%
4. How Well Doctors Communicate (Always + Usually)								
91.66%	93.11%	93.52%	92.63%	92.47%	93.35%	91.37%	92.59%	91%
5.Shared Decision Making (Definitely Yes)								
68.01%	68.06%	71.04%	74.08%	63.47%	65.39%	61.78%	67.40%	
6. Rating of Personal Doctor (9+10)								
74.68%	72.63%	73.81%	67.50%	67.14%	74.85%	68.18%	71.26%	92%
7. Rating of Specialist Seen Most Often (9+10)								
69.01%	72.95%	71.13%	69.55%	69.53%	66.85%	64.54%	69.08%	89%
8. Rating of All Health Care (9+10)								
63.73%	65.57%	64.11%	61.46%	58.45%	59.88%	59.00%	61.74%	89%
9. Rating of Health Plan (9+10)								
65.49%	72.00%	71.28%	66.83%	61.05%	66.55%	59.91%	66.16%	89%
10. Access to Prescription Medicines (Always + Usually)								
93.96%	93.12%	91.72	90.17%	92.15%	91.79%	91.58%	92.07%	
11. Access to Specialized Services (Always + Usually)								
NA	NA	NA	76.15%	76.96%	74.58%	NA	75.90%	
12. Family-Centered Care: Getting Needed Information (Always + Usually)								
87.27%	90.63%	89.12%	88.86%	91.70%	91.45%	87.64%	89.52%	
13. Family-Centered Care: Personal Doctor or Nurse Who Knows Child (Yes)								
89.17%	87.29%	90.65%	90.50%	87.87%	89.03%	86.81%	88.76%	
14. Family-Centered Care: Coordination of Care (Yes)								
81.63%	81.90%	NA	82.20%	80.21%	78.35%	NA	80.86%	

APPENDICES

APPENDIX A | *2011 HEDIS Additional Measures, Rates and Benchmarks*

Use of Services 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
- ED Visits

Inpatient Utilization – General Hospital/Acute Care (IPU)

This measure summarizes utilization of acute inpatient 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 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

Use of Services Measures: Plan-Specific Rates / National Benchmarks

In **Table A1**, cells are shaded gray for those measures where age and/or sex segregation data were not available and 'NA' is a representation of Not Applicable.

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures

Measure by Age / as Stated	Sex	Ameri group	BlueCare -East	BlueCare -West	TennCare *Select*	UnitedHealthcare -East	UnitedHealthcare -Middle	UnitedHealthcare -West	National Medicaid HEDIS 2010 Means and Percentiles Mean	P10	P25	P50	P75	P90
Frequency of Ongoing Prenatal Care (FPC):														
<21%	NA	5.85%	1.46%	4.14%	9.09%	12.76%	NR	12.90%	10.3%	2.2%	3.4%	7.0%	13.9%	22.2%
21-40%	NA	7.38%	2.68%	6.08%	10.14%	15.31%	NR	12.17%	6.3%	2.1%	2.8%	4.6%	7.9%	13.4%
41-60%	NA	8.40%	4.87%	9.00%	17.13%	9.18%	NR	17.27%	8.0%	3.4%	5.3%	7.2%	10.2%	13.6%
61-80%	NA	15.27%	9.49%	22.87%	18.88%	12.76%	NR	19.46%	13.9%	7.5%	10.1%	13.5%	17.5%	19.9%
81+%	NA	63.10%	81.51%	57.91%	44.76%	50.00%	NR	38.20%	61.6%	31.5%	52.1%	64.2%	73.7%	82.2%
Well-Child Visits in the First 15 Months of Life (W15):														
0 Visits	NA	0.79%	1.11%	1.53%	8.32%	1.69%	0.52%	3.16%	2.3%	0.5%	0.7%	1.4%	2.9%	5.1%
1 Visits	NA	1.31%	2.11%	3.35%	4.81%	2.82%	2.60%	5.60%	2.1%	0.5%	1.0%	1.6%	3.0%	4.4%
2 Visits	NA	2.36%	3.61%	6.38%	6.11%	5.93%	1.82%	8.03%	3.4%	1.2%	2.1%	2.8%	4.6%	5.9%
3 Visits	NA	5.76%	6.07%	10.81%	8.58%	7.63%	5.99%	11.68%	5.7%	2.1%	3.7%	5.4%	7.4%	9.5%
4 Visits	NA	9.42%	11.10%	16.67%	17.43%	9.60%	8.59%	12.65%	10.7%	5.7%	7.5%	10.3%	12.7%	15.3%
5 Visits	NA	17.54%	18.03%	21.78%	20.42%	11.02%	13.02%	12.41%	16.4%	10.4%	13.4%	16.5%	18.9%	22.2%
6 or More Visits	NA	62.83%	57.97%	39.48%	34.33%	61.30%	67.45%	46.47%	59.4%	40.9%	52.2%	60.1%	69.7%	76.3%
Frequency of Selected Procedures (FSP)														
Bariatric weight loss surgery:														
0-19	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
20-44		0.03	0.02	0.01	0.00	0.07	0.03	0.01						
45-64		0.04	0.03	0.02	0.00	0.07	0.04	0.01						
Tonsillectomy - *Procedures /1,000 Member Months:*														
0-9	M&F	0.97	1.50	0.70	1.42	1.47	1.08	0.71	0.7	0.3	0.5	0.7	0.9	1.1
10-19		0.49	0.65	0.35	0.41	0.75	0.57	0.37	0.4	0.1	0.2	0.4	0.5	0.6
Hysterectomy – Abdominal (A) and Vaginal (V) - *Procedures /1,000 Member Months:*														
A 15-44	F	0.28	0.28	0.24	0.03	0.23	0.36	0.17	0.3	0.1	0.2	0.3	0.3	0.4
A 45-64		0.45	0.27	0.45	0.00	0.33	0.38	0.43	0.6	0.2	0.4	0.5	0.7	0.9
V 15-44	F	0.26	0.49	0.08	0.01	0.40	0.34	0.10	0.2	0.0	0.1	0.1	0.2	0.3
V 45-64		0.29	0.34	0.17	0.00	0.38	0.28	0.11	0.2	0.0	0.1	0.2	0.3	0.5

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures														
Measure by Age / as Stated	Sex	Ameri group	BlueCare		TennCare *Select*	UnitedHealthcare			National Medicaid HEDIS 2010 Means and Percentiles					
			-East	-West		-East	-Middle	-West	Mean	P10	P25	P50	P75	P90
Cholecystectomy – Open (O) and Closed / Laparoscopic (C) - *Procedures /1,000 Member Months:*														
O 30-64	M	0.06	0.07	0.04	0.48	0.03	0.08	0.03	0.0	0.0	0.0	0.0	0.1	0.1
O 15-44	F	0.01	0.02	0.02	0.08	0.02	0.02	0.02	0.0	0.0	0.0	0.0	0.0	0.0
O 45-64		0.07	0.05	0.12	0.60	0.02	0.09	0.08	0.1	0.0	0.0	0.0	0.1	0.2
C 30-64	M	0.48	0.58	0.30	2.42	0.60	0.55	0.25	0.3	0.1	0.2	0.3	0.4	0.5
C 15-44	F	0.97	1.21	0.67	1.28	1.23	1.09	0.64	0.8	0.4	0.6	0.8	1.0	1.2
C 45-64		0.83	1.03	0.71	3.01	0.97	1.09	0.72	0.8	0.3	0.5	0.7	0.9	1.2
Back Surgery - *Procedures /1,000 Member Months*:														
20-44	M	0.45	0.46	0.33	0.60	0.52	0.67	0.24	0.3	0.0	0.2	0.3	0.5	0.6
	F	0.34	0.30	0.16	0.08	0.33	0.48	0.13	0.2	0.0	0.1	0.2	0.3	0.4
45-64	M	0.88	0.75	0.50	0.45	0.91	1.08	0.42	0.6	0.1	0.4	0.6	0.9	1.1
	F	0.91	0.70	0.52	0.30	0.71	1.00	0.24	0.6	0.1	0.3	0.6	0.8	1.0
Mastectomy - *Procedures /1,000 Member Months*:														
15-44	F	0.03	0.04	0.04	0.00	0.03	0.02	0.01	0.0	0.0	0.0	0.0	0.0	0.0
45-64		0.21	0.51	0.67	0.00	0.26	0.46	0.19	0.2	0.0	0.1	0.1	0.2	0.3
Lumpectomy - *Procedures /1,000 Member Months*:														
15-44	F	0.18	0.24	0.24	0.07	0.21	0.25	0.14	0.2	0.1	0.1	0.2	0.2	0.3
45-64		0.81	0.97	1.25	0.30	0.47	1.05	0.33	0.5	0.0	0.3	0.5	0.6	0.8
Ambulatory Care: Total (AMB)														
Outpatient Visits - *Visits/1,000 Member Months*:														
<1	NA	788.18	839.75	707.18	941.09	795.64	807.61	658.49	718.3	486.6	641.4	743.2	822.5	885.9
1-9	NA	309.42	349.47	294.81	451.87	286.07	315.55	255.01	312.7	206.2	269.2	311.6	351.0	394.7
10-19	NA	247.59	298.87	235.47	302.68	230.47	238.19	178.74	243.1	159.8	210.5	241.7	283.6	316.7
20-44	NA	395.70	476.84	390.30	261.45	369.98	472.52	315.55	432.9	252.1	376.0	428.8	496.7	571.3
45-64	NA	660.19	811.55	695.02	311.96	599.72	806.43	512.28	606.7	374.6	516.4	625.6	710.6	805.2
65-74	NA	522.03	616.37	498.09	261.29	268.51	206.24	220.30	880.3	157.0	315.6	534.2	720.2	865.8
75-84	NA	231.62	300.23	239.11	17.24	47.72	51.45	39.20	541.0	23.5	250.0	480.5	611.1	826.4
85+	NA	64.39	175.09	153.10	0.00	29.68	21.49	9.62	441.8	23.9	254.0	395.4	546.5	751.2
Unknown	NA													
Total	**NA**	**363.03**	**433.58**	**347.58**	**367.59**	**338.11**	**388.49**	**283.41**	**367.2**	**248.7**	**317.6**	**365.9**	**416.7**	**470.5**

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures														
Measure by Age / as Stated	Sex	Ameri group	BlueCare		TennCare *Select*	UnitedHealthcare			National Medicaid HEDIS 2010 Means and Percentiles					
			-East	-West		-East	-Middle	-West	Mean	P10	P25	P50	P75	P90
ED Visits - *Visits/1,000 Member Months*:														
<1	NA	88.52	121.01	120.02	110.63	119.04	92.30	111.96	98.3	70.6	87.2	99.3	110.2	127.2
1-9	NA	48.08	69.86	55.02	64.83	65.15	51.01	50.67	56.3	41.9	50.2	56.6	62.3	71.3
10-19	NA	49.23	70.17	43.88	59.12	67.14	53.48	41.47	46.9	31.8	39.6	46.2	54.0	62.0
20-44	NA	109.10	141.31	104.23	94.18	137.46	124.24	97.99	105.2	68.8	81.7	107.7	126.6	144.5
45-64	NA	83.79	116.26	96.00	68.82	96.18	100.46	85.40	79.6	46.1	60.1	82.9	101.0	113.2
65-74	NA	40.03	68.72	57.31	103.23	38.32	19.10	28.34	57.5	0.0	20.3	35.2	51.1	80.0
75-84	NA	20.64	25.29	31.22	68.97	5.14	5.23	2.98	37.2	0.0	9.2	23.1	40.5	57.0
85+	NA	7.15	11.75	12.09	0.00	3.84	1.66	1.43	25.5	0.0	0.0	21.9	37.1	62.1
Unknown	NA													
Total	**NA**	**68.46**	**95.88**	**70.42**	**64.41**	**88.42**	**75.10**	**65.08**	**67.4**	**48.3**	**58.5**	**67.7**	**77.2**	**84.7**
Inpatient Utilization—General Hospital/Acute Care: Total (IPU)														
Total Inpatient														
Discharges - *Discharges/1,000 Member Months*:														
<1	NA	11.02	12.27	9.63	37.27	9.03	9.49	8.34	11.6	6.0	8.1	10.3	12.6	15.0
1-9	NA	1.41	3.60	2.14	9.59	1.42	1.42	1.27	2.6	1.3	1.7	2.1	2.6	3.1
10-19	NA	3.27	6.52	4.17	7.06	3.46	3.64	3.28	4.4	2.6	3.1	3.9	4.8	5.8
20-44	NA	15.56	21.14	16.81	67.95	14.80	18.29	15.32	22.9	13.2	15.3	19.3	26.9	36.6
45-64	NA	28.48	34.01	27.78	52.93	25.85	26.74	25.68	21.4	8.3	12.9	20.1	27.8	33.0
65-74	NA	22.84	40.02	32.21	177.42	17.48	9.90	15.53	23.7	0.0	6.0	15.3	23.0	32.8
75-84	NA	6.55	16.86	21.36	275.86	4.22	4.84	3.58	23.6	0.0	4.4	18.2	27.4	35.5
85+	NA	4.77	17.63	20.15	441.18	2.41	4.08	1.17	29.7	0.0	0.0	20.1	39.0	62.5
Unknown	NA													
Total	**NA**	**7.89**	**12.33**	**8.59**	**12.73**	**7.94**	**8.50**	**7.60**	**8.9**	**6.3**	**7.1**	**8.6**	**9.9**	**11.8**
Days - *Days/1,000 Member Months*:														
<1	NA	72.90	43.35	58.28	599.35	56.91	48.93	64.20	73.6	24.1	34.0	50.3	68.3	97.6
1-9	NA	4.64	7.63	6.01	61.25	5.03	4.44	4.35	13.7	3.7	4.6	6.2	8.2	10.8
10-19	NA	9.98	14.88	10.44	43.05	12.33	11.27	10.71	17.4	7.5	9.5	12.0	14.8	18.2
20-44	NA	50.36	74.74	68.63	256.01	53.64	58.88	54.24	71.7	42.3	50.0	62.4	84.7	111.9
45-64	NA	152.24	391.15	293.41	593.39	157.29	131.59	166.55	114.9	33.2	59.4	103.5	144.7	177.3
65-74	NA	162.28	640.54	400.38	1,061.29	91.00	69.33	104.71	127.8	0.0	16.5	82.0	137.3	183.3
75-84	NA	15.61	1,243.09	792.11	3,431.03	23.45	20.14	29.81	128.3	0.0	15.2	91.0	153.8	258.7
85+	NA	23.85	3,641.21	1,087.03	1,882.35	13.14	25.10	6.11	165.6	0.0	0.0	102.8	187.5	340.7
Unknown	NA													
Total	**NA**	**31.44**	**68.85**	**45.78**	**81.02**	**35.43**	**31.38**	**33.81**	**37.5**	**20.4**	**25.1**	**31.4**	**37.5**	**47.0**

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2010 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
Average Length of Stay - *Average # of Days:*														
<1	NA	6.62	3.53	6.06	16.08	6.31	5.15	7.70	5.2	3.2	3.8	4.6	6.0	7.7
1-9	NA	3.29	2.12	2.81	6.38	3.56	3.13	3.43	3.5	2.4	2.6	3.0	3.5	4.0
10-19	NA	3.05	2.28	2.51	6.10	3.57	3.09	3.27	3.3	2.5	2.8	3.0	3.3	3.7
20-44	NA	3.24	3.54	4.08	3.77	3.62	3.22	3.54	3.2	2.6	2.8	3.1	3.5	3.9
45-64	NA	5.35	11.50	10.56	11.21	6.08	4.92	6.49	5.0	3.6	4.4	4.9	5.6	6.0
65-74	NA	7.11	16.00	12.43	5.98	5.21	7.00	6.74	5.5	3.0	4.1	5.2	6.7	7.5
75-84	NA	2.38	73.72	37.08	12.44	5.56	4.16	8.33	5.9	2.8	4.1	5.6	6.7	8.4
85+	NA	5.00	206.58	53.96	4.27	5.44	6.14	5.22	5.9	2.5	3.9	5.5	6.5	8.7
Unknown	NA	NA	15.00	3.67	NA	NA	NA	NA	2.8	1.0	2.0	3.0	4.0	4.0
Total	**NA**	**3.99**	**5.59**	**5.33**	**6.37**	**4.46**	**3.69**	**4.45**	**3.9**	**2.8**	**3.2**	**3.7**	**4.0**	**4.5**
Medicine														
Discharges - *Discharges/1,000 Member Months*:														
<1	NA	9.18	11.25	8.73	29.08	7.34	7.79	6.16	9.8	5.2	6.5	8.6	10.7	13.0
1-9	NA	1.10	3.37	1.88	7.69	1.05	1.07	0.93	2.1	1.0	1.2	1.8	2.2	2.6
10-19	NA	0.81	3.57	1.60	4.55	0.72	0.73	0.55	1.4	0.6	0.8	1.0	1.4	1.9
20-44	NA	4.01	9.34	5.49	14.82	4.09	3.91	3.62	4.7	2.1	2.8	3.8	5.0	7.7
45-64	NA	19.74	28.08	22.07	36.67	17.43	17.28	16.97	13.8	4.9	7.7	12.2	19.0	23.3
65-74	NA	18.00	34.74	24.84	125.81	12.73	6.97	10.09	17.3	0.0	0.0	10.1	16.3	24.6
75-84	NA	6.55	15.93	17.26	172.41	3.50	4.20	2.53	17.5	0.0	0.0	13.7	18.0	26.1
85+	NA	3.18	17.23	19.34	382.35	2.06	3.43	0.91	22.9	0.0	0.0	15.4	29.5	53.2
Unknown	NA													
Total	**NA**	**3.46**	**7.64**	**4.38**	**7.25**	**3.50**	**3.17**	**2.94**	**3.8**	**1.7**	**2.5**	**3.4**	**4.2**	**6.0**
Days - *Days/1,000 Member Months*:														
<1	NA	47.49	35.31	47.82	451.87	34.01	32.31	27.29	47.1	17.6	22.4	31.0	42.6	57.7
1-9	NA	2.79	6.36	4.43	38.01	2.92	2.67	2.44	8.8	2.3	2.9	4.4	5.5	7.9
10-19	NA	2.39	6.37	3.40	30.11	3.65	2.73	2.43	7.9	1.7	2.1	2.9	4.4	6.2
20-44	NA	14.13	38.91	32.06	73.89	16.43	13.71	14.79	16.8	6.3	9.2	13.9	18.2	27.4
45-64	NA	79.68	345.13	244.35	418.89	84.99	69.36	79.81	57.8	14.6	27.1	49.9	78.3	101.9
65-74	NA	111.50	558.22	323.69	622.58	60.67	38.51	59.24	76.4	0.0	0.0	42.4	71.0	106.9
75-84	NA	15.61	1,230.44	726.38	1,189.66	18.10	16.20	15.65	76.8	0.0	0.0	52.8	84.6	140.6
85+	NA	13.51	3,636.90	1,078.16	1,441.18	11.27	14.92	3.38	113.1	0.0	0.0	61.4	125.5	273.9
Unknown	NA													
Total	**NA**	**13.21**	**51.77**	**29.91**	**49.60**	**15.40**	**11.72**	**12.54**	**17.3**	**4.9**	**8.5**	**12.7**	**15.9**	**23.3**

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures													
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2010 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
Average Length of Stay - *Average # of Days:*														
<1	NA	5.18	3.14	5.48	15.54	4.64	4.15	4.43	4.0	2.7	3.2	3.7	4.4	5.1
1-9	NA	2.53	1.89	2.36	4.94	2.77	2.50	2.63	3.0	2.1	2.3	2.5	2.9	3.2
10-19	NA	2.97	1.78	2.13	6.62	5.07	3.72	4.39	3.3	2.3	2.6	3.0	3.3	3.6
20-44	NA	3.52	4.17	5.84	4.98	4.02	3.51	4.09	3.5	2.8	3.1	3.5	3.9	4.3
45-64	NA	4.04	12.29	11.07	11.42	4.88	4.01	4.70	4.0	2.9	3.5	4.0	4.4	4.8
65-74	NA	6.19	16.07	13.03	4.95	4.76	5.52	5.87	4.4	2.7	3.5	4.2	5.0	6.2
75-84	NA	2.38	77.26	42.10	6.90	5.18	3.86	6.18	4.8	2.5	3.4	4.3	5.8	7.0
85+	NA	4.25	211.02	55.75	3.77	5.48	4.34	3.71	5.0	2.5	3.4	4.5	5.8	6.2
Unknown	NA	NA	15.00	3.67	NA	NA	NA	NA	2.8	2.0	2.0	2.5	3.5	4.0
Total	**NA**	**3.82**	**6.78**	**6.83**	**6.84**	**4.40**	**3.69**	**4.27**	**3.7**	**2.8**	**3.2**	**3.6**	**3.9**	**4.3**
Surgery														
Discharges - *Discharges/1,000 Member Months*:														
<1	NA	1.84	0.95	0.80	6.10	1.69	1.70	2.19	1.7	0.5	1.0	1.5	2.0	2.6
1-9	NA	0.31	0.20	0.23	1.74	0.36	0.35	0.34	0.5	0.2	0.3	0.4	0.5	0.6
10-19	NA	0.47	0.36	0.30	1.03	0.54	0.43	0.46	0.7	0.3	0.4	0.5	0.7	0.8
20-44	NA	2.17	1.50	1.26	7.11	2.36	2.50	2.07	2.4	1.4	1.9	2.3	2.7	3.2
45-64	NA	8.61	4.99	4.85	13.55	8.36	9.31	8.63	6.3	2.8	4.6	6.5	8.1	9.3
65-74	NA	4.84	4.98	6.00	38.71	4.74	2.93	5.44	6.3	0.0	0.0	5.1	7.5	9.5
75-84	NA	0.00	0.47	4.11	86.21	0.72	0.65	1.04	6.1	0.0	0.0	3.9	7.7	11.6
85+	NA	1.59	0.39	0.00	29.41	0.36	0.65	0.26	5.4	0.0	0.0	2.5	6.5	15.4
Unknown	NA													
Total	**NA**	**1.47**	**1.06**	**0.84**	**1.91**	**1.70**	**1.59**	**1.52**	**1.5**	**0.7**	**1.0**	**1.4**	**1.7**	**2.2**
Days - *Days/1,000 Member Months*:														
<1	NA	25.42	6.32	8.16	103.02	22.91	16.62	36.91	25.8	3.9	8.0	13.9	22.8	37.5
1-9	NA	1.85	1.15	1.26	18.31	2.11	1.77	1.90	4.8	0.7	1.3	1.8	2.8	4.0
10-19	NA	2.45	1.56	1.30	7.66	3.07	2.01	2.90	3.1	1.2	1.8	2.4	3.1	4.7
20-44	NA	11.85	7.77	7.77	48.73	16.29	13.51	15.85	12.4	5.3	7.8	11.5	14.7	17.7
45-64	NA	72.14	34.84	39.96	138.01	72.10	61.90	86.00	48.2	13.9	24.8	43.7	60.9	75.6
65-74	NA	50.78	44.71	61.41	335.48	30.33	30.82	45.47	50.9	0.0	0.0	30.6	58.5	84.6
75-84	NA	0.00	1.41	65.74	2,120.69	5.35	3.94	14.16	51.3	0.0	0.0	26.7	59.3	127.0
85+	NA	10.33	4.31	0.00	88.24	1.88	10.18	2.73	46.3	0.0	0.0	15.3	59.7	121.4
Unknown	NA													
Total	**NA**	**10.55**	**6.30**	**5.84**	**17.71**	**13.12**	**9.73**	**13.58**	**10.4**	**3.9**	**5.8**	**8.4**	**12.2**	**18.0**

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures													
Measure by Age / as Stated	Sex	Ameri group	BlueCare -East	BlueCare -West	TennCare *Select*	UnitedHealthcare -East	UnitedHealthcare -Middle	UnitedHealthcare -West	National Medicaid HEDIS 2010 Means and Percentiles Mean	P10	P25	P50	P75	P90
Average Length of Stay - *Average # of Days:*														
<1	NA	13.78	6.66	10.24	16.89	13.55	9.76	16.88	11.5	6.0	7.5	9.5	13.7	20.1
1-9	NA	5.98	5.63	5.54	10.50	5.82	5.01	5.61	5.6	3.0	3.8	4.8	6.1	8.3
10-19	NA	5.16	4.33	4.34	7.44	5.63	4.66	6.25	5.0	2.8	3.8	4.7	5.6	6.3
20-44	NA	5.47	5.19	6.18	6.85	6.91	5.40	7.65	5.2	3.3	4.1	5.0	5.8	7.0
45-64	NA	8.38	6.98	8.24	10.19	8.63	6.65	9.96	7.4	4.5	5.6	6.7	8.1	9.0
65-74	NA	10.50	8.97	10.23	8.67	6.39	10.51	8.35	8.2	3.0	5.6	7.4	9.7	12.6
75-84	NA	NA	3.00	16.00	24.60	7.43	6.10	13.57	8.6	4.5	5.5	7.9	10.0	12.4
85+	NA	6.50	11.00	NA	3.00	5.25	15.64	10.50	9.5	2.5	6.0	8.0	11.8	17.3
Unknown	NA	NA	NA	NA	NA	NA	NA	NA	1.0	1.0	1.0	1.0	1.0	1.0
Total	**NA**	**7.18**	**5.97**	**6.93**	**9.29**	**7.72**	**6.11**	**8.93**	**6.7**	**4.2**	**5.1**	**6.2**	**7.3**	**8.7**
Maternity (calculated using member months for members 10-64 years)														
Discharges - *Discharges/1,000 Member Months*:														
10-19	NA	1.99	2.53	2.22	1.33	2.19	2.48	2.26	2.3	0.9	1.7	2.2	2.8	3.6
20-44	NA	9.39	10.02	9.85	43.67	8.35	11.88	9.63	15.7	6.7	8.6	11.9	20.7	28.8
45-64	NA	0.13	0.11	0.12	0.18	0.07	0.14	0.08	1.2	0.0	0.0	0.1	0.2	0.3
Unknown	NA													
Total	**NA**	**4.99**	**5.51**	**5.34**	**5.15**	**4.47**	**6.48**	**5.12**	**6.4**	**2.7**	**4.3**	**6.0**	**7.7**	**11.2**
Days - *Days/1,000 Member Months*:														
10-19	NA	5.14	6.53	5.41	3.14	5.62	6.53	5.39	6.1	2.5	4.2	5.8	7.6	9.7
20-44	NA	24.38	24.93	26.35	105.38	20.91	31.67	23.59	41.6	18.2	24.0	31.5	51.7	77.7
45-64	NA	0.41	0.52	0.45	0.18	0.20	0.33	0.74	8.1	0.0	0.1	0.2	0.6	1.1
Unknown	NA													
Total	**NA**	**12.97**	**13.83**	**14.04**	**12.37**	**11.24**	**17.23**	**12.55**	**17.1**	**7.5**	**12.4**	**15.3**	**20.7**	**29.8**
Average Length of Stay - *Average # of Days:*														
10-19	NA	2.59	2.58	2.44	2.37	2.56	2.64	2.38	2.7	2.3	2.5	2.6	2.8	3.0
20-44	NA	2.60	2.49	2.68	2.41	2.50	2.66	2.45	2.7	2.3	2.5	2.7	2.9	3.1
45-64	NA	3.28	4.86	3.73	1.00	2.83	2.37	9.60	3.4	1.8	2.2	2.9	3.6	5.9
Unknown	NA	NA	NA	NA	NA	NA	NA	NA	9.0	2.7	2.7	9.0	15.3	15.3
Total	**NA**	**2.60**	**2.51**	**2.63**	**2.40**	**2.52**	**2.66**	**2.45**	**2.7**	**2.3**	**2.5**	**2.7**	**2.9**	**3.0**
Identification of Alcohol and Other Drug Services: Total (IAD)														
Any Services														
0-12	M	0.03%	0.06%	0.06%	0.22%	0.06%	0.03%	0.03%	0.1%	0.0%	0.0%	0.0%	0.1%	0.1%
	F	0.03%	0.06%	0.04%	0.19%	0.05%	0.03%	0.05%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%
	M&F	0.03%	0.06%	0.05%	0.21%	0.06%	0.03%	0.04%	0.1%	0.0%	0.0%	0.0%	0.1%	0.1%

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2010 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
13-17	M	2.47%	3.11%	1.88%	7.85%	3.18%	3.03%	1.66%	2.4%	0.7%	1.3%	1.8%	3.0%	4.2%
	F	1.31%	1.91%	0.90%	7.49%	1.82%	1.81%	0.87%	1.6%	0.5%	0.9%	1.3%	1.9%	2.5%
	M&F	1.88%	2.51%	1.38%	7.72%	2.50%	2.43%	1.26%	2.0%	0.7%	1.1%	1.5%	2.3%	3.7%
18-24	M	6.15%	5.48%	4.43%	5.44%	6.69%	7.18%	5.17%	6.4%	2.1%	3.2%	5.1%	8.2%	12.6%
	F	5.19%	6.28%	3.64%	4.60%	6.66%	6.05%	3.85%	4.5%	2.0%	2.7%	4.2%	6.0%	7.3%
	M&F	5.50%	6.03%	3.87%	5.12%	6.67%	6.42%	4.28%	5.1%	2.4%	3.0%	4.5%	6.4%	9.0%
25-34	M	11.55%	9.19%	10.14%	13.61%	12.08%	14.50%	11.70%	10.7%	4.6%	7.2%	8.6%	13.6%	19.7%
	F	9.50%	9.13%	5.75%	3.95%	9.57%	12.11%	6.14%	6.6%	2.8%	4.4%	6.0%	8.6%	10.3%
	M&F	9.94%	9.15%	6.34%	8.58%	10.17%	12.61%	6.98%	7.6%	3.6%	4.9%	6.8%	9.5%	12.7%
35-64	M	15.83%	10.79%	13.35%	14.05%	12.95%	17.76%	15.62%	13.6%	6.3%	9.2%	11.8%	16.5%	21.4%
	F	11.64%	7.21%	7.31%	7.97%	7.98%	14.08%	7.65%	8.0%	3.9%	5.4%	6.8%	9.7%	13.4%
	M&F	13.12%	8.36%	8.82%	10.40%	9.94%	15.28%	10.23%	10.1%	4.4%	6.5%	8.9%	11.4%	17.5%
65+	M	3.33%	3.23%	3.70%	14.29%	0.97%	1.79%	1.63%	4.9%	0.0%	0.0%	0.0%	3.6%	7.1%
	F	0.81%	1.11%	2.59%	5.13%	0.22%	0.33%	0.31%	6.6%	0.0%	0.0%	0.0%	1.4%	3.3%
	M&F	1.72%	1.80%	2.94%	8.96%	0.41%	0.72%	0.64%	4.6%	0.0%	0.0%	0.5%	2.1%	4.4%
Unknown	M	NA	NA	NA	NA	NA	NA	NA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**M**	**3.39%**	**3.01%**	**2.27%**	**3.67%**	**3.84%**	**3.81%**	**3.07%**	**3.5%**	**0.8%**	**1.3%**	**2.7%**	**4.1%**	**7.7%**
	F	**4.20%**	**4.01%**	**2.83%**	**3.16%**	**3.96%**	**5.17%**	**2.92%**	**3.1%**	**1.0%**	**1.6%**	**2.5%**	**4.1%**	**5.7%**
	M&F	**3.85%**	**3.60%**	**2.61%**	**3.47%**	**3.91%**	**4.60%**	**2.98%**	**3.3%**	**1.0%**	**1.6%**	**2.6%**	**4.1%**	**6.1%**
Inpatient														
0-12	M	0.01%	0.00%	0.00%	0.03%	0.00%	0.00%	0.00%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	F	0.00%	0.01%	0.01%	0.07%	0.00%	0.00%	0.01%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	M&F	0.00%	0.01%	0.01%	0.04%	0.00%	0.00%	0.01%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
13-17	M	0.49%	0.64%	0.62%	0.98%	0.55%	0.62%	0.45%	0.4%	0.1%	0.2%	0.3%	0.5%	0.8%
	F	0.26%	0.35%	0.30%	0.67%	0.40%	0.41%	0.30%	0.4%	0.1%	0.2%	0.3%	0.5%	0.7%
	M&F	0.37%	0.49%	0.46%	0.87%	0.47%	0.52%	0.37%	0.4%	0.1%	0.2%	0.3%	0.4%	0.7%
18-24	M	1.82%	1.67%	1.06%	1.62%	2.32%	2.13%	1.43%	1.7%	0.3%	0.7%	1.3%	1.9%	3.3%
	F	1.24%	2.69%	1.17%	1.66%	2.78%	1.54%	1.13%	2.0%	0.5%	0.9%	1.4%	2.3%	2.7%
	M&F	1.43%	2.37%	1.14%	1.64%	2.61%	1.73%	1.23%	1.9%	0.5%	0.9%	1.4%	2.2%	2.9%
25-34	M	2.66%	2.82%	2.42%	10.03%	4.53%	4.37%	3.76%	2.7%	0.7%	1.2%	2.6%	3.5%	5.6%
	F	2.24%	3.35%	1.57%	1.98%	3.48%	2.82%	1.73%	4.5%	0.7%	1.3%	1.9%	2.6%	3.4%
	M&F	2.33%	3.23%	1.68%	5.84%	3.73%	3.15%	2.03%	5.3%	0.7%	1.4%	2.1%	2.9%	4.0%

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures													
Measure by Age / as Stated	Sex	Amerigroup	BlueCare -East	BlueCare -West	TennCare *Select*	UnitedHealthcare -East	UnitedHealthcare -Middle	UnitedHealthcare -West	National Medicaid HEDIS 2010 Means and Percentiles Mean	P10	P25	P50	P75	P90
35-64	M	4.98%	4.16%	5.07%	9.83%	5.29%	5.04%	6.48%	519.8%	1.3%	2.4%	4.7%	6.3%	9.4%
	F	2.19%	2.50%	1.91%	2.81%	2.71%	2.52%	2.10%	19.7%	0.8%	1.2%	2.3%	3.3%	4.2%
	M&F	3.17%	3.03%	2.70%	5.62%	3.72%	3.34%	3.52%	36.0%	1.0%	1.8%	3.0%	4.4%	6.0%
65+	M	2.38%	1.94%	2.47%	7.14%	0.65%	1.39%	0.93%	1.3%	0.0%	0.0%	0.0%	1.3%	3.4%
	F	0.27%	0.47%	1.15%	5.13%	0.06%	0.22%	0.15%	0.5%	0.0%	0.0%	0.0%	0.1%	0.9%
	M&F	1.03%	0.95%	1.57%	5.97%	0.21%	0.53%	0.35%	0.7%	0.0%	0.0%	0.0%	0.6%	2.1%
Unknown	M	NA	NA	NA	NA	NA	NA	NA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**M**	**0.96%**	**0.98%**	**0.72%**	**0.75%**	**1.38%**	**1.08%**	**1.11%**	**1.2%**	**0.2%**	**0.4%**	**0.8%**	**1.5%**	**2.5%**
	F	**0.90%**	**1.46%**	**0.79%**	**0.58%**	**1.42%**	**1.11%**	**0.83%**	**1.1%**	**0.2%**	**0.5%**	**0.8%**	**1.3%**	**1.7%**
	M&F	**0.93%**	**1.26%**	**0.76%**	**0.68%**	**1.40%**	**1.09%**	**0.94%**	**1.1%**	**0.3%**	**0.5%**	**0.9%**	**1.3%**	**1.8%**
Intensive Outpatient / Partial Hospitalization														
0-12	M	0.00%	0.00%	0.01%	0.00%	0.00%	0.00%	0.01%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	F	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	M&F	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
13-17	M	0.93%	1.38%	0.39%	2.53%	1.29%	1.15%	0.27%	0.2%	0.0%	0.0%	0.0%	0.3%	0.8%
	F	0.32%	0.59%	0.14%	1.77%	0.57%	0.62%	0.10%	0.1%	0.0%	0.0%	0.0%	0.1%	0.4%
	M&F	0.62%	0.98%	0.26%	2.26%	0.93%	0.89%	0.18%	0.2%	0.0%	0.0%	0.0%	0.2%	0.6%
18-24	M	1.24%	1.07%	0.46%	0.77%	1.13%	1.64%	0.39%	0.5%	0.0%	0.0%	0.1%	0.7%	1.2%
	F	0.94%	1.41%	0.38%	0.79%	1.55%	1.35%	0.30%	0.3%	0.0%	0.0%	0.0%	0.5%	1.1%
	M&F	1.04%	1.31%	0.40%	0.78%	1.39%	1.44%	0.33%	0.4%	0.0%	0.0%	0.1%	0.6%	1.2%
25-34	M	1.69%	1.11%	0.56%	0.00%	1.79%	2.53%	1.34%	0.8%	0.0%	0.0%	0.2%	1.3%	2.1%
	F	1.39%	1.73%	0.61%	0.00%	1.81%	2.14%	0.54%	0.5%	0.0%	0.0%	0.1%	0.9%	1.6%
	M&F	1.45%	1.58%	0.60%	0.00%	1.81%	2.22%	0.66%	0.6%	0.0%	0.0%	0.1%	1.0%	1.7%
35-64	M	1.08%	0.47%	0.68%	0.00%	0.89%	1.54%	1.02%	0.8%	0.0%	0.0%	0.2%	1.1%	2.2%
	F	0.84%	0.59%	0.35%	0.23%	0.77%	1.15%	0.47%	0.6%	0.0%	0.0%	0.1%	0.8%	1.5%
	M&F	0.92%	0.55%	0.44%	0.14%	0.82%	1.28%	0.64%	0.6%	0.0%	0.0%	0.2%	0.9%	1.6%
65+	M	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	F	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	M&F	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown	M	NA	NA	NA	NA	NA	NA	NA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures													
Measure by Age / as Stated	Sex	Ameri group	BlueCare		TennCare *Select*	UnitedHealthcare			National Medicaid HEDIS 2010 Means and Percentiles					
			-East	-West		-East	-Middle	-West	Mean	P10	P25	P50	P75	P90
Total	**M**	**0.47%**	**0.45%**	**0.19%**	**0.91%**	**0.55%**	**0.62%**	**0.26%**	**0.3%**	**0.0%**	**0.0%**	**0.0%**	**0.3%**	**0.7%**
	F	**0.52%**	**0.66%**	**0.23%**	**0.63%**	**0.68%**	**0.77%**	**0.22%**	**0.2%**	**0.0%**	**0.0%**	**0.1%**	**0.4%**	**0.7%**
	M&F	**0.50%**	**0.57%**	**0.22%**	**0.80%**	**0.62%**	**0.71%**	**0.23%**	**0.2%**	**0.0%**	**0.0%**	**0.0%**	**0.4%**	**0.7%**
Outpatient / ED														
0-12	M	0.03%	0.05%	0.05%	0.19%	0.06%	0.03%	0.02%	0.1%	0.0%	0.0%	0.0%	0.1%	0.1%
	F	0.03%	0.06%	0.03%	0.12%	0.05%	0.03%	0.04%	0.1%	0.0%	0.0%	0.0%	0.1%	0.1%
	M&F	0.03%	0.05%	0.04%	0.16%	0.05%	0.03%	0.03%	0.1%	0.0%	0.0%	0.0%	0.1%	0.1%
13-17	M	1.78%	2.23%	1.33%	5.63%	2.55%	2.33%	1.16%	2.3%	0.7%	1.2%	1.6%	2.7%	4.9%
	F	0.96%	1.46%	0.60%	6.57%	1.57%	1.41%	0.57%	1.6%	0.5%	0.7%	1.2%	1.6%	3.4%
	M&F	1.37%	1.84%	0.95%	5.97%	2.06%	1.88%	0.86%	1.9%	0.6%	1.0%	1.4%	2.1%	4.0%
18-24	M	4.60%	4.13%	3.56%	3.90%	4.99%	5.46%	3.98%	5.7%	2.0%	2.7%	4.3%	7.6%	11.3%
	F	4.29%	4.24%	2.67%	3.13%	4.88%	4.80%	3.03%	4.1%	1.4%	2.0%	3.3%	4.9%	6.6%
	M&F	4.39%	4.21%	2.93%	3.61%	4.92%	5.01%	3.34%	4.6%	1.7%	2.2%	3.4%	5.8%	9.2%
25-34	M	9.67%	7.34%	8.42%	4.30%	9.59%	12.16%	9.19%	9.5%	2.9%	5.0%	7.5%	12.2%	18.7%
	F	8.01%	6.69%	4.59%	2.64%	7.46%	10.48%	4.97%	6.9%	2.1%	3.4%	4.9%	7.5%	11.2%
	M&F	8.36%	6.84%	5.11%	3.43%	7.97%	10.84%	5.61%	8.2%	2.7%	3.9%	5.8%	8.6%	13.2%
35-64	M	13.24%	8.33%	10.13%	5.27%	9.91%	14.85%	11.81%	11.5%	4.8%	6.9%	9.3%	13.7%	21.0%
	F	10.41%	5.58%	6.01%	5.16%	6.31%	12.74%	6.37%	12.1%	3.2%	4.1%	5.7%	8.6%	13.0%
	M&F	11.41%	6.46%	7.04%	5.20%	7.73%	13.43%	8.13%	19.2%	3.5%	5.4%	7.0%	10.2%	16.3%
65+	M	1.43%	1.61%	1.85%	7.14%	0.32%	0.50%	0.93%	4.2%	0.0%	0.0%	0.0%	2.0%	4.8%
	F	0.54%	0.95%	1.44%	0.00%	0.17%	0.11%	0.23%	6.6%	0.0%	0.0%	0.0%	0.8%	2.4%
	M&F	0.86%	1.17%	1.57%	2.99%	0.21%	0.21%	0.41%	4.3%	0.0%	0.0%	0.1%	1.6%	3.5%
Unknown	M	NA	NA	NA	NA	NA	NA	NA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**M**	**2.74%**	**2.31%**	**1.76%**	**2.57%**	**2.96%**	**3.10%**	**2.32%**	**3.2%**	**0.7%**	**1.0%**	**2.2%**	**4.1%**	**7.1%**
	F	**3.61%**	**2.96%**	**2.24%**	**2.55%**	**3.08%**	**4.48%**	**2.37%**	**2.7%**	**0.8%**	**1.2%**	**2.0%**	**3.7%**	**5.2%**
	M&F	**3.23%**	**2.69%**	**2.05%**	**2.56%**	**3.03%**	**3.90%**	**2.35%**	**2.9%**	**0.9%**	**1.2%**	**2.0%**	**3.8%**	**6.0%**
Mental Health Utilization: Total (MPT)														
Any Services														
0-12	M	6.69%	7.59%	5.41%	23.87%	8.30%	8.07%	5.03%	6.9%	2.2%	3.8%	6.3%	9.2%	12.7%
	F	3.96%	4.99%	3.22%	18.75%	5.28%	4.94%	2.63%	4.4%	1.3%	2.0%	3.8%	5.9%	8.2%
	M&F	5.35%	6.32%	4.32%	21.85%	6.82%	6.54%	3.84%	5.7%	1.7%	2.9%	5.0%	7.6%	10.9%

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures													
Measure by Age / as Stated	Sex	Amerigroup	BlueCare -East	BlueCare -West	TennCare *Select*	UnitedHealthcare -East	UnitedHealthcare -Middle	UnitedHealthcare -West	National Medicaid HEDIS 2010 Means and Percentiles Mean	P10	P25	P50	P75	P90
13-17	M	11.53%	13.77%	9.03%	41.89%	14.32%	14.39%	7.88%	11.8%	3.3%	6.3%	11.6%	17.0%	20.6%
	F	11.12%	12.86%	8.29%	44.60%	14.05%	13.62%	7.20%	11.5%	3.7%	6.1%	10.5%	15.9%	22.5%
	M&F	11.32%	13.31%	8.66%	42.87%	14.18%	14.01%	7.54%	11.7%	3.5%	6.6%	11.2%	16.6%	21.8%
18-64	M	11.96%	11.51%	11.29%	20.47%	16.25%	14.72%	13.99%	12.1%	2.7%	6.1%	11.6%	17.8%	21.6%
	F	14.57%	15.57%	11.30%	20.72%	19.73%	18.36%	10.78%	13.8%	3.6%	6.9%	14.0%	17.9%	26.0%
	M&F	13.78%	14.39%	11.30%	20.57%	18.53%	17.31%	11.68%	13.3%	3.4%	7.2%	13.3%	18.2%	24.6%
65+	M	11.42%	12.91%	7.40%	0.00%	17.55%	12.44%	15.85%	6.8%	0.0%	0.0%	1.8%	5.3%	9.4%
	F	15.39%	18.81%	13.51%	10.26%	16.05%	14.42%	12.39%	7.4%	0.0%	0.0%	1.8%	6.6%	12.0%
	M&F	13.95%	16.87%	11.56%	5.97%	16.43%	13.89%	13.25%	6.9%	0.0%	0.0%	2.2%	6.3%	10.1%
Unknown	M	NA	NA	NA	NA	NA	NA	NA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	F	NA	NA	NA	NA	NA	NA	NA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	M&F	NA	NA	NA	NA	NA	NA	NA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**M**	**8.80%**	**9.70%**	**7.29%**	**28.84%**	**11.75%**	**10.72%**	**7.92%**	**9.1%**	**2.7%**	**5.2%**	**8.5%**	**11.5%**	**16.7%**
	F	**9.67%**	**11.23%**	**7.74%**	**26.36%**	**13.18%**	**12.18%**	**7.19%**	**9.4%**	**2.9%**	**4.9%**	**9.2%**	**12.2%**	**18.8%**
	M&F	**9.30%**	**10.59%**	**7.56%**	**27.88%**	**12.55%**	**11.56%**	**7.49%**	**9.3%**	**2.8%**	**5.1%**	**8.8%**	**11.8%**	**17.7%**
Inpatient														
0-12	M	0.14%	0.12%	0.07%	1.07%	0.14%	0.11%	0.09%	0.3%	0.0%	0.1%	0.2%	0.3%	0.5%
	F	0.06%	0.06%	0.04%	0.45%	0.03%	0.08%	0.06%	0.1%	0.0%	0.0%	0.1%	0.1%	0.3%
	M&F	0.10%	0.09%	0.06%	0.82%	0.09%	0.10%	0.08%	0.2%	0.0%	0.1%	0.1%	0.2%	0.4%
13-17	M	0.75%	0.96%	0.77%	3.70%	0.82%	1.28%	0.99%	1.1%	0.0%	0.5%	0.9%	1.3%	1.6%
	F	0.94%	0.96%	0.82%	4.38%	1.09%	1.11%	0.90%	1.4%	0.0%	0.6%	1.1%	1.8%	2.3%
	M&F	0.85%	0.96%	0.80%	3.95%	0.96%	1.20%	0.95%	1.3%	0.0%	0.6%	1.0%	1.6%	1.9%
18-64	M	1.86%	1.77%	2.02%	2.76%	2.33%	2.02%	3.14%	1.9%	0.2%	0.8%	1.7%	2.6%	3.7%
	F	1.29%	1.59%	1.30%	2.97%	1.73%	1.51%	1.47%	1.3%	0.2%	0.8%	1.4%	1.8%	2.4%
	M&F	1.46%	1.65%	1.46%	2.84%	1.94%	1.66%	1.94%	1.5%	0.2%	0.9%	1.5%	1.9%	2.8%
65+	M	6.66%	9.68%	6.17%	0.00%	15.60%	11.25%	12.35%	1.2%	0.0%	0.0%	0.0%	0.7%	1.8%
	F	11.07%	14.55%	7.47%	10.26%	14.21%	13.33%	10.38%	0.8%	0.0%	0.0%	0.0%	0.8%	1.7%
	M&F	9.47%	12.95%	7.06%	5.97%	14.56%	12.77%	10.87%	0.9%	0.0%	0.0%	0.0%	0.7%	1.7%
Unknown	M	NA	NA	NA	NA	NA	NA	NA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	F	NA	NA	NA	NA	NA	NA	NA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	M&F	NA	NA	NA	NA	NA	NA	NA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**M**	**0.70%**	**0.76%**	**0.62%**	**2.19%**	**1.06%**	**0.91%**	**1.12%**	**0.9%**	**0.1%**	**0.4%**	**0.8%**	**1.0%**	**1.4%**
	F	**0.76%**	**1.00%**	**0.76%**	**2.04%**	**1.22%**	**1.19%**	**0.98%**	**0.8%**	**0.1%**	**0.5%**	**0.8%**	**1.1%**	**1.3%**
	M&F	**0.73%**	**0.90%**	**0.71%**	**2.13%**	**1.15%**	**1.07%**	**1.04%**	**0.9%**	**0.2%**	**0.5%**	**0.8%**	**1.0%**	**1.4%**

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures														
Measure by Age / as Stated	**Sex**	**Amerigroup**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2010 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
Intensive Outpatient / Partial Hospitalization														
0-12	M	0.00%	0.01%	0.09%	0.18%	0.23%	0.26%	0.08%	0.4%	0.0%	0.0%	0.0%	0.3%	0.9%
	F	0.00%	0.01%	0.05%	0.08%	0.11%	0.15%	0.03%	0.2%	0.0%	0.0%	0.0%	0.1%	0.5%
	M&F	0.00%	0.01%	0.07%	0.14%	0.17%	0.21%	0.06%	0.3%	0.0%	0.0%	0.0%	0.2%	0.8%
13-17	M	0.00%	0.35%	0.26%	0.92%	0.82%	0.25%	0.22%	0.7%	0.0%	0.0%	0.1%	0.6%	2.3%
	F	0.01%	0.15%	0.26%	0.72%	0.68%	0.32%	0.29%	0.7%	0.0%	0.0%	0.1%	0.7%	2.1%
	M&F	0.00%	0.25%	0.26%	0.85%	0.75%	0.28%	0.25%	0.7%	0.0%	0.0%	0.1%	0.7%	2.2%
18-64	M	0.03%	0.14%	0.04%	0.14%	0.50%	0.37%	0.78%	0.7%	0.0%	0.0%	0.1%	0.8%	2.3%
	F	0.03%	0.16%	0.14%	0.22%	0.55%	0.57%	0.44%	0.8%	0.0%	0.0%	0.2%	0.9%	2.2%
	M&F	0.03%	0.15%	0.12%	0.17%	0.53%	0.51%	0.54%	0.7%	0.0%	0.0%	0.2%	0.9%	2.2%
65+	M	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.2%	0.0%	0.0%	0.0%	0.0%	0.2%
	F	0.00%	0.16%	0.29%	0.00%	0.00%	0.00%	0.00%	0.4%	0.0%	0.0%	0.0%	0.0%	0.3%
	M&F	0.00%	0.11%	0.20%	0.00%	0.00%	0.00%	0.00%	0.3%	0.0%	0.0%	0.0%	0.0%	0.4%
Unknown	M	NA	NA	NA	NA	NA	NA	NA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	F	NA	NA	NA	NA	NA	NA	NA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	M&F	NA	NA	NA	NA	NA	NA	NA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**M**	**0.01%**	**0.10%**	**0.11%**	**0.40%**	**0.40%**	**0.28%**	**0.29%**	**0.6%**	**0.0%**	**0.0%**	**0.1%**	**0.5%**	**1.7%**
	F	**0.01%**	**0.10%**	**0.12%**	**0.28%**	**0.37%**	**0.36%**	**0.26%**	**0.6%**	**0.0%**	**0.0%**	**0.1%**	**0.5%**	**1.5%**
	M&F	**0.01%**	**0.10%**	**0.11%**	**0.36%**	**0.38%**	**0.33%**	**0.27%**	**0.6%**	**0.0%**	**0.0%**	**0.1%**	**0.5%**	**1.7%**
Outpatient / ED														
0-12	M	6.66%	7.58%	5.39%	23.72%	8.29%	8.06%	5.01%	6.9%	2.3%	3.7%	6.3%	9.1%	12.7%
	F	3.94%	4.97%	3.20%	18.64%	5.27%	4.92%	2.61%	4.3%	1.3%	2.0%	3.8%	5.8%	8.1%
	M&F	5.33%	6.30%	4.30%	21.71%	6.80%	6.52%	3.82%	5.7%	1.9%	2.8%	5.0%	7.5%	10.9%
13-17	M	11.33%	13.44%	8.76%	40.75%	14.13%	14.14%	7.46%	11.5%	3.6%	6.0%	11.3%	16.3%	20.5%
	F	10.74%	12.65%	7.90%	43.47%	13.94%	13.43%	6.81%	11.2%	3.7%	5.8%	10.1%	15.6%	22.2%
	M&F	11.03%	13.04%	8.32%	41.74%	14.03%	13.79%	7.13%	11.4%	3.7%	6.3%	10.8%	16.1%	20.9%
18-64	M	11.25%	10.64%	10.37%	19.35%	15.53%	14.11%	12.86%	11.5%	2.9%	6.0%	11.0%	15.3%	21.3%
	F	14.16%	14.95%	10.79%	19.49%	19.37%	18.05%	10.25%	13.4%	4.7%	6.8%	13.1%	17.6%	25.1%
	M&F	13.28%	13.69%	10.69%	19.41%	18.05%	16.91%	10.98%	12.9%	4.4%	7.1%	13.0%	17.3%	23.6%
65+	M	5.23%	3.23%	1.23%	0.00%	2.27%	1.69%	3.50%	5.8%	0.0%	0.0%	1.1%	4.4%	7.8%
	F	4.32%	5.06%	6.61%	0.00%	2.01%	1.31%	2.40%	6.9%	0.0%	0.0%	1.4%	5.7%	12.0%
	M&F	4.65%	4.46%	4.90%	0.00%	2.07%	1.41%	2.67%	6.2%	0.0%	0.0%	1.5%	5.0%	10.1%
Unknown	M	NA	NA	NA	NA	NA	NA	NA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	F	NA	NA	NA	NA	NA	NA	NA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	M&F	NA	NA	NA	NA	NA	NA	NA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures														
Measure by Age / as Stated	Sex	Ameri group	BlueCare -East	BlueCare -West	TennCare *Select*	UnitedHealthcare -East	UnitedHealthcare -Middle	UnitedHealthcare -West	National Medicaid HEDIS 2010 Means and Percentiles Mean	P10	P25	P50	P75	P90
Total	**M**	**8.55%**	**9.36%**	**7.02%**	**28.21%**	**11.35%**	**10.38%**	**7.46%**	**8.8%**	**2.7%**	**5.0%**	**8.2%**	**11.4%**	**16.5%**
	F	**9.39%**	**10.82%**	**7.41%**	**25.74%**	**12.71%**	**11.67%**	**6.74%**	**9.2%**	**2.9%**	**4.8%**	**8.8%**	**11.8%**	**18.4%**
	M&F	**9.03%**	**10.21%**	**7.26%**	**27.25%**	**12.12%**	**11.12%**	**7.03%**	**9.1%**	**2.7%**	**5.0%**	**8.7%**	**11.8%**	**17.6%**
Antibiotic Utilization: Total (ABX)														
Antibiotic Utilization														
Average Scripts PMPY for Antibiotics - *PMPY or Per Member Per Year:*														
0-9	M	1.36	1.73	1.36	1.83	1.48	1.45	1.13						
	F	1.36	1.80	1.36	2.01	1.53	1.51	1.12						
	M&F	1.36	1.76	1.36	1.91	1.51	1.48	1.13						
10-17	M	0.79	1.07	0.71	1.04	0.93	0.81	0.59						
	F	1.10	1.44	1.04	1.53	1.24	1.15	0.85						
	M&F	0.94	1.25	0.88	1.22	1.09	0.98	0.72						
18-34	M	0.88	1.09	0.90	1.06	0.94	0.96	0.77						
	F	1.99	2.22	2.16	1.92	1.98	2.07	1.81						
	M&F	1.69	1.92	1.88	1.39	1.66	1.77	1.55						
35-49	M	1.09	1.26	1.32	0.61	1.03	1.25	1.01						
	F	1.82	1.99	1.98	0.91	1.73	1.96	1.61						
	M&F	1.60	1.77	1.84	0.79	1.48	1.75	1.46						
50-64	M	1.25	1.32	1.39	0.54	1.05	1.36	1.08						
	F	1.74	1.92	1.84	0.92	1.54	1.87	1.41						
	M&F	1.52	1.70	1.68	0.76	1.31	1.67	1.26						
65-74	M	1.22	1.37	0.90	0.20	0.51	0.55	0.46						
	F	1.39	1.52	1.20	1.09	0.87	0.54	0.51						
	M&F	1.32	1.47	1.11	0.74	0.74	0.54	0.49						
75-84	M	0.99	0.69	1.00	0.00	0.22	0.26	0.10						
	F	1.14	0.66	0.50	0.00	0.22	0.19	0.17						
	M&F	1.09	0.67	0.69	0.00	0.22	0.21	0.15						
85+	M	0.72	0.47	0.58	0.00	0.15	0.14	0.07						
	F	0.96	0.47	0.54	0.00	0.16	0.13	0.09						
	M&F	0.90	0.47	0.55	0.00	0.16	0.13	0.09						
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 A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2010 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
Total	**M**	**1.12**	**1.40**	**1.11**	**1.33**	**1.18**	**1.19**	**0.91**	**0.9**	**0.6**	**0.8**	**1.0**	**1.1**	**1.3**
	F	**1.57**	**1.89**	**1.65**	**1.77**	**1.60**	**1.65**	**1.34**	**1.3**	**0.9**	**1.1**	**1.3**	**1.5**	**1.7**
	M&F	**1.38**	**1.68**	**1.44**	**1.50**	**1.42**	**1.45**	**1.17**	**1.1**	**0.7**	**1.0**	**1.2**	**1.3**	**1.5**
Average Days Supplied per Antibiotic Script														
0-9	M	9.16	9.11	9.30	10.34	9.05	9.24	9.27						
	F	9.33	9.38	9.41	10.93	9.26	9.42	9.34						
	M&F	9.24	9.25	9.35	10.60	9.16	9.33	9.31						
10-17	M	9.61	9.93	9.71	11.24	10.18	9.51	9.39						
	F	9.10	9.35	9.00	10.12	9.32	9.13	8.83						
	M&F	9.31	9.59	9.28	10.73	9.69	9.29	9.06						
18-34	M	9.55	9.61	9.31	12.29	9.44	9.39	9.34						
	F	8.33	8.41	7.99	9.52	8.40	8.31	7.91						
	M&F	8.50	8.60	8.13	10.83	8.58	8.47	8.09						
35-49	M	10.18	9.87	10.79	10.53	9.93	10.34	10.22						
	F	8.86	8.78	8.78	10.70	8.82	8.78	8.67						
	M&F	9.14	9.01	9.07	10.65	9.09	9.11	8.94						
50-64	M	10.76	10.20	11.16	8.97	9.85	10.42	10.29						
	F	9.11	9.10	9.30	8.64	8.96	9.33	9.20						
	M&F	9.71	9.41	9.83	8.73	9.30	9.69	9.62						
65-74	M	9.84	10.39	10.65	22.00	8.47	10.50	9.13						
	F	10.12	9.82	8.31	9.82	10.22	10.36	8.32						
	M&F	10.02	10.01	8.88	11.11	9.77	10.42	8.60						
75-84	M	7.63	7.20	9.23	NA	9.90	9.38	9.21						
	F	8.40	6.53	5.58	NA	10.42	9.45	8.13						
	M&F	8.13	6.78	7.61	NA	10.28	9.43	8.31						
85+	M	6.85	7.16	10.06	NA	9.45	7.50	6.67						
	F	8.38	8.20	8.90	NA	8.25	9.38	9.48						
	M&F	8.05	7.94	9.26	NA	8.42	9.08	9.19						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	10.00	NA	NA	NA	NA	NA						
	M&F	NA	10.00	NA	NA	NA	NA	NA						
Total	**M**	**9.43**	**9.44**	**9.54**	**10.93**	**9.44**	**9.43**	**9.43**	**9.7**	**9.2**	**9.3**	**9.6**	**10**	**10.4**
	F	**8.84**	**8.93**	**8.66**	**10.37**	**8.90**	**8.88**	**8.57**	**9.0**	**8.5**	**8.7**	**8.9**	**9.1**	**9.4**
	M&F	**9.05**	**9.11**	**8.93**	**10.67**	**9.09**	**9.07**	**8.85**	**9.2**	**8.8**	**9.0**	**9.1**	**9.4**	**9.7**

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2010 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
Average Scripts PMPY for Antibiotics of Concern - *PMPY or Per Member Per Year*:														
0-9	M	0.70	0.93	0.70	0.96	0.80	0.74	0.55						
	F	0.66	0.89	0.65	0.99	0.76	0.73	0.51						
	M&F	0.68	0.91	0.68	0.97	0.78	0.74	0.53						
10-17	M	0.38	0.52	0.34	0.47	0.44	0.41	0.28						
	F	0.50	0.65	0.47	0.66	0.57	0.53	0.37						
	M&F	0.44	0.59	0.41	0.53	0.51	0.47	0.32						
18-34	M	0.37	0.44	0.39	0.41	0.38	0.41	0.33						
	F	0.79	0.87	0.82	0.74	0.78	0.82	0.68						
	M&F	0.67	0.75	0.73	0.54	0.66	0.71	0.59						
35-49	M	0.51	0.58	0.63	0.34	0.47	0.60	0.47						
	F	0.86	0.97	0.94	0.42	0.83	0.96	0.72						
	M&F	0.75	0.85	0.87	0.39	0.70	0.86	0.66						
50-64	M	0.62	0.65	0.66	0.29	0.53	0.67	0.55						
	F	0.91	1.01	1.00	0.49	0.82	0.99	0.70						
	M&F	0.79	0.88	0.88	0.40	0.68	0.86	0.63						
65-74	M	0.55	0.69	0.42	0.10	0.30	0.32	0.19						
	F	0.73	0.79	0.62	0.89	0.43	0.24	0.30						
	M&F	0.66	0.76	0.56	0.58	0.38	0.27	0.26						
75-84	M	0.54	0.52	0.33	0.00	0.14	0.12	0.05						
	F	0.60	0.38	0.21	0.00	0.09	0.10	0.07						
	M&F	0.58	0.43	0.26	0.00	0.10	0.11	0.07						
85+	M	0.43	0.36	0.16	0.00	0.10	0.10	0.03						
	F	0.53	0.21	0.21	0.00	0.09	0.07	0.05						
	M&F	0.51	0.25	0.19	0.00	0.09	0.08	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**	**0.55**	**0.70**	**0.55**	**0.63**	**0.59**	**0.59**	**0.44**	**0.4**	**0.2**	**0.3**	**0.4**	**0.5**	**0.6**
	F	**0.70**	**0.85**	**0.72**	**0.80**	**0.73**	**0.74**	**0.56**	**0.5**	**0.3**	**0.4**	**0.5**	**0.6**	**0.7**
	M&F	**0.64**	**0.79**	**0.65**	**0.70**	**0.67**	**0.68**	**0.51**	**0.5**	**0.3**	**0.4**	**0.5**	**0.6**	**0.7**
Percentage of Antibiotics of Concern of All Antibiotic Scripts														
0-9	M	51.74%	53.61%	51.63%	52.13%	53.93%	51.11%	48.62%						
	F	48.17%	49.36%	47.72%	49.19%	49.68%	48.31%	45.83%						
	M&F	49.99%	51.49%	49.68%	50.86%	51.80%	49.71%	47.24%						

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2010 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
10-17	M	48.43%	48.82%	48.63%	44.67%	47.65%	50.18%	47.37%						
	F	45.70%	45.43%	45.30%	42.89%	45.89%	46.17%	43.20%						
	M&F	46.85%	46.88%	46.62%	43.86%	46.65%	47.87%	44.89%						
18-34	M	41.59%	40.20%	43.74%	38.78%	40.50%	42.86%	42.83%						
	F	39.52%	39.21%	38.12%	38.57%	39.32%	39.71%	37.45%						
	M&F	39.82%	39.36%	38.70%	38.67%	39.53%	40.17%	38.13%						
35-49	M	46.41%	45.96%	47.71%	55.43%	45.50%	47.92%	46.87%						
	F	47.19%	48.62%	47.28%	45.79%	47.99%	49.12%	44.98%						
	M&F	47.02%	48.05%	47.34%	48.69%	47.40%	48.87%	45.32%						
50-64	M	50.18%	49.46%	47.25%	53.42%	50.74%	49.40%	50.52%						
	F	52.61%	52.57%	54.35%	52.84%	53.09%	52.88%	49.74%						
	M&F	51.72%	51.69%	52.32%	53.01%	52.19%	51.76%	50.04%						
65-74	M	45.21%	50.38%	46.99%	50.00%	57.81%	57.83%	42.05%						
	F	52.27%	52.30%	51.56%	82.35%	48.63%	44.41%	58.58%						
	M&F	49.76%	51.67%	50.44%	78.95%	51.01%	49.82%	52.92%						
75-84	M	54.84%	75.00%	33.33%	NA	62.50%	48.42%	57.14%						
	F	52.54%	58.67%	41.94%	NA	40.77%	52.00%	42.03%						
	M&F	53.33%	64.71%	37.14%	NA	46.63%	50.74%	44.58%						
85+	M	60.00%	76.00%	27.78%	NA	68.18%	73.33%	50.00%						
	F	55.41%	45.33%	38.46%	NA	55.04%	53.46%	53.85%						
	M&F	56.38%	53.00%	35.09%	NA	56.95%	56.61%	53.45%						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	0.00%	NA	NA	NA	NA	NA						
	M&F	NA	0.00%	NA	NA	NA	NA	NA						
Total	**M**	**49.51%**	**50.27%**	**49.80%**	**47.66%**	**50.16%**	**49.68%**	**47.65%**	**43.7%**	**33.4%**	**39.5%**	**45.4%**	**48.5%**	**52.5%**
	F	**44.61%**	**45.27%**	**43.64%**	**45.06%**	**45.45%**	**45.16%**	**42.05%**	**41.0%**	**33.4%**	**37.5%**	**41.6%**	**45.5%**	**49.2%**
	M&F	**46.32%**	**47.01%**	**45.52%**	**46.47%**	**47.17%**	**46.73%**	**43.87%**	**41.1%**	**33.8%**	**37.6%**	**42.4%**	**45.8%**	**48.6%**
Antibiotics of Concern Utilization														
Average Scripts PMPY for Quinolones - *PMPY or Per Member Per Year*:														
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	0.02	0.03	0.02	0.05	0.03	0.03	0.02						
	M&F	0.02	0.02	0.02	0.03	0.02	0.02	0.01						

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2010 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
18-34	M	0.07	0.08	0.07	0.07	0.07	0.07	0.06						
	F	0.19	0.20	0.20	0.17	0.18	0.19	0.17						
	M&F	0.15	0.17	0.17	0.11	0.14	0.16	0.14						
35-49	M	0.13	0.16	0.17	0.14	0.12	0.15	0.12						
	F	0.24	0.25	0.27	0.12	0.22	0.26	0.20						
	M&F	0.20	0.22	0.25	0.13	0.18	0.23	0.18						
50-64	M	0.22	0.20	0.25	0.10	0.17	0.22	0.22						
	F	0.32	0.32	0.34	0.19	0.25	0.33	0.26						
	M&F	0.27	0.28	0.31	0.15	0.21	0.29	0.24						
65-74	M	0.18	0.23	0.28	0.00	0.16	0.17	0.06						
	F	0.28	0.27	0.29	0.45	0.18	0.09	0.15						
	M&F	0.24	0.25	0.28	0.27	0.18	0.12	0.12						
75-84	M	0.19	0.27	0.21	0.00	0.06	0.05	0.03						
	F	0.28	0.12	0.10	0.00	0.05	0.04	0.03						
	M&F	0.25	0.17	0.14	0.00	0.05	0.05	0.03						
85+	M	0.22	0.09	0.10	0.00	0.06	0.05	0.00						
	F	0.14	0.05	0.17	0.00	0.04	0.04	0.03						
	M&F	0.16	0.06	0.15	0.00	0.04	0.04	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**	**0.03**	**0.03**	**0.04**	**0.03**	**0.03**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	F	**0.10**	**0.12**	**0.12**	**0.06**	**0.10**	**0.11**	**0.09**	**0.1**	**0.0**	**0.1**	**0.1**	**0.1**	**0.1**
	M&F	**0.07**	**0.09**	**0.08**	**0.04**	**0.07**	**0.08**	**0.07**	**0.1**	**0.0**	**0.0**	**0.1**	**0.1**	**0.1**
Average Scripts PMPY for Cephalosporins 2nd-4th Generation - *PMPY or Per Member Per Year*:														
0-9	M	0.25	0.30	0.22	0.31	0.25	0.27	0.15						
	F	0.24	0.30	0.21	0.35	0.25	0.28	0.14						
	M&F	0.25	0.30	0.21	0.32	0.25	0.27	0.14						
10-17	M	0.07	0.10	0.06	0.08	0.07	0.08	0.04						
	F	0.10	0.12	0.08	0.12	0.10	0.10	0.05						
	M&F	0.09	0.11	0.07	0.10	0.09	0.09	0.04						
18-34	M	0.03	0.03	0.03	0.04	0.02	0.03	0.02						
	F	0.06	0.06	0.05	0.06	0.05	0.06	0.03						
	M&F	0.05	0.05	0.05	0.05	0.04	0.05	0.03						

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2010 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
35-49	M	0.04	0.03	0.05	0.01	0.03	0.04	0.03						
	F	0.07	0.06	0.06	0.03	0.05	0.08	0.04						
	M&F	0.06	0.05	0.06	0.02	0.04	0.07	0.04						
50-64	M	0.05	0.05	0.03	0.04	0.04	0.06	0.04						
	F	0.09	0.07	0.07	0.04	0.07	0.08	0.04						
	M&F	0.07	0.06	0.06	0.04	0.06	0.07	0.04						
65-74	M	0.08	0.11	0.03	0.00	0.04	0.02	0.02						
	F	0.08	0.08	0.06	0.00	0.05	0.02	0.01						
	M&F	0.08	0.09	0.05	0.00	0.05	0.02	0.01						
75-84	M	0.06	0.08	0.10	0.00	0.02	0.01	0.01						
	F	0.10	0.13	0.02	0.00	0.02	0.01	0.01						
	M&F	0.08	0.11	0.05	0.00	0.02	0.01	0.01						
85+	M	0.07	0.06	0.00	0.00	0.01	0.00	0.01						
	F	0.14	0.07	0.01	0.00	0.02	0.01	0.00						
	M&F	0.12	0.07	0.01	0.00	0.02	0.01	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**	**0.15**	**0.17**	**0.13**	**0.16**	**0.13**	**0.16**	**0.08**	**0.1**	**0.0**	**0.0**	**0.1**	**0.1**	**0.2**
	F	**0.13**	**0.14**	**0.11**	**0.20**	**0.13**	**0.14**	**0.07**	**0.1**	**0.0**	**0.0**	**0.1**	**0.1**	**0.1**
	M&F	**0.14**	**0.15**	**0.12**	**0.17**	**0.13**	**0.15**	**0.08**	**0.1**	**0.0**	**0.0**	**0.1**	**0.1**	**0.1**
Average Scripts PMPY for Azithromycins and Clarithromycins - *PMPY or Per Member Per Year*:														
0-9	M	0.25	0.37	0.25	0.33	0.34	0.26	0.20						
	F	0.23	0.35	0.22	0.34	0.31	0.25	0.18						
	M&F	0.24	0.36	0.23	0.34	0.32	0.26	0.19						
10-17	M	0.20	0.27	0.16	0.21	0.24	0.21	0.13						
	F	0.25	0.34	0.23	0.30	0.30	0.26	0.18						
	M&F	0.22	0.31	0.20	0.24	0.27	0.24	0.16						
18-34	M	0.16	0.18	0.17	0.16	0.16	0.18	0.14						
	F	0.35	0.38	0.37	0.32	0.34	0.36	0.31						
	M&F	0.30	0.32	0.32	0.22	0.28	0.31	0.26						
35-49	M	0.20	0.20	0.22	0.10	0.17	0.24	0.18						
	F	0.36	0.39	0.37	0.16	0.35	0.39	0.29						
	M&F	0.31	0.34	0.34	0.14	0.28	0.35	0.26						

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2010 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
50-64	M	0.20	0.22	0.21	0.08	0.17	0.22	0.16						
	F	0.33	0.39	0.34	0.17	0.32	0.37	0.24						
	M&F	0.27	0.33	0.30	0.13	0.25	0.31	0.20						
65-74	M	0.15	0.20	0.08	0.00	0.05	0.06	0.09						
	F	0.19	0.30	0.15	0.26	0.12	0.07	0.08						
	M&F	0.17	0.26	0.13	0.15	0.09	0.07	0.08						
75-84	M	0.18	0.05	0.03	0.00	0.01	0.02	0.01						
	F	0.16	0.05	0.06	0.00	0.02	0.03	0.01						
	M&F	0.16	0.05	0.05	0.00	0.01	0.03	0.01						
85+	M	0.00	0.08	0.03	0.00	0.01	0.03	0.01						
	F	0.10	0.06	0.01	0.00	0.02	0.01	0.01						
	M&F	0.08	0.06	0.02	0.00	0.01	0.02	0.01						
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**	**0.22**	**0.29**	**0.21**	**0.24**	**0.25**	**0.23**	**0.17**	**0.2**	**0.1**	**0.1**	**0.2**	**0.2**	**0.3**
	F	**0.29**	**0.36**	**0.29**	**0.32**	**0.31**	**0.30**	**0.23**	**0.2**	**0.1**	**0.2**	**0.2**	**0.3**	**0.3**
	M&F	**0.26**	**0.34**	**0.26**	**0.27**	**0.29**	**0.27**	**0.21**	**0.2**	**0.1**	**0.2**	**0.2**	**0.3**	**0.3**
Average Scripts PMPY for Amoxicillin / Clavulanates - *PMPY or Per Member Per Year*:														
0-9	M	0.17	0.24	0.20	0.27	0.20	0.19	0.17						
	F	0.16	0.22	0.18	0.25	0.19	0.17	0.15						
	M&F	0.17	0.23	0.19	0.26	0.20	0.18	0.16						
10-17	M	0.08	0.11	0.08	0.10	0.10	0.08	0.07						
	F	0.09	0.12	0.09	0.13	0.11	0.10	0.07						
	M&F	0.09	0.12	0.08	0.11	0.11	0.09	0.07						
18-34	M	0.07	0.08	0.07	0.08	0.07	0.08	0.06						
	F	0.11	0.14	0.12	0.11	0.12	0.13	0.10						
	M&F	0.10	0.13	0.11	0.09	0.11	0.11	0.09						
35-49	M	0.09	0.12	0.11	0.07	0.09	0.11	0.10						
	F	0.13	0.17	0.16	0.06	0.14	0.16	0.12						
	M&F	0.12	0.15	0.15	0.07	0.12	0.14	0.11						
50-64	M	0.11	0.13	0.11	0.05	0.10	0.11	0.09						
	F	0.12	0.16	0.17	0.05	0.12	0.14	0.11						
	M&F	0.12	0.15	0.15	0.05	0.11	0.13	0.10						

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2010 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
65-74	M	0.13	0.09	0.02	0.10	0.03	0.05	0.02						
	F	0.14	0.10	0.07	0.06	0.06	0.03	0.03						
	M&F	0.14	0.10	0.06	0.08	0.05	0.04	0.03						
75-84	M	0.10	0.05	0.00	0.00	0.02	0.02	0.01						
	F	0.07	0.04	0.03	0.00	0.01	0.01	0.00						
	M&F	0.08	0.04	0.02	0.00	0.01	0.01	0.01						
85+	M	0.14	0.08	0.03	0.00	0.02	0.02	0.01						
	F	0.10	0.02	0.01	0.00	0.01	0.00	0.00						
	M&F	0.11	0.03	0.02	0.00	0.01	0.01	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**	**0.13**	**0.17**	**0.14**	**0.16**	**0.14**	**0.14**	**0.11**	**0.1**	**0.0**	**0.1**	**0.1**	**0.1**	**0.2**
	F	**0.13**	**0.17**	**0.14**	**0.17**	**0.14**	**0.14**	**0.11**	**0.1**	**0.0**	**0.1**	**0.1**	**0.1**	**0.2**
	M&F	**0.13**	**0.17**	**0.14**	**0.16**	**0.14**	**0.14**	**0.11**	**0.1**	**0.0**	**0.1**	**0.1**	**0.1**	**0.2**
Average Scripts PMPY for Ketolides - *PMPY or Per Member Per Year*:														
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						

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures													
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2010 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
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**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	F	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	M&F	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Average Scripts PMPY for Clindamycins - *PMPY or Per Member Per Year*:														
0-9	M	0.02	0.02	0.04	0.04	0.01	0.02	0.03						
	F	0.02	0.02	0.04	0.04	0.01	0.02	0.04						
	M&F	0.02	0.02	0.04	0.04	0.01	0.02	0.04						
10-17	M	0.03	0.03	0.04	0.05	0.02	0.03	0.03						
	F	0.03	0.03	0.05	0.05	0.03	0.03	0.05						
	M&F	0.03	0.03	0.04	0.05	0.03	0.03	0.04						
18-34	M	0.04	0.06	0.05	0.05	0.06	0.05	0.05						
	F	0.08	0.09	0.08	0.07	0.09	0.08	0.07						
	M&F	0.07	0.09	0.07	0.05	0.08	0.07	0.07						
35-49	M	0.04	0.07	0.07	0.02	0.06	0.05	0.05						
	F	0.07	0.09	0.08	0.04	0.07	0.07	0.07						
	M&F	0.06	0.08	0.08	0.03	0.07	0.07	0.06						
50-64	M	0.04	0.05	0.05	0.01	0.04	0.04	0.05						
	F	0.05	0.06	0.06	0.03	0.05	0.05	0.05						
	M&F	0.05	0.05	0.06	0.02	0.05	0.05	0.05						
65-74	M	0.03	0.06	0.01	0.00	0.02	0.01	0.00						
	F	0.03	0.03	0.06	0.13	0.00	0.01	0.02						
	M&F	0.03	0.04	0.04	0.08	0.01	0.01	0.02						
75-84	M	0.02	0.00	0.00	0.00	0.02	0.00	0.00						
	F	0.00	0.03	0.00	0.00	0.00	0.00	0.01						
	M&F	0.01	0.02	0.00	0.00	0.01	0.00	0.01						

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2010 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
85+	M	0.00	0.04	0.00	0.00	0.00	0.00	0.00						
	F	0.01	0.01	0.00	0.00	0.00	0.00	0.00						
	M&F	0.01	0.02	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**	**0.03**	**0.03**	**0.04**	**0.05**	**0.03**	**0.03**	**0.04**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	F	**0.05**	**0.06**	**0.06**	**0.05**	**0.05**	**0.05**	**0.05**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.1**
	M&F	**0.04**	**0.05**	**0.05**	**0.05**	**0.04**	**0.04**	**0.05**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Average Scripts PMPY for Misc. Antibiotics of Concern - *PMPY or Per Member Per Year*:														
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	0.01	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	0.01	0.00	0.00	0.00	0.02	0.01	0.00						
	F	0.01	0.00	0.01	0.01	0.01	0.01	0.00						
	M&F	0.01	0.00	0.01	0.00	0.01	0.01	0.00						
65-74	M	0.00	0.01	0.00	0.00	0.00	0.00	0.01						
	F	0.00	0.01	0.00	0.00	0.01	0.01	0.00						
	M&F	0.00	0.01	0.00	0.00	0.01	0.01	0.00						
75-84	M	0.00	0.08	0.00	0.00	0.00	0.01	0.00						
	F	0.00	0.01	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.03	0.00	0.00	0.00	0.00	0.00						
85+	M	0.00	0.02	0.00	0.00	0.00	0.00	0.00						
	F	0.03	0.01	0.00	0.00	0.01	0.00	0.00						
	M&F	0.02	0.01	0.00	0.00	0.01	0.00	0.00						

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures													
Measure by Age / as Stated	**Sex**	**Amerigroup**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2010 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**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**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	F	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	M&F	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
All Other Antibiotics Utilization														
Average Scripts PMPY for Absorbable Sulfonamides - *PMPY or Per Member Per Year*:														
0-9	M	0.08	0.10	0.09	0.16	0.07	0.09	0.07						
	F	0.13	0.16	0.13	0.24	0.14	0.15	0.10						
	M&F	0.10	0.13	0.11	0.19	0.10	0.12	0.08						
10-17	M	0.07	0.08	0.05	0.11	0.07	0.06	0.04						
	F	0.13	0.16	0.11	0.18	0.13	0.13	0.09						
	M&F	0.10	0.12	0.08	0.13	0.10	0.10	0.07						
18-34	M	0.12	0.14	0.09	0.13	0.12	0.12	0.08						
	F	0.23	0.24	0.22	0.23	0.21	0.23	0.19						
	M&F	0.20	0.21	0.19	0.17	0.19	0.20	0.16						
35-49	M	0.16	0.16	0.18	0.06	0.14	0.18	0.14						
	F	0.22	0.21	0.20	0.10	0.19	0.23	0.18						
	M&F	0.20	0.19	0.20	0.09	0.17	0.21	0.17						
50-64	M	0.19	0.16	0.20	0.07	0.13	0.21	0.12						
	F	0.19	0.18	0.18	0.08	0.16	0.23	0.17						
	M&F	0.19	0.17	0.19	0.07	0.15	0.22	0.15						
65-74	M	0.13	0.18	0.12	0.00	0.09	0.07	0.06						
	F	0.19	0.15	0.13	0.06	0.11	0.06	0.05						
	M&F	0.16	0.16	0.12	0.04	0.10	0.06	0.05						
75-84	M	0.13	0.02	0.31	0.00	0.03	0.03	0.01						
	F	0.11	0.10	0.10	0.00	0.02	0.01	0.02						
	M&F	0.11	0.07	0.18	0.00	0.02	0.02	0.02						
85+	M	0.04	0.00	0.06	0.00	0.00	0.01	0.01						
	F	0.04	0.03	0.11	0.00	0.01	0.01	0.01						
	M&F	0.04	0.02	0.10	0.00	0.01	0.01	0.01						
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 A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2010 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
Total	**M**	**0.09**	**0.11**	**0.09**	**0.13**	**0.09**	**0.10**	**0.07**	**0.1**	**0.0**	**0.0**	**0.1**	**0.1**	**0.1**
	F	**0.17**	**0.19**	**0.17**	**0.21**	**0.16**	**0.18**	**0.14**	**0.1**	**0.0**	**0.1**	**0.1**	**0.1**	**0.2**
	M&F	**0.14**	**0.16**	**0.13**	**0.16**	**0.13**	**0.14**	**0.11**	**0.1**	**0.0**	**0.1**	**0.1**	**0.1**	**0.1**
Average Scripts PMPY for Aminoglycosides - *PMPY or Per Member Per Year*:														
0-9	M	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.02	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	0.00	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	0.00	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	0.01	0.00	0.00	0.01	0.00	0.00						
	F	0.02	0.00	0.00	0.00	0.00	0.01	0.00						
	M&F	0.01	0.00	0.00	0.00	0.00	0.01	0.00						
75-84	M	0.08	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.02	0.01	0.02	0.00	0.00	0.00	0.00						
	M&F	0.04	0.01	0.01	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	0.01	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.01	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**	**0.01**	**0.00**	**0.00**	**0.00**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	F	**0.00**	**0.00**	**0.00**	**0.01**	**0.00**	**0.00**	**0.00**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	M&F	**0.00**	**0.00**	**0.00**	**0.01**	**0.00**	**0.00**	**0.00**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures

Measure by Age / as Stated	Sex	Ameri group	BlueCare -East	BlueCare -West	TennCare *Select*	UnitedHealthcare -East	UnitedHealthcare -Middle	UnitedHealthcare -West	National Medicaid HEDIS 2010 Means and Percentiles Mean	P10	P25	P50	P75	P90
Average Scripts PMPY for 1st Generation Cephalosporins - *PMPY or Per Member Per Year*:														
0-9	M	0.07	0.07	0.08	0.08	0.07	0.07	0.05						
	F	0.07	0.08	0.07	0.08	0.07	0.07	0.05						
	M&F	0.07	0.08	0.07	0.08	0.07	0.07	0.05						
10-17	M	0.08	0.09	0.07	0.08	0.08	0.07	0.05						
	F	0.09	0.10	0.08	0.10	0.09	0.09	0.06						
	M&F	0.08	0.10	0.07	0.09	0.09	0.08	0.06						
18-34	M	0.09	0.11	0.08	0.09	0.09	0.10	0.06						
	F	0.16	0.18	0.14	0.13	0.15	0.17	0.11						
	M&F	0.14	0.16	0.13	0.10	0.14	0.15	0.10						
35-49	M	0.11	0.14	0.11	0.06	0.11	0.13	0.10						
	F	0.15	0.17	0.12	0.07	0.14	0.17	0.11						
	M&F	0.14	0.16	0.12	0.07	0.13	0.16	0.11						
50-64	M	0.11	0.14	0.12	0.06	0.11	0.15	0.09						
	F	0.15	0.18	0.14	0.09	0.13	0.16	0.11						
	M&F	0.13	0.16	0.13	0.08	0.12	0.16	0.10						
65-74	M	0.09	0.13	0.10	0.00	0.04	0.05	0.05						
	F	0.07	0.15	0.14	0.00	0.07	0.04	0.03						
	M&F	0.08	0.14	0.13	0.00	0.06	0.04	0.04						
75-84	M	0.10	0.03	0.03	0.00	0.02	0.02	0.01						
	F	0.07	0.03	0.11	0.00	0.03	0.03	0.02						
	M&F	0.08	0.03	0.08	0.00	0.03	0.02	0.02						
85+	M	0.04	0.00	0.19	0.00	0.01	0.00	0.00						
	F	0.06	0.06	0.04	0.00	0.01	0.01	0.01						
	M&F	0.06	0.04	0.09	0.00	0.01	0.01	0.01						
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**	**0.08**	**0.09**	**0.08**	**0.08**	**0.08**	**0.08**	**0.06**	**0.1**	**0.0**	**0.0**	**0.1**	**0.1**	**0.1**
	F	**0.11**	**0.13**	**0.11**	**0.10**	**0.11**	**0.12**	**0.08**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**
	M&F	**0.10**	**0.12**	**0.09**	**0.09**	**0.10**	**0.10**	**0.07**	**0.1**	**0.0**	**0.1**	**0.1**	**0.1**	**0.1**
Average Scripts PMPY for Lincosamides - *PMPY or Per Member Per Year*:														
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						

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2010 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
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**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	F	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	M&F	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Average Scripts PMPY for Macrolides (not azith. or clarith.) *- PMPY or Per Member Per Year*:														
0-9	M	0.00	0.01	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	0.01	0.00	0.01	0.00	0.00	0.00						
10-17	M	0.00	0.01	0.00	0.01	0.01	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	0.00	0.00						

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2010 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
18-34	M	0.01	0.01	0.01	0.02	0.01	0.01	0.01						
	F	0.02	0.02	0.01	0.01	0.02	0.02	0.01						
	M&F	0.01	0.02	0.01	0.02	0.02	0.01	0.01						
35-49	M	0.01	0.01	0.01	0.01	0.02	0.01	0.01						
	F	0.02	0.02	0.01	0.01	0.02	0.02	0.01						
	M&F	0.01	0.02	0.01	0.01	0.02	0.01	0.01						
50-64	M	0.01	0.01	0.01	0.00	0.01	0.01	0.00						
	F	0.02	0.02	0.01	0.01	0.01	0.02	0.01						
	M&F	0.02	0.02	0.01	0.00	0.01	0.01	0.01						
65-74	M	0.02	0.01	0.00	0.00	0.00	0.00	0.01						
	F	0.00	0.01	0.01	0.00	0.01	0.02	0.00						
	M&F	0.01	0.01	0.01	0.00	0.01	0.01	0.00						
75-84	M	0.00	0.00	0.03	0.00	0.00	0.00	0.01						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.01	0.00	0.00	0.00	0.00						
85+	M	0.07	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.01	0.00	0.00	0.00	0.00	0.00						
	M&F	0.02	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**	**0.01**	**0.01**	**0.00**	**0.01**	**0.01**	**0.00**	**0.00**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	F	**0.01**	**0.02**	**0.01**	**0.01**	**0.01**	**0.01**	**0.01**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	M&F	**0.01**	**0.01**	**0.01**	**0.01**	**0.01**	**0.01**	**0.01**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Average Scripts PMPY for Penicillins - *PMPY or Per Member Per Year*:														
0-9	M	0.50	0.61	0.49	0.59	0.53	0.55	0.46						
	F	0.49	0.63	0.49	0.62	0.54	0.55	0.45						
	M&F	0.50	0.62	0.49	0.60	0.54	0.55	0.46						
10-17	M	0.20	0.27	0.18	0.26	0.24	0.20	0.16						
	F	0.26	0.35	0.24	0.36	0.30	0.26	0.21						
	M&F	0.23	0.31	0.21	0.30	0.27	0.23	0.19						
18-34	M	0.18	0.26	0.18	0.21	0.22	0.20	0.16						
	F	0.32	0.40	0.35	0.36	0.35	0.34	0.30						
	M&F	0.28	0.36	0.31	0.27	0.31	0.30	0.26						

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2010 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
35-49	M	0.17	0.21	0.18	0.05	0.17	0.18	0.17						
	F	0.24	0.28	0.28	0.13	0.24	0.25	0.24						
	M&F	0.22	0.26	0.26	0.10	0.22	0.23	0.22						
50-64	M	0.14	0.16	0.18	0.06	0.12	0.17	0.14						
	F	0.18	0.20	0.21	0.07	0.15	0.17	0.16						
	M&F	0.16	0.19	0.20	0.06	0.13	0.17	0.15						
65-74	M	0.13	0.10	0.10	0.10	0.03	0.03	0.05						
	F	0.14	0.13	0.12	0.06	0.05	0.04	0.03						
	M&F	0.14	0.12	0.11	0.08	0.04	0.04	0.03						
75-84	M	0.05	0.03	0.03	0.00	0.01	0.02	0.01						
	F	0.09	0.03	0.02	0.00	0.01	0.02	0.01						
	M&F	0.07	0.03	0.02	0.00	0.01	0.02	0.01						
85+	M	0.00	0.02	0.06	0.00	0.01	0.01	0.00						
	F	0.05	0.04	0.03	0.00	0.01	0.01	0.00						
	M&F	0.04	0.04	0.04	0.00	0.01	0.01	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**	**0.34**	**0.41**	**0.33**	**0.37**	**0.35**	**0.36**	**0.30**	**0.3**	**0.2**	**0.3**	**0.4**	**0.4**	**0.5**
	F	**0.35**	**0.43**	**0.36**	**0.46**	**0.37**	**0.37**	**0.31**	**0.4**	**0.3**	**0.3**	**0.4**	**0.4**	**0.5**
	M&F	**0.34**	**0.42**	**0.35**	**0.40**	**0.36**	**0.37**	**0.31**	**0.4**	**0.2**	**0.3**	**0.4**	**0.4**	**0.5**
Average Scripts PMPY for Tetracyclines - *PMPY or Per Member Per Year*:														
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	0.06	0.08	0.05	0.10	0.08	0.06	0.04						
	F	0.06	0.09	0.07	0.09	0.07	0.06	0.05						
	M&F	0.06	0.08	0.06	0.09	0.08	0.06	0.05						
18-34	M	0.09	0.11	0.12	0.16	0.09	0.10	0.10						
	F	0.14	0.14	0.19	0.16	0.13	0.14	0.16						
	M&F	0.12	0.13	0.17	0.16	0.12	0.13	0.15						
35-49	M	0.09	0.11	0.14	0.07	0.09	0.10	0.10						
	F	0.13	0.15	0.17	0.11	0.14	0.13	0.14						
	M&F	0.12	0.14	0.17	0.10	0.12	0.12	0.13						

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2010 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
50-64	M	0.09	0.13	0.14	0.07	0.10	0.11	0.12						
	F	0.13	0.17	0.14	0.11	0.15	0.12	0.13						
	M&F	0.11	0.16	0.14	0.09	0.13	0.12	0.13						
65-74	M	0.21	0.12	0.06	0.00	0.02	0.06	0.03						
	F	0.11	0.14	0.09	0.06	0.06	0.03	0.04						
	M&F	0.15	0.13	0.08	0.04	0.05	0.04	0.03						
75-84	M	0.02	0.06	0.00	0.00	0.00	0.02	0.01						
	F	0.04	0.05	0.02	0.00	0.03	0.01	0.01						
	M&F	0.03	0.06	0.01	0.00	0.02	0.02	0.01						
85+	M	0.11	0.08	0.06	0.00	0.00	0.00	0.01						
	F	0.09	0.01	0.07	0.00	0.01	0.01	0.01						
	M&F	0.10	0.02	0.07	0.00	0.01	0.01	0.01						
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**	**0.05**	**0.04**	**0.07**	**0.05**	**0.04**	**0.04**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	F	**0.07**	**0.09**	**0.10**	**0.07**	**0.08**	**0.07**	**0.08**	**0.1**	**0.0**	**0.0**	**0.1**	**0.1**	**0.1**
	M&F	**0.06**	**0.08**	**0.08**	**0.07**	**0.07**	**0.06**	**0.07**	**0.0**	**0.0**	**0.0**	**0.0**	**0.1**	**0.1**
Average Scripts PMPY for Misc. Antibiotics - *PMPY or Per Member Per Year*:														
0-9	M	0.00	0.02	0.00	0.02	0.01	0.00	0.00						
	F	0.01	0.03	0.01	0.05	0.02	0.01	0.01						
	M&F	0.01	0.02	0.01	0.03	0.01	0.01	0.01						
10-17	M	0.00	0.01	0.00	0.02	0.01	0.01	0.00						
	F	0.06	0.08	0.07	0.13	0.06	0.06	0.06						
	M&F	0.03	0.04	0.04	0.06	0.03	0.03	0.03						
18-34	M	0.03	0.03	0.03	0.03	0.02	0.02	0.02						
	F	0.35	0.37	0.42	0.28	0.32	0.36	0.36						
	M&F	0.26	0.27	0.34	0.12	0.23	0.27	0.28						
35-49	M	0.05	0.04	0.06	0.02	0.03	0.05	0.03						
	F	0.20	0.19	0.26	0.07	0.17	0.20	0.21						
	M&F	0.15	0.15	0.22	0.05	0.12	0.16	0.16						
50-64	M	0.08	0.06	0.08	0.00	0.05	0.05	0.05						
	F	0.15	0.16	0.15	0.08	0.13	0.17	0.12						
	M&F	0.12	0.12	0.12	0.05	0.09	0.12	0.09						

Table A1. HEDIS 2011 Plan-Specific Rates with National Benchmarks: Use of Services Measures													
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2010 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
65-74	M	0.10	0.13	0.10	0.00	0.03	0.02	0.08						
	F	0.14	0.15	0.09	0.00	0.15	0.10	0.06						
	M&F	0.13	0.14	0.09	0.00	0.10	0.07	0.07						
75-84	M	0.08	0.03	0.28	0.00	0.01	0.04	0.00						
	F	0.22	0.04	0.03	0.00	0.04	0.02	0.04						
	M&F	0.17	0.04	0.13	0.00	0.03	0.02	0.03						
85+	M	0.04	0.02	0.03	0.00	0.02	0.00	0.01						
	F	0.18	0.10	0.08	0.00	0.03	0.03	0.01						
	M&F	0.14	0.08	0.07	0.00	0.03	0.02	0.01						
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**	**0.02**	**0.01**	**0.02**	**0.01**	**0.01**	**0.01**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	F	**0.15**	**0.17**	**0.19**	**0.12**	**0.14**	**0.15**	**0.16**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.2**
	M&F	**0.09**	**0.11**	**0.12**	**0.06**	**0.08**	**0.09**	**0.10**	**0.1**	**0.0**	**0.1**	**0.1**	**0.1**	**0.1**

APPENDIX B | HEDIS 2010 National Medicaid Means and Percentiles

Table B1. HEDIS 2010 National Medicaid Means and Percentiles						
Measure	Medicaid Mean	Percentile				
		10th	25th	50th	75th	90th
HEDIS Effectiveness of Care Measures						
Prevention and Screening						
Adult BMI Assessment (ABA)	34.6%	2.6%	22.4%	35.3%	48.7%	60.8%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC):						
BMI Percentile: 3-11 years (yrs)	30.4%	0.3%	11.2%	27.8%	45.1%	65.3%
12-17 yrs	30.1%	0.4%	14.7%	27.1%	44.2%	59.3%
Total	30.3%	0.3%	13.0%	29.3%	45.2%	63.0%
Counseling for Nutrition: 3-11 yrs	43.8%	0.3%	35.1%	49.6%	60.8%	70.8%
12-17 yrs	38.1%	0.7%	28.2%	41.1%	53.0%	61.8%
Total	41.9%	0.4%	34.3%	46.2%	57.7%	67.9%
Counseling for Physical Activity:						
3-11 yrs	31.8%	0.0%	19.9%	33.0%	46.0%	54.9%
12-17 yrs	34.2%	0.0%	26.4%	37.2%	46.9%	57.4%
Total	**32.5%**	**0.0%**	**22.9%**	**35.3%**	**45.5%**	**56.7%**
Childhood Immunization Status (CIS):						
DTaP/DT	79.6%	68.8%	75.5%	81.8%	85.2%	88.5%
IPV	89.0%	83.8%	87.1%	90.7%	93.7%	95.6%
MMR	91.2%	86.3%	89.4%	91.7%	93.9%	95.8%
HiB	93.7%	88.3%	92.6%	95.4%	96.6%	97.8%
HepB	89.1%	82.6%	87.0%	91.8%	94.3%	96.4%
VZV	90.6%	84.5%	88.3%	91.3%	93.9%	95.4%
PCV	77.6%	65.9%	72.3%	79.3%	84.0%	87.8%
HepA	35.5%	22.2%	28.2%	34.8%	42.8%	48.4%
RV	49.8%	31.7%	42.6%	49.9%	59.0%	64.7%
Influenza	40.6%	23.4%	31.7%	40.0%	49.5%	57.2%
Combination 2	74.3%	61.8%	68.8%	76.6%	81.6%	85.6%
Combination 3	69.4%	56.0%	63.5%	71.0%	76.6%	82.0%
Combination 4	30.4%	17.1%	24.3%	29.5%	37.1%	42.5%
Combination 5	41.6%	26.9%	33.8%	42.0%	49.1%	57.0%
Combination 6	33.8%	17.3%	25.4%	32.9%	41.0%	50.7%
Combination 7	20.6%	9.7%	15.0%	19.7%	25.6%	31.0%
Combination 8	17.2%	7.8%	11.6%	16.0%	21.4%	27.1%
Combination 9	23.2%	9.6%	15.7%	21.1%	30.3%	37.2%
Combination 10	12.6%	4.6%	7.7%	11.7%	15.9%	20.9%
Immunizations for Adolescents (IMA):						
Meningococcal	47.4%	27.7%	36.4%	46.7%	58.9%	69.6%
Tdap/Td	59.1%	32.8%	44.6%	60.8%	75.3%	85.8%
Combination 1	42.5%	21.9%	31.2%	42.4%	53.9%	65.9%
Lead Screening in Children (LSC)	66.4%	42.3%	57.6%	71.6%	81.0%	88.4%
Breast Cancer Screening (BCS)	52.4%	39.8%	46.2%	52.0%	59.6%	63.8%
Cervical Cancer Screening (CCS)	65.8%	50.4%	61.0%	67.8%	72.9%	78.9%
Chlamydia Screening in Women (CHL):						
16-20 year-old women	54.4%	43.8%	48.5%	53.0%	61.1%	66.4%
21-24 year-old women	61.6%	49.5%	55.8%	62.4%	69.1%	73.4%
Total	**56.7%**	**44.2%**	**50.6%**	**55.7%**	**63.7%**	**69.5%**

Table B1. HEDIS 2010 National Medicaid Means and Percentiles						
Measure	Medicaid Mean	Percentile				
		10th	25th	50th	75th	90th
Respiratory Conditions						
Appropriate Testing for Children with Pharyngitis (CWP)	62.3%	40.2%	54.3%	65.5%	73.5%	80.9%
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	86.0%	77.7%	82.1%	85.8%	90.6%	94.9%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)	25.6%	16.8%	19.7%	23.5%	27.0%	35.9%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	28.6%	17.4%	23.1%	28.0%	35.1%	39.9%
Pharmacotherapy Management of COPD Exacerbation (PCE):						
Systemic corticosteroid	61.8%	42.6%	53.6%	63.4%	71.3%	76.2%
Bronchodilator	80.7%	64.5%	76.5%	84.1%	87.7%	90.0%
Use of Appropriate Medications for People with Asthma (ASM):						
5-11 years old	91.8%	88.2%	90.0%	92.2%	93.9%	95.5%
12-50 years old	86.0%	79.9%	83.8%	86.3%	89.1%	90.7%
Total	**88.6%**	**84.6%**	**86.7%**	**88.6%**	**90.8%**	**92.8%**
Cardiovascular Conditions						
Cholesterol Management for Patients with Cardiovascular Conditions (CMC):						
LDL-C Screening	80.7%	72.1%	78.1%	80.9%	84.8%	88.8%
LDL-C Controlled (<100 mg/dL)	41.2%	22.9%	34.3%	43.2%	50.0%	54.4%
Controlling High Blood Pressure (CBP)	55.3%	41.9%	49.4%	57.1%	63.3%	67.2%
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)	76.6%	59.2%	71.4%	77.8%	85.7%	88.9%
Diabetes						
Comprehensive Diabetes Care (CDC):						
HbA1c Testing	80.6%	69.4%	76.0%	81.1%	86.4%	90.2%
HbA1c Control (<7.0%)	33.9%	20.0%	27.4%	35.5%	39.5%	44.5%
HbA1c Control (<8.0%)	45.7%	29.9%	38.7%	46.6%	54.2%	58.8%
Retinal Eye Exam Performed	52.7%	32.1%	41.4%	54.0%	63.7%	70.1%
LDL-C Screening	74.2%	62.6%	69.3%	75.4%	80.1%	84.0%
LDL-C Controlled (<100 mg/dL)	33.5%	19.5%	27.2%	33.6%	40.9%	45.5%
Medical Attention for Nephropathy	76.9%	65.7%	72.5%	77.7%	82.7%	86.2%
Blood Pressure Control (<130/80 mm Hg)	32.2%	21.4%	27.1%	32.5%	36.7%	44.3%
Blood Pressure Control (<140/90 mm Hg)	59.8%	43.8%	53.5%	61.6%	68.2%	73.4%
Musculoskeletal Conditions						
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	70.5%	57.3%	64.9%	71.5%	79.7%	83.3%
Use of Imaging Studies for Low Back Pain (LBP)	76.1%	68.6%	72.0%	76.2%	79.8%	84.1%
Behavioral Health						
Antidepressant Medication Management (AMM):						
Effective Acute Phase Treatment	49.6%	40.9%	45.2%	48.1%	52.9%	58.4%
Effective Continuation Phase Treatment	33.0%	24.8%	27.8%	31.0%	35.2%	43.3%
Follow-Up Care for Children Prescribed ADHD Medication (ADD):						
Initiation Phase	36.6%	24.8%	30.9%	35.7%	42.2%	48.1%
Continuation and Maintenance Phase	41.7%	24.8%	34.7%	42.1%	50.7%	57.6%
Follow-Up After Hospitalization for Mental Illness (FUH):						
7-day follow-up	42.9%	18.2%	29.6%	43.5%	59.1%	64.3%
30-day follow-up	60.2%	31.8%	49.0%	62.6%	74.3%	83.6%

Table B1. HEDIS 2010 National Medicaid Means and Percentiles

Measure	Medicaid Mean	Percentile				
		10th	25th	50th	75th	90th
Medication Management						
Annual Monitoring for Patients on Persistent Medications (MPM):						
ACE Inhibitors or ARBs	85.9%	80.0%	84.1%	86.3%	89.2%	90.5%
Digoxin	88.9%	82.0%	86.0%	90.0%	92.7%	95.2%
Diuretics	85.4%	79.4%	82.6%	86.1%	88.4%	90.6%
Anticonvulsants	68.7%	60.4%	64.5%	68.6%	72.7%	78.1%
Total	83.2%	77.2%	81.2%	84.3%	86.8%	88.5%
Measures Collected Through CAHPS Health Plan Survey						
Medical Assistance with Smoking Cessation (MSC):						
Advising Smokers and Tobacco Users to Quit*						
Discussing Smoking Cessation Medications*						
Discussing Smoking Cessation Strategies*						
HEDIS Effectiveness of Care Measures Where Lower Rates Indicated Better Performance						
Comprehensive Diabetes Care (CDC):						
HbA1c Poor Control (>9.0%)	44.9%	27.7%	33.8%	43.2%	53.4%	63.5%
HEDIS Access/Availability of Care Measures						
Adults' Access to Preventive/Ambulatory Health Services (AAP):						
20-44 year-olds	80.5%	67.4%	78.0%	82.9%	86.7%	88.5%
45-64 year-olds	85.3%	73.2%	83.2%	88.1%	90.1%	91.3%
Children and Adolescents' Access to Primary Care Practitioners (CAP):						
12-24 months	95.2%	90.6%	95.1%	96.8%	97.9%	98.5%
25 months-6 years	88.3%	81.0%	87.1%	89.8%	92.2%	94.1%
7-11 years	90.3%	85.0%	87.7%	91.3%	93.4%	95.6%
12-19 years	87.9%	80.6%	85.4%	88.9%	91.8%	93.7%
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET):						
Initiation of AOD Treatment: 13-17 years	42.5%	22.4%	32.3%	41.4%	54.1%	62.7%
18 + years	44.7%	32.5%	38.1%	43.9%	49.8%	58.6%
Total	44.3%	31.8%	38.4%	43.9%	48.8%	57.3%
Engagement of AOD Treatment: 13-17 years	17.7%	2.5%	7.1%	13.9%	25.7%	40.0%
18 + years	11.8%	2.5%	3.4%	8.5%	16.7%	22.2%
Total	12.3%	2.3%	4.1%	10.2%	17.6%	21.4%
Prenatal and Postpartum Care (PPC):						
Timeliness of Prenatal Care	83.4%	70.6%	80.3%	86.0%	90.0%	92.7%
Postpartum Care	64.1%	53.0%	58.7%	65.5%	70.3%	74.4%
Call Answer Timeliness (CAT)	82.2%	71.7%	77.8%	83.0%	89.0%	93.6%
HEDIS Access/Availability of Care Measures Where Lower Rates Indicated Better Performance						
Call Abandonment (CAB)	3.0%	0.9%	1.4%	2.6%	3.6%	6.1%
HEDIS Use of Services Measures						
Frequency of Ongoing Prenatal Care (FPC):						
< 21 percent	10.3%	2.2%	3.4%	7.0%	13.9%	22.2%
21-40 percent	6.3%	2.1%	2.8%	4.6%	7.9%	13.4%
41-60 percent	8.0%	3.4%	5.3%	7.2%	10.2%	13.6%
61-80 percent	13.9%	7.5%	10.1%	13.5%	17.5%	19.9%
≥ 81 percent	61.6%	31.5%	52.1%	64.2%	73.7%	82.2%

Table B1. HEDIS 2010 National Medicaid Means and Percentiles						
Measure	**Medicaid Mean**	**Percentile**				
		10th	**25th**	**50th**	**75th**	**90th**
Well-Child Visits in the First 15 Months of Life (W15):						
0 Visits	2.3%	0.5%	0.7%	1.4%	2.9%	5.1%
1 Visits	2.1%	0.5%	1.0%	1.6%	3.0%	4.4%
2 Visits	3.4%	1.2%	2.1%	2.8%	4.6%	5.9%
3 Visits	5.7%	2.1%	3.7%	5.4%	7.4%	9.5%
4 Visits	10.7%	5.7%	7.5%	10.3%	12.7%	15.3%
5 Visits	16.4%	10.4%	13.4%	16.5%	18.9%	22.2%
6 or More Visits	59.4%	40.9%	52.2%	60.1%	69.7%	76.3%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	71.6%	59.9%	65.9%	71.8%	77.3%	82.5%
Adolescent Well-Care Visits (AWC)	47.7%	34.4%	38.8%	46.8%	56.0%	63.2%

** The three MSC rates were not included in Quality Compass in 2010 because the measure was revised; a rolling average was used for the measure's rates; therefore, two years of data is needed (rates will be calculated in 2011); all other Medicaid national rates taken from NCQA's HEDIS Audit Means, Percentiles and Rations: 2010.*

APPENDIX C | MCO Population Reported in Member Months

Table C1. HEDIS 2011 MCO Population Reported in Member Months by Age and Sex

Age Group	Amerigroup			BlueCare-East			BlueCare-West			TennCare*Select*			UnitedHealthcare-East			UnitedHealthcare -Middle			UnitedHealthcare -West		
Age	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
<1	56,608	52,919	109,527	55,923	53,696	109,619	46,455	44,432	90,887	6,020	5,593	11,613	39,936	38,726	78,662	56,179	53,691	109,870	40,222	38,888	79,110
1-4	197,140	187,825	384,965	198,957	191,067	390,024	172,729	170,448	343,177	41,331	33,673	75,004	156,053	150,896	306,949	197,221	189,950	387,171	153,205	149,426	302,631
5-9	188,400	183,877	372,277	201,956	193,145	395,101	177,358	177,439	354,797	69,896	41,460	111,356	165,347	160,508	325,855	191,230	185,431	376,661	148,966	146,735	295,701
10-14	154,740	150,852	305,592	172,272	167,273	339,545	149,049	149,355	298,404	80,585	45,939	126,524	137,562	135,185	272,747	151,397	145,083	296,480	129,675	129,975	259,650
15-17	78,614	81,155	159,769	94,738	97,099	191,837	78,691	85,167	163,858	67,250	37,729	104,979	73,812	74,072	147,884	76,518	73,993	150,511	72,273	75,314	147,587
18-19	45,209	63,002	108,211	50,345	66,131	116,476	43,534	59,362	102,896	39,284	22,442	61,726	44,472	54,528	99,000	43,545	54,545	98,090	43,443	58,293	101,736
0-19 Subtotal	**720,711**	**719,630**	**1,440,341**	**774,191**	**768,411**	**1,542,602**	**667,816**	**686,203**	**1,354,019**	**304,366**	**186,836**	**491,202**	**617,182**	**613,915**	**1,231,097**	**716,090**	**702,693**	**1,418,783**	**587,784**	**598,631**	**1,186,415**
0-19 %	**78.35%**	**58.98%**	**67.30%**	**76.10%**	**54.26%**	**63.39%**	**83.54%**	**56.29%**	**67.08%**	**94.08%**	**91.85%**	**93.22%**	**73.27%**	**56.86%**	**64.05%**	**78.09%**	**56.17%**	**65.44%**	**78.91%**	**56.44%**	**65.71%**
20-24	42,979	120,657	163,636	42,339	139,972	182,311	32,585	125,495	158,080	13,906	9,411	23,317	43,464	96,740	140,204	41,360	122,467	163,827	40,598	112,864	153,462
25-29	25,013	100,412	125,425	34,032	122,708	156,740	17,098	115,310	132,408	955	982	1,937	22,298	80,016	102,314	25,536	108,099	133,635	13,117	85,977	99,094
30-34	25,491	85,655	111,146	33,200	102,384	135,584	15,099	93,630	108,729	720	839	1,559	25,899	73,657	99,556	26,673	88,431	115,104	15,598	75,319	90,917
35-39	23,236	65,241	88,477	30,416	84,295	114,711	13,689	66,451	80,140	500	937	1,437	26,064	61,107	87,171	22,860	67,213	90,073	14,733	58,378	73,111
40-44	19,789	41,941	61,730	26,401	57,476	83,877	11,294	43,164	54,458	704	861	1,565	23,135	41,598	64,733	19,543	43,860	63,403	13,500	38,662	52,162
20-44 Subtotal	**136,508**	**413,906**	**550,414**	**166,388**	**506,835**	**673,223**	**89,765**	**444,050**	**533,815**	**16,785**	**13,030**	**29,815**	**140,860**	**353,118**	**493,978**	**135,972**	**430,070**	**566,042**	**97,546**	**371,200**	**468,746**
20-44 %	**14.84%**	**33.92%**	**25.72%**	**16.36%**	**35.79%**	**27.66%**	**11.23%**	**36.42%**	**26.45%**	**5.19%**	**6.41%**	**5.66%**	**16.72%**	**32.70%**	**25.70%**	**14.83%**	**34.38%**	**26.11%**	**13.10%**	**35.00%**	**25.96%**
45-49	19,181	30,897	50,078	23,574	46,270	69,844	11,539	31,045	42,584	592	1,027	1,619	22,044	31,235	53,279	17,384	31,122	48,506	14,690	27,222	41,912
50-54	17,089	22,676	39,765	20,452	35,139	55,591	11,399	23,285	34,684	683	894	1,577	22,766	25,019	47,785	14,160	23,389	37,549	15,521	21,479	37,000
55-59	14,844	16,378	31,222	16,226	28,516	44,742	9,822	17,117	26,939	546	791	1,337	19,825	20,000	39,825	12,342	16,764	29,106	15,001	15,617	30,618
60-64	9,028	12,274	21,302	12,770	23,457	36,227	7,075	13,240	20,315	392	611	1,003	12,237	14,888	27,125	8,968	14,040	23,008	9,145	10,960	20,105
45-64 Subtotal	**60,142**	**82,225**	**142,367**	**73,022**	**133,382**	**206,404**	**39,835**	**84,687**	**124,522**	**2,213**	**3,323**	**5,536**	**76,872**	**91,142**	**168,014**	**52,854**	**85,315**	**138,169**	**54,357**	**75,278**	**129,635**
45-64 %	**6.54%**	**6.74%**	**6.65%**	**7.18%**	**9.42%**	**8.48%**	**4.98%**	**6.95%**	**6.17%**	**0.68%**	**1.63%**	**1.05%**	**9.13%**	**8.44%**	**8.74%**	**5.76%**	**6.82%**	**6.37%**	**7.30%**	**7.10%**	**7.18%**
65-69	1,093	1,728	2,821	1,959	3,862	5,821	881	2,129	3,010	100	131	231	1,771	2,920	4,691	2,937	4,159	7,096	1,504	2,562	4,066
70-74	346	555	901	363	437	800	229	425	654	22	57	79	1,216	2,104	3,320	2,094	3,431	5,525	791	1,389	2,180
75-79	384	650	1,034	360	590	950	230	428	658	10	25	35	1,280	3,024	4,304	2,436	4,782	7,218	904	2,113	3,017
80-84	365	587	952	402	783	1,185	236	323	559	18	5	23	1,354	4,065	5,419	2,029	6,243	8,272	844	2,848	3,692
85-89	171	454	625	352	919	1,271	221	407	628	2	8	10	1,041	4,908	5,949	1,716	7,084	8,800	656	3,398	4,054
≥90	163	470	633	283	999	1,282	149	464	613	16	8	24	723	4,513	5,236	844	7,249	8,093	450	3,186	3,636
≥65 Subtotal	**2,522**	**4,444**	**6,966**	**3,719**	**7,590**	**11,309**	**1,946**	**4,176**	**6,122**	**168**	**234**	**402**	**7,385**	**21,534**	**28,919**	**12,056**	**32,948**	**45,004**	**5,149**	**15,496**	**20,645**
≥65 %	**0.27%**	**0.36%**	**0.33%**	**0.37%**	**0.54%**	**0.46%**	**0.24%**	**0.34%**	**0.30%**	**0.05%**	**0.12%**	**0.08%**	**0.88%**	**1.99%**	**1.50%**	**1.31%**	**2.63%**	**2.08%**	**0.69%**	**1.46%**	**1.14%**
Total	**919,883**	**1,220,205**	**2,140,088**	**1,017,320**	**1,416,218**	**2,433,538**	**799,362**	**1,219,116**	**2,018,478**	**323,532**	**203,423**	**526,955**	**842,299**	**1,079,709**	**1,922,008**	**916,972**	**1,251,026**	**2,167,998**	**744,836**	**1,060,605**	**1,805,441**

ATTACHMENT F

QUALITY IMPROVEMENT STRATEGY

STATE OF TENNESSEE

BUREAU OF TENNCARE

2011

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY

And

Quality Strategy: Annual Update Report

Contents

I. Introduction

I.A Overview

Driver for implementation of managed care

The purpose of the TennCare program is to demonstrate that a state Medicaid program can implement a managed care approach incorporating waivers of some federal Medicaid requirements and through this approach can be successful in (a) providing more services than Medicaid provided and (b) covering more people than Medicaid covered, all while assuring quality of care and spending no more money than would have been spent under Medicaid.

History of managed care program

On January 1, 1994, Tennessee began a new health care reform program called TennCare. This was the original TennCare waiver named TennCare I, and was designed as a managed care model, essentially replacing the Medicaid program in Tennessee. At the start of TennCare I, Tennessee moved almost its entire Medicaid program into a managed care model. The original TennCare design was extraordinarily ambitious. It involved extending coverage to large numbers of uninsured and uninsurable people. Almost all benefits were delivered by Managed Care Organizations (MCOs) of varying size, operating at full risk. The TennCare program was implemented as a five-year demonstration program and received several extensions after the original waiver expiration date of December 30, 1999. It should be noted that 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 determined 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 new 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 is for Medicaid eligible's, while TennCare Standard is for the demonstration population. At the time that 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", meaning persons losing Medicaid eligibility who met the criteria for the demonstration population.

In 2004, in the face of projections from an outside consultant that TennCare was growing at a rate that would soon make it impossible for the state to both support TennCare and meet its obligations in other critical areas, Governor Phil Bredesen proposed a TennCare Reform package to accomplish goals such as "right sizing" program enrollment and reducing the dramatic growth in pharmacy spending. With CMS approval, 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 demonstration children 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.

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 execution 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 included 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 managed Care Organization (MCO).

Major operational changes were required in order to ensure that the CHOICES program could be smoothly integrated into the existing managed care structure. MCO contract amendments had to be approved, training materials prepared, systems changes made, contracts executed with Nursing Facilities and Home and Community Based Services (HCBS) providers, an electronic visit verification (EVV) system put in place, and the development of numerous protocols covering all aspects of the

program. 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 August2010, 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. Maintaining MCO participation in Middle Tennessee has been troublesome 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 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 BlueCross BlueShield of Tennessee (BCBST). TennCare Select operates statewide and serves enrollees such as foster children, children receiving SSI benefits and nursing facility or IDF-MR residents under age 21. It also serves as the back-up MCO should there be capacity problems with any of the other MCOs.

Dental Benefits Manager (DBM)

Currently, TennCare services are offered through several managed care entities. Each enrollee has a 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).

On October 1, 2010, following a competitive bid process and a thorough readiness review and implementation period, Delta Dental assumed its responsibilities as the new TennCare Dental Benefits Manager (DBM). Delta Dental named its TennCare product "TennDent" and is responsible, among other things, for establishing and managing an adequate statewide network of dentists, processing and paying dental claims, utilization management and utilization review, detecting fraud and abuse, meeting utilization benchmarks and conducting outreach efforts reasonably calculated to ensure participation of children who have not received dental services. TennCare has approved Delta Dental's 2011 proposed EPSDT outreach program which includes the following nine initiatives designed to educate enrollees and their caregivers about the availability of EPSDT services and to increase the number of enrollees utilizing dental services:

- Collaboration
- Oral Health Educational Series
- Dental Screening Program
- Member Mailings (annual reminder notices, annual Member Handbook, quarterly Member Newsletter)
- Member Education
- Rural County Targeted Outreach
- Preconception/ Prenatal Oral Health Care and Coordination
- Teens
- "See Your Dentist" Reminder Pad

Pharmacy Benefits Manager (PBM)

TennCare's quality strategy encompasses many different aspects of the pharmacy benefit. The following highlights major components of the pharmacy program:

- To ensure **clinical quality**, the following initiatives are performed:
  - Every drug class on the preferred drug list (PDL) is reviewed by the Pharmacy Advisory Committee (PAC). TennCare uses their recommendations to guide the listing of preferred and non-preferred products on the PDL. In addition, the committee discusses/votes on any proposed prior authorization (PA) criteria or quantity limits.
  - Clinical pharmacists within SXC (TennCare's PBM) convert the PAC's recommendations for PA criteria and quantity limits into objective questions on a decision tree, thus helping ensure consistent decisions when applying clinical criteria.
  - Individuals who are denied PA for a drug are issued a letter informing them why their request was denied, and explaining their appeal rights. Pharmacy appeals are reviewed by a committee of pharmacists within SXC to evaluate if the request was appropriately denied.
  - Prospective Drug Utilization Review (ProDUR) Edits function at point of sale (POS) identifying potential drug interactions, high doses, and therapeutic duplications. These edits help to prevent adverse drug actions.
  - The TennCare Drug Utilization Review Board (DUR) board meets quarterly to review TennCare drug utilization trends for appropriateness.

- To ensure **data integrity**, the following quality strategies have been implemented:
  - Quarterly pharmacy desk and field audits are performed to identify misbilled or fraudulent claims.
  - Daily error report to identify any problems that are then investigated in coordination with Member Services and the Department of Human Services (DHS), so that correct eligibility information is reflected within pharmacy benefit.
  - TennCare requires that the POS claims adjudication system check all submitted pharmacy claims for valid NPIs for prescriber and pharmacy, as well as valid drug NDCs.

- To ensure quality within **pharmacy network**, the following steps are taken:
  - All pharmacies within the network are required to submit a pharmacy application, agreement, and disclosure form which is used to verify that the pharmacy is licensed and in good standing. The agreement sets forth all of the responsibilities of the pharmacies when serving TennCare recipients (Grier notices, 3-day emergency supplies, no automatic refills, monthly LEIE list checks for all pharmacy employees, etc.).
  - TennCare closely monitors pharmacies in its network to determine whether geoaccess standards, as set forth in the PBM contract, are met.

- To guard against **fraud and abuse**, we have incorporated the following quality strategies:
  - Annual fraud and abuse report required from the PBM.
  - TennCare developed specific criteria, involving multiple controlled substances, multiple prescribers, and multiple pharmacies, to identify candidates for pharmacy lock-in. This criterion is run on a monthly basis and reviewed by pharmacists to select individuals for pharmacy lock-in.
  - Verification of benefits (VOB) letters are sent to recipients to ensure they received medications for which TennCare was billed.
  - Twice annually, TennCare runs a report to identify the top 100 prescribers of narcotics based on a composite rank involving overall narcotic prescription volume and percentage of total prescriptions represented by narcotics. Letters are sent to these prescribers, and the report is shared with the MCOs.
  - Referrals from TennCare/SXC to OIG and TBI of suspected cases of TennCare fraud and abuse.

- **Additional quality control measures include:**
  - Monitoring of call center metrics, to ensure acceptable handle times, wait times, etc.
  - Monthly monitoring and refresh of MAC pricing list, including analysis of MAC disputes.
  - Monitoring of prompt pay requirements for the PBM.
  - Monitoring of call center PA turnaround time (max 24 hrs once complete request received)
  - Standard reporting to monitor: claims processing time, high dollar edits, 3-day emergency supply, etc.

Population description/changes

All Medicaid and demonstration eligible's 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 two mechanisms for TennCare eligibility; TennCare Medicaid and TennCare Standard.

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

- 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 when one of the parents has lost their job or had their work hours cut, or has a health or mental health problem expected to last 30 days
- Women who need treatment for breast or cervical cancer
- People who receive an 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 get 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:

- Who 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:

- To qualify as UNINSURED:
    - The child's eligibility through TennCare Medicaid is ending and
    - The child must be under the age of 19 and
    - The child must lack access to group health insurance through their own job or a parent's job, and
    - The family income is below 200 percent of poverty. (If the family's income is above 200 percent of poverty, the child may qualify for TennCare Standard as Medically Eligible, see below).

- To qualify as "MEDICALLY ELIGIBLE": The child must be under the age of 19, and have a health condition which makes the child "uninsurable" (or unable to access private health insurance because of their health condition), and must lack access to group health insurance through their job or a parent's job.

TennCare Standard Spend Down is only available to adults who have Standard Spend Down now:

- Aged (65 or older), or
- Blind or
- Disabled, or
- The caretaker of a minor child.
- In a two-parent family with a minor child one of the parents must have lost a job or had work hours cut, or have health or mental health problems expected to last 30 days.

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 care. 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:

- CHOICES Group 1 is for individuals receiving services in a Nursing Facility. These individuals are enrolled in TennCare Medicaid.

- CHOICES Group 2 is for individuals who meet the NF LOC and are receiving HCBS as an alternative to NF care. Those in CHOICES 2 may be enrolled in either TennCare Medicaid, if they are SSI-eligible, or TennCare Standard, if they are not SSI-eligible. The non-SSI group in CHOICES 2 is called the CHOICES 217-Like HCBS Group. The CHOICES 217-Like HCBS Group is composed of individuals age 65 and older or adults age 21 and older with physical disabilities who:
    - Meet the NF level of care requirement;
    - Are receiving HCBS; and
    - Who 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.

TENNCARE intends to include CHOICES Group 3 at such time that the State is permitted to modify nursing facility level of care based on interpretation of the maintenance of effort requirements delineated in the Affordable Care Act.

- CHOICES 3 is for individuals age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who qualify for TennCare as SSI recipients, 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 (CHS) for its statewide implementation of the new TennCare CHOICES Long-Term Care 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, were noted as "true pioneers" 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 care coordination. The "whole person" care coordination approach includes:

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

Other components of CHOICES include:

- Consumer Choice and Options
    - Creation of 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 new 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.

Strategy evaluation and revision

Annually, in January, TennCare plans to review the Quality Strategy and provide a report to CMS by April 1 of each year that will include information on the implementation and effectiveness of the strategy. A revised strategy will be provided whenever significant changes occur in the TennCare Program. These changes may include additional programs, new Managed Care Contractors, etc.

Process to obtain public input on strategy

The Quality Strategy will be available on TennCare's Web site. When the Quality Strategy is updated, TennCare will notify MCOs, providers, and advocacy groups that an updated Quality Strategy is posted on TennCare's Web site or is alternately available in print. TennCare staff will be available to make presentations as requested. Comments on the Strategy will be encouraged.

I.B Strategy Goals and Objectives

Medical and Behavioral Health

The table below discusses the Quality Strategy goals and objectives established by the State for medical and behavioral health.

Goal	Objective	Additional Information
1. Assure appropriate access to care for enrollees.	1.1 By 2013, the statewide weighted HEDIS rate for adults' access to preventive/ambulatory health services will increase to 75% for enrollees 20-44 years old and the rate for enrollees 45-64 years old will be maintained at 79% or above. 1.2 By 2013, the statewide weighted HEDIS rate for children and adolescents' access to primary care practitioners will increase to 89% for enrollees 7-11 years old and 85% for enrollees 12-19 years old. 1.3 By 2013, 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: *A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs).* Data source: *A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs).* Data source: *The Impact of TennCare: A Survey of Recipients*.
2. Provide quality care to enrollees.	2.1 By 2013, the statewide weighted HEDIS rate for adolescent well-care visits will increase to 41%. 2.2 By 2013, the statewide weighted HEDIS rate for timeliness of prenatal care will be maintained at 82% or above. 2.3 By 2013, the statewide weighted HEDIS rate for breast cancer screening will increase to 48%. 2.4 By 2013, the statewide weighted HEDIS rate for cervical cancer	Data source: *A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs).* Data source: *A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs).* Data source: *A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs).* Data source: *A Comparative Analysis of Audited Results from TennCare Managed Care*

Goal	Objective	Additional Information
	screening will increase to 65%. 2.5 By 2013, providers of EPSDT screening services will document the delivery of 95% of the required seven components of an EPSDT screen.	*Organizations (MCOs)*. Data source: EPSDT Medical Record Review.
3. Assure enrollees' satisfaction with services.	3.1 By 2013, 95% of TennCare enrollees will be satisfied with TennCare. 3.2 By 2013, the statewide average for adult CAHPS getting needed care-always or usually will increase to 82%. 3.3 By 2013, the statewide average for child CAHPS getting care quickly-always or usually will increase to 81%.	Data source: *The Impact of TennCare: A Survey of Recipients*. Data source: *A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs)*. Data source: *A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs)*.
4. Improve health care for program enrollees.	4.1 By 2013, the statewide weighted HEDIS rate for HbA1c testing will be maintained at 73% or above. 4.2 By 2013, the statewide weighted HEDIS rate for controlling high blood pressure will increase to 55%. 4.3 By 2013, the statewide weighted HEDIS rate for follow-up after hospitalization for mental illness will be maintained at 51% for follow-up within 7 days of discharge and 72% for follow-up within 30 days of discharge. 4.4 By the end of each demonstration year, the state will achieve a total statewide EPSDT screening rate of at least 80%.	Data source: *A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs)*. Data source: *A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs)*. Data source: *A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs)*. Data source: *CMS-416.*

Goal	Objective	Additional Information
	4.5 By 2013, the statewide weighted HEDIS rate for antidepressant medication management will be maintained at 63% for acute phase and 48% for continuation phase. 4.6 By 2013, the statewide weighted HEDIS rate for follow-up care for children prescribed ADHD medication will be maintained at 36% for initiation and 46% for continuation and maintenance.	Data source: *A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs)*. Data source: *A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs)*.

Long-Term Care

In July 2009, CMS approved an amendment to the TennCare waiver that allows TennCare to integrate nursing facility services and HCBS for the elderly and adults with physical disabilities into the existing managed care program. MCOs now coordinate all of the care a TennCare member needs, including medical, behavioral and long-term care. Implementation of CHOICES for the Middle Grand Region MCOs occurred March 1, 2010 and the East and West Grand Region MCOs on August 1, 2010.

The table below discusses the long-term care sub-assurances and performance measures established by the State to identify levels of compliance/noncompliance with federal assurances pertaining to Section 1915(c) waiver programs, including level of care, service plan, qualified providers, health and welfare, administrative authority, and participant rights; to ensure prompt remediation of individual findings, and to promote system improvements in the managed long-term care delivery system.

Assurance	Sub-Assurance	Performance Measure	Additional Information
Level of Care	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.	1. Number and percent of CHOICES Group 2 members who had an approved CHOICES PAE (i.e., nursing facility level of care eligibility determination) 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

Assurance	Sub-Assurance	Performance Measure	Additional Information
			Remediation: TennCare is responsible for quarterly reports and review/ analysis of data, as well as remediation of individual findings.
Service Plan	2. CHOICES members are offered choice between institutional (NF) services and HCBS.	2. 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, the sample size will consist of sixty (60) records per stratum with a ten percent (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 ninety-five percent (95%) confidence interval. Frequency: Semi-Annually, in May and November Remediation: TennCare is responsible for semi-

Assurance	Sub-Assurance	Performance Measure	Additional Information
			annual member record review and review/ analysis of data. MCOs will be responsible for remediation of individual findings with review/ validation by TennCare.
Service Plan	3. Plans of Care are reviewed/ updated at least annually.	3. Number and percent of CHOICES Group 2 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 members enrolled in each of the MCOs per region serving the CHOICES Group 2 population. Sample size will be based on the first auditing year's sampling error in order to achieve a ninety-five percent (95%) confidence interval. Any records used previously in a semi-annual audit will be excluded. Frequency: Annually, in November, following the first full year of CHOICES implementation Remediation: TennCare is responsible for annual member record review and review/ analysis of data. MCOs will be responsible for remediation of individual

Assurance	Sub-Assurance	Performance Measure	Additional Information
			findings with review/ validation by TennCare.
Qualified Providers	4. CHOICES HCBS providers meet minimum provider qualifications established by the State prior to enrollment in CHOICES and delivery of HCBS.	4. 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 in accordance with NCQA guidelines 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 population; sample size – 25 records per stratum. Sample size may be adjusted in subsequent years based on individual findings. Frequency: Annually, in November 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.

Assurance	Sub-Assurance	Performance Measure	Additional Information
Health and Welfare	5. CHOICES Group 2 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.	5. Number and percent of CHOICES Group 2 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 population. Sample size will be based on the first auditing year's sampling error in order to achieve a ninety-five (95%) confidence interval. Any records used previously in a semi-annual audit will be excluded. Frequency: Annually, in November 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.

Assurance	Sub-Assurance	Performance Measure	Additional Information
Health and Welfare	6. Critical incidents are reported within timeframes specified in the Contractor Risk Agreement.	6. 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 members enrolled in each of the MCOs per region serving the CHOICES Group 2 population. For the first auditing year, the sample size will consist of sixty (60) records per stratum with a ten percent (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 ninety-five percent (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.

Assurance	Sub-Assurance	Performance Measure	Additional Information
Administrative Authority	7. The State ensures that MCO provider agreements meet uniform requirements set forth in the Contractor Risk Agreement. Data Source: TDCI report of provider agreement template approval Sampling Approach: 100% of all MCO provider agreement templates Frequency: Annual TDCI is responsible for quarterly reports and for remediation of individual findings. TennCare is responsible for review/ analysis of data, as well as review/ validation of remediation activities.	7. Number and percent of MCO provider agreements reviewed which meet uniform requirements set forth in the Contractor Risk Agreement.	Data Source: TDCI report of provider agreement template approval Sampling Approach: 100% of all MCO provider agreement templates Frequency: Annually Remediation: TDCI is responsible for quarterly reports. TDCI and MCOs are responsible for remediation of individual findings. TennCare is responsible for review/ analysis of data, as well as review/ validation of remediation activities.

Assurance	Sub-Assurance	Performance Measure	Additional Information
Participant Rights	8. CHOICES members are informed of and afforded the right to request a Fair Hearing when services are denied, reduced, suspended or terminated.	8. Number and percent of 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.	Data Source: Member record review Sampling Approach: Stratified, with strata comprised of reported incidents for CHOICES Group 2 members enrolled in each of the MCOs per region serving the CHOICES Group 2 population. Sample size will be a subset of the sample used in Sub-Assurance 2. 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.

II. Assessment

II.A Quality and Appropriateness of Care

Identification of race, ethnicity, and primary language spoken of each enrollee and transmission to managed care plans

Eligibility for TennCare and other Medicaid programs is determined by the Department of Human Services (DHS). All 95 counties in Tennessee have a DHS office. Applicants complete the Application for Family Assistance Programs and Benefits and indicate that they are applying for TennCare/Medicaid. 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 need for an interpreter and for what language interpretation is needed. The contracts with the MCOs contain eligibility and enrollment data exchange requirements in section 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 twenty-four 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 five percent (5%) of the TennCare population or one-thousand (1,000) enrollees, whichever is less. In section 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 ninety 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 section 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 sections 2.17.4.5.23 and 2.17.5.3.2.

Use of EQRO Technical Report to evaluate quality and appropriateness of care

The EQRO Technical Report summarizes the manner in which data from mandated external quality review activities were aggregated, analyzed, and conclusions drawn. Conclusions relate to the quality and timeliness of, and access to, care furnished to TennCare-enrolled recipients by its contracted MCOs and dental benefits manager (DBM). The three federally mandated activities – performed by the external quality review organization (EQRO) for TennCare – are: validation of performance measures (PMVs); validation of performance improvement projects (PIPs); and monitoring compliance with federal and state standards. The EQRO monitors compliance with federal and state standards through Annual Quality Surveys (AQS) and Annual Provider Network Adequacy and Benefit Delivery Reviews also known as Annual Network Adequacy (ANA). Beginning in 2011, the AQS and the ANA will include CHOICES.

Independent external quality reviews and activities are a primary means of assessing the quality, timeliness and accessibility of services provided by TennCare MCCs. QSource's annual technical report compiles the results of these reviews and activities, making it a streamlined source of unbiased, actionable data. TennCare can use this data to measure progress toward stated goals and objectives and to determine if new or restated goals are necessary.

Where applicable, the data in the annual technical report are trended over time to help TennCare identify areas where targeted quality improvement interventions might be needed. Trending from the 2009 Technical Report to the 2010 Technical Report will not be possible due to the transition of health plans and subsequent changes in their enrollee populations. More complete trending will again be possible with the 2011 Technical Report since all MCOs will have returned to an integrated service model and have achieved NCQA accreditation.

As mandated by 42 CFR § 438.364, technical report data make it possible to benchmark performance both statewide and nationally. In presenting part of the state's healthcare picture, the data aid TennCare as it collaborates with other state agencies to address common health issues – particularly those that are prevalent, chronic and preventable.

Specific performance measures or performance improvement projects required by the State based on Strategy Objectives and associated performance standards

Strategy Objective	Performance Measure	Benchmark	Sanction
4.4 By the end of each demonstration year, the state will achieve a total statewide EPSDT screening ratio of at least 80%.	Attachment VII-Performance Standards 16 TENNderCare screening ratio (calculated quarterly by TennCare)	Equal to or greater than 80 percent	$5,000 for each full percentage point ratio is below 80 percent for the most recent rolling twelve month period

This strategy objective is a statewide rate related to a performance measure calculated quarterly by TennCare. This performance measure is specified in the MCO contracts in Attachment VII-Performance Standards. The contracts specify that the MCO benchmark for the TENNderCare screening ratio is equal to or greater than 80%.

Strategy Objective	Performance Measure	Benchmark	Sanction
2.5 By 2013, providers of EPSDT screening services will document the delivery of 95% of the required seven components of an EPSDT screen.	Rate of documentation of the delivery of the required seven components of an EPSDT screen	Within one standard deviation of the statewide average	Plan of correction for results that are greater than one standard deviation below the statewide average

This strategy objective is a statewide average based on MCO results obtained from the annual EPSDT Medical Record Review (MRR) conducted by TennCare. The medical record review is conducted in medical provider offices and Health Department clinics throughout the state by nursing consultants on a stratified random sample of records. The purpose of the review is to determine the extent to which medical providers are in compliance regarding the documentation of the delivery of the seven components of the EPSDT exam. MCOs with Medical Record Review results that are greater than one standard deviation below the statewide average are required to submit a plan of correction to TennCare.

Several of the strategy objectives are either statewide weighted HEDIS rates or statewide average CAHPS rates and are based on HEDIS and CAHPS results submitted by the MCOs. The contracts require the MCOs to annually complete all HEDIS measures designated by NCQA as relevant to Medicaid. The only exclusion from the complete Medicaid HEDIS data set is dental measures. The MCOs are required to contract with an NCQA certified HEDIS auditor to validate the processes of the CONTRACTOR in accordance with NCQA requirements. The contracts also require that the MCOs submit the audited HEDIS results to TENNCARE, NCQA, and TENNCARE's EQRO annually by June 15 of each calendar year. In addition, the contracts require the MCOs to annually conduct a CAHPS survey. The MCOs are required to enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The MCO's CAHPS vendor is required to perform the CAHPS adult survey, CAHPS child survey and the CAHPS children with chronic conditions survey. The contracts also require that the MCOs submit survey results to TENNCARE, NCQA, and TENNCARE's EQRO annually by June 15 of each calendar year. There are no performance standards for HEDIS/CAHPS results, but pay-for-performance quality incentive payments are offered for MCOs who demonstrate significant improvement from the previous reporting period for specified measures.

Provision of clinical guidelines to managed care plans

The state does not provide clinical practice guidelines to the MCOs, but the contracts require that each Disease Management (DM) program (Maternity Care Management, Diabetes, Congestive Heart Failure, Asthma, Coronary Artery Disease, Chronic obstructive pulmonary disease, Bipolar Disorder, Major Depression, Schizophrenia, and Obesity) utilize evidence-based clinical practice guidelines that have been formally adopted by the MCO's Quality Management/Quality Improvement (QM/QI) committee or other clinical committee. The contracts stipulate that the guidelines for the required DM programs include a requirement to conduct a mental health and substance abuse screening. The DM programs for bipolar disorder, major depression, and schizophrenia are also required to include the use of the evidence-based practice for co-occurring disorders.

The contracts require that the MCOs measure performance against at least two important clinical aspects of the guidelines associated with each DM program. The MCOs report results to TennCare on July 1 in the annual DM Report.

II.B MCO Requirements and Contractual Compliance

The following section discusses requirements established by the State for the managed care plans in the following domains: access to care; structure and operations; and quality measurement and improvement. Monitoring mechanisms used by the State to provide oversight to the managed care plans and contract provisions that hold the managed care plans accountable for meeting the standards established by the state are also discussed.

Access to Care

As stated in section I.B, one of the goals of this Quality Strategy is to assure appropriate access to care for enrollees. Section I.B also lists the accompanying objectives to assess attainment of this goal. This section addresses the standards that have been established in the MCO contracts for access to care, how TennCare determines whether the MCOs are in compliance with the contract requirements, and disincentives for nonperformance.

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
42 CFR 438.206 Availability of Services	The contracts with the MCOs address provider networks in section 2.11 including: primary care providers, specialty service providers, prenatal care providers, behavioral health services, long-term care providers, and safety net providers; credentialing and other certification; and network notice requirements. The contracts with the MCOs address provider agreements in section 2.12. The contracts with the MCOs address customer service for members in section 2.18 including: member services toll-free phone line; interpreter and translation services; cultural competency; member involvement with behavioral health services.	2.30.7 requires the MCOs to submit provider network reports including, but not limited to: monthly Provider Enrollment File, annual Provider Compliance with Access Requirements, quarterly PCP Assignment Report, annual Report of Essential Hospital Services, quarterly Behavioral Health Initial Appointment Timeliness Report, annual Long-Term Care Provider Network Development Plan, and quarterly Long-Term Care Provider Capacity Performance Report. 2.30.12 requires the MCOs to submit customer service reports including, but not limited to:	4.20.2.1.1 – Liquidated damages can be assessed for each day that a report or deliverable is late, incorrect, or deficient. 4.20.2.2.7 C.2 - Liquidated damages can be assessed for failure to report provider notice of termination of participation in the MCO. C.7 - Liquidated damages can be assessed for failure to submit a Provider Enrollment File that meets TennCare's specifications. B.23 - Liquidated damages can be assessed for failure to

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
	Contractor Risk Agreement (CRA) Attachment III addresses general access standards and attachment IV addresses specialty network standards. Attachment V addresses access and availability for behavioral health services.	quarterly Member Services and Provider Services Phone Line Report; quarterly 24/7 Nurse Triage Line Report; quarterly ED Assistance Tracking Report; and quarterly Translation/Interpretation Services Report.	maintain provider agreements in accordance with Section 2.12 and Attachment XI of the contract.
		CRA Attachment VII Performance Standards requires the MCOs to meet established benchmarks for performance measures relating to these requirements. The performance measures include, but are not limited to: provider network documentation, provider participation accuracy, and distance from provider to member. The measurement frequency for these measures ranges from monthly to quarterly. The MCOs are required to meet established benchmarks for performance measures relating to: Telephone Response Time/Call Answer Timeliness -Member Services Line and Telephone Call Abandonment Rate (unanswered calls) – Member Services Line. The measurement frequency for these measures is quarterly.	CRA Attachment VII Performance Standards - Liquidated damages can be assessed if an MCO fails to meet the benchmark for the performance measures.

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
		CRA Attachment VIII requires the MCOs to submit documentation for review and/or approval by TennCare during readiness review and/or during operations: 27. Policies and procedures to develop and maintain a provider network that ensure compliance with Section 2.11.1, including policies and procedures for selection and/or retention of providers. 28. Policies and procedures for PCP selection and assignment that ensure compliance with Section 2.11.2, including policies and procedures regarding change of PCP and use of specialist as PCP. 29. Plan to identify, develop, or enhance existing inpatient and residential treatment capacity for adults and adolescents with co-occurring mental health and substance abuse disorders to ensure compliance with Section 2.11.5.2. 33. Provider agreement template(s) and revisions to TDCI as required in Section 2.12.	
		CRA Attachment VIII requires the MCOs to submit documentation for review and/or approval by	

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
		TennCare during readiness review and/or during operations: 53. Member services phone line policies and procedures that ensure compliance with Section 2.18.1. 54. Policies and procedures regarding interpreter and translation services that ensure compliance with Section 2.18.2. 56. Description of 24/7 ED Assistance Line (see Section 2.18.4.7).	
		Some of these requirements are evaluated by the Provider Data Validation Quarterly Report[i], an EQRO contractual activity.	
		Some of these requirements are evaluated as part of the Annual Network Adequacy (ANA)[ii], an EQRO mandatory activity.	
		Some of these requirements are evaluated as part of the Annual Quality Survey (AQS)[iii], an EQRO mandatory activity.	TennCare requires that each MCC submit a plan of correction (POC) for any element not meeting 100% compliance. 4.20.2.2.7 B.2 – Liquidated damages can be assessed for failure to complete or comply with corrective action plans as

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
			required by TENNCARE.
		Some of these requirements are deemed met by the NCQA Accreditation Survey. For specific information, see Attachment A: State Requirements Deemed Met by NCQA Accreditation Survey- Availability of Services.	4.20.2.2.7 B.4 – Liquidated damages can be assessed for failure to submit NCQA Accreditation Report within 10 days of receipt.
42 CFR 438.208 Coordination and Continuity of Care	The contracts with the MCOs address management, coordination, and continuity of care in 2.9. This section specifies requirements for transition of new members; transition of members receiving long-term care services at the time of CHOICES implementation; transition of care; MCO case management; care coordination (for CHOICES members); consumer direction of HCBS; coordination and collaboration for members with behavioral health needs; coordination and collaboration among behavioral health providers; coordination of pharmacy services; coordination of dental benefits; coordination with Medicare; ICF/MR services and alternatives to ICF/MR services and inter-agency coordination. Section 2.9.5.1 specifies that the MCOs must maintain a case management program that includes a component for systematically identifying eligible members. In addition,	2.30.6 requires the MCOs to submit service coordination reports including, but not limited to: MCO Case Management Reports (annual MCO Case Management Program Description, annual MCO Case Management Services Report, quarterly MCO Case Management Update Report), monthly Status of Transitioning CHOICES Members Report, quarterly Care Coordination Report, semi-annual Nursing Facility Diversion Report, quarterly Nursing Facility to Community Transition Report, monthly HCBS Missed Visits Report, and quarterly Consumer Direction of HCBS Report.	4.20.2.1.1 – Liquidated damages can be assessed for each day that a report or deliverable is late, incorrect, or deficient.
		CRA Attachment VIII requires the MCOs to submit documentation	

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
	section 2.9.5.2 requires the MCOs to provide case management to members who are at high risk or have unique, chronic, or complex needs. This shall include but not be limited to members with co-occurring mental illness and substance abuse and/or co-morbid physical health and behavioral health conditions.	for review and/or approval by TennCare during readiness review and/or during operations: 11. Service coordination policies and procedures that ensure compliance with Section 2.9.1. 12. Policies and procedures for transition of new members that ensure compliance with the requirements of Section 2.9.2. 13. Policies and procedures for transition of member receiving long-term care services at the time of CHOICES implementation that ensure compliance with Section 2.9.3. 14. Transition of care policies and procedures that ensure compliance with Section 2.9.4. 15. MCO case management policies and procedures that ensure compliance with Section 2.9.5. 16. Care coordination policies and procedures that ensure compliance with Section 2.9.6. 17. Policies and procedures for consumer direction of HCBS that ensure compliance with Section 2.9.7. 18. Policies and procedures for coordination of physical health, behavioral health, and long-term	

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
		care services that ensure compliance with Section 2.9.8. 20. Policies and procedures for coordination among behavioral health providers that ensure compliance with Section 2.9.9. 21. Policies and procedures for coordination of pharmacy services that ensure compliance with Section 2.9.10. 22. Policies and procedures for coordination of dental services that ensure compliance with Section 2.9.11. 25. Policies and procedures for inter-agency coordination that ensure compliance with Section 2.9.14.	
		Some of these requirements are evaluated as part of the Annual Quality Survey (AQS)[iii], an EQRO mandatory activity.	TennCare requires that each MCC submit a plan of correction (POC) for any element not meeting 100% compliance.
		Some of these requirements are deemed met by the NCQA Accreditation Survey. For specific information, see Attachment A: State Requirements Deemed Met by NCQA Accreditation Survey- Coordination and Continuity of Care.	4.20.2.2.7 B.4 – Liquidated damages can be assessed for failure to submit NCQA Accreditation Report within 10 days of receipt.

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
42 CFR 438.210 Coverage and Authorization of Services	The contracts with the MCOs address benefits, service requirements and limits in section 2.6. This section requires the provision and integration of medical, behavioral health, and long-term care benefits and services. This section specifies requirements for contractor covered benefits, TennCare benefits provided by TennCare, medical necessity determination, second opinions, use of cost effective alternative services, additional services and use of incentives, and cost sharing and patient liability. In addition, section 2.7 addresses specialized services such as: emergency services; behavioral health services; self-direction of health care tasks for CHOICES members; health education and outreach; preventive services; TENNderCare; advance directives; and sterilizations, hysterectomies, and abortions. Attachment I addresses behavioral health specialized service descriptions for mental health case management and psychiatric rehabilitation. Section 2.8 specifies requirements for disease management including: member identification strategies, stratification, program content, informing and education members, informing and educating providers, program evaluation (satisfaction and effectiveness), and obesity disease management. The contracts with the MCOs address utilization management (UM) in 2.14. This	2.30.4 requires the MCOs to submit specialized service reports including, but not limited to: quarterly Psychiatric Hospital/RTF Readmission Report, quarterly Mental Health Case Management Report, quarterly Behavioral Health Crisis Response Report, quarterly Adverse Occurrences Report, and quarterly TENNderCare Report. The Quality Oversight Division of the Bureau of TennCare conducts periodic abortion, sterilization, hysterectomy (ASH) medical record reviews. 2.30.5 requires the MCOs to submit disease management reports, including, but not limited to: quarterly Disease Management Update Report, annual Disease Management Report, and an annual updated Disease Management Program Description. 2.30.10 requires the MCOs to submit UM reports including, but not limited to: annual UM Program Description, Work Plan and Evaluation; quarterly Cost and Utilization Reports; monthly	4.20.2.1.1 – Liquidated damages can be assessed for each day that a report or deliverable is late, incorrect, or deficient. 4.20.2.2.7 A.7 – Liquidated damages can be assessed for failure to comply with this Agreement and federal rules/law regarding Sterilizations/Abortions/ Hysterectomies as outlined in Section 2.7.8. 4.20.2.2.7 B.20 - Liquidated damages can be assessed if the MCOs Impose arbitrary utilization guidelines or other quantitative coverage limits as prohibited in Section 2.6.3 and 2.14.1 of this Agreement.

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
	section specifies general UM requirements, prior authorization for physical health and behavioral health covered services, referrals for physical health and behavioral health, exemptions to prior authorization and/or referrals for physical health and behavioral health, authorization of long-term care services, transition of members receiving long-term care services at the time of CHOICES implementation, notice of adverse action requirements, medical history information requirements and PCP profiling.	CHOICES Utilization Report; quarterly Prior Authorization Report; Referral Provider Listing; and semi-annual Emergency Department Threshold Report.	
		CRA Attachment VIII requires the MCOs to submit documentation for review and/or approval by TennCare during readiness review and/or during operations: 6. Policies and procedures for self-direction of health care tasks in accordance with Section 2.7.3.	

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
		8. TENNderCare policies and procedures that ensure compliance with the requirements of Section 2.7.6. 9. Policies and procedures for advance directives that ensure compliance with Section 2.7.7. 10. Disease management program policies and procedures that ensure compliance with Section 2.8.	
		CRA Attachment VIII requires the MCOs to submit documentation for review and/or approval by TennCare during readiness review and/or during operations: 38. Policies and procedures for PCP profiling to ensure compliance with Section 2.14.9.	
		Some of these requirements are deemed met by the NCQA Accreditation Survey. For specific information, see Attachment A: State Requirements Deemed Met by NCQA Accreditation Survey- Coverage and Authorization of Services.	4.20.2.2.7 B.4 – Liquidated damages can be assessed for failure to submit NCQA Accreditation Report within 10 days of receipt.

Structure and Operations

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
42 CFR 438.214 Provider Selection	The contracts with the MCOs address requirements for credentialing and other certification in 2.11.8. This section includes credentialing of contract providers, credentialing of non-contract providers, credentialing of behavioral health entities, credentialing of long-term care providers, compliance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA), and Weight Watchers or other weight management program.		4.20.2.2.7 B.22 – Liquidated damages can be assessed for applications that have not been approved and loaded into the MCO's system or denied within thirty (30) calendar days of receipt of a completed credentialing application and a signed provider agreement/contract if applicable.
		Attachment VIII requires the MCOs to submit documentation for review and/or approval by TennCare during readiness review and/or during operations: 30. Credentialing manual and policies and procedures that ensure compliance with Section 2.11.8	
		Some of these requirements are evaluated as part of the Annual Network Adequacy (ANA)[ii], an EQRO mandatory activity.	
42 CFR 438.218 Enrollee Information	The contracts with the MCOs contain requirements for member materials in	2.17.1.1 requires the MCOs to submit to TennCare for review and	4.20.2.2.7 B.7 - Liquidated damages can

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
	section 2.17. This section addresses: prior approval process for all member materials; written material guidelines; distribution of member materials; member handbooks; quarterly member newsletter; identification card; CHOICES member materials; provider directories; additional information available upon request.	prior written approval all materials that will be distributed to members. This includes but is not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, member education and outreach activities.	be assessed for failure to obtain approval of member materials as required by Section 2.17. B. 8 – Liquidated damages can be assessed for failure to comply with time frames for providing Member Handbooks, I.D. cards, Provider Directories, Quarterly Member Newsletters, and CHOICES member education materials as required in Section 2.17
		Some of these requirements are evaluated as part of the Annual Quality Survey (AQS)[iii], an EQRO mandatory activity.	TennCare requires that each MCC submit a plan of correction (POC) for any element not meeting 100% compliance. 4.20.2.2.7 B.2 – Liquidated damages can be assessed for failure to complete or comply with corrective action plans as required by TENNCARE.
		Some of these requirements are deemed met by the NCQA Accreditation Survey. For specific information, see Attachment A: State Requirements Deemed Met by NCQA Accreditation Survey-	4.20.2.2.7 B.4 – Liquidated damages can be assessed for failure to submit NCQA Accreditation Report within 10 days of receipt.

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
		Enrollee Information.	
42 CFR 438.224 Confidentiality	The contracts with the MCOs contain requirements for compliance with the Health Insurance Portability and Accountability Act (HIPAA) in section 2.27 and additional requirements for confidentiality of information in section 4.33.	2.30.20 requires the MCOs to submit a HIPAA Report annually entitled Privacy/Security Incident Report. The MCOs must provide the report more frequently if requested by TennCare.	2.27.2 - In accordance with HIPAA regulations, the MCOs are required to, at a minimum: 2.27.2.3 Agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security and all subsequent HIPAA standards, that it will be in breach of the contract and will then take all reasonable steps to cure the breach or end the violation as applicable… if for any reason the MCO cannot meet the requirements of this Section, TennCare may terminate the contract.
		CRA Attachment VIII requires the MCOs to submit documentation for review and/or approval by TennCare during readiness review and/or during operations: 87. HIPAA policies and procedures that ensure compliance with Section 2.27.	
		Some of these requirements are	4.20.2.2.7 B.4 – Liquidated

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
		deemed met by the NCQA Accreditation Survey. For specific information, see Attachment A: State Requirements Deemed Met by NCQA Accreditation Survey-Confidentiality.	damages can be assessed for failure to submit NCQA Accreditation Report within 10 days of receipt.
42 CFR 438.226 Enrollment and Disenrollment	The contracts with the MCOs address enrollment requirements in section 2.4. This section includes: general; authorized service area; maximum enrollment; MCO selection and assignment; effective date of enrollment; eligibility and enrollment data; enrollment period; transfers from other MCOs; enrollment of newborns; and information requirements upon enrollment. In addition, the contracts with the MCOs address disenrollment requirements in section 2.5. This section includes: general; acceptable reasons for disenrollment from a MCO; unacceptable reasons for disenrollment from a MCO; informing TennCare of potential ineligibility; and effective date of disenrollment from a MCO.	2.30.2 requires the MCOs to submit Eligibility, Enrollment and Disenrollment Reports including, but not limited to the Monthly Enrollment/Capitation Payment Reconciliation Report and the Quarterly Member Enrollment/Capitation Payment Report.	4.20.2.1.1 – Liquidated damages can be assessed for each day that a report or deliverable is late, incorrect, or deficient.

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
42 CFR 438.228 Grievance Systems - Complaints	The contracts with the MCOs address complaints and appeals in section 2.19. The MCOs are required to have internal complaint procedures for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees, or court orders governing the appeals process. In addition, 2.17.4.5.11 requires the MCOs to inform members of their right to file a complaint in the member handbook and 2.17.5.3.5 requires the MCOs to inform members of their right to file a complaint in the quarterly MCO newsletters.	2.30.13 requires the MCOs to submit a quarterly Member Complaints Report.	4.20.2.1.1 – Liquidated damages can be assessed for each day that a report or deliverable is late, incorrect, or deficient. 4.20.2.2.7 B.16 - Liquidated damages can be assessed for failure to maintain a complaint and appeal system as required in Section 2.19. B. 17 - Liquidated damages can be assessed for failure to comply with the timeframe for resolving complaints (see Section 2.19.2).
		CRA Attachment VIII requires the MCOs to submit documentation for review and/or approval by TennCare during readiness review and/or during operations: 65. Appeal and complaint policies and procedures that ensure compliance with Section 2.19.	
		Some of these requirements are evaluated as part of the Annual Quality Survey (AQS)[iii], an EQRO mandatory activity.	TennCare requires that each MCC submit a plan of correction (POC) for any element not meeting 100% compliance.

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
			4.20.2.2.7 B.2 – Liquidated damages can be assessed for failure to complete or comply with corrective action plans as required by TENNCARE.
42 CFR 438.228 Grievance Systems - Appeals	The contracts with the MCOs address appeals in section 2.19.3. Citation 2.19.3.2 requires the MCOs to direct all appeals to TennCare. In addition, 2.19.3.1 requires the MCO's appeal process to meet the requirements outlined in 2.19.3. including the requirement that the MCO have internal appeal procedures for members. In addition, 2.17.4.7.23 and -24 require the MCOs to include appeal procedures and notification of the right to file an appeal in the member handbook.	4.20.2.2.7 A.12 requires the MCOs to provide complete documentation and comply with the timelines for responding to a medical appeal.	4.20.2.2.7 A.12 – Liquidated damages can be assessed for each calendar day beyond the required time frame that the appeal is unanswered…and/or the appeal is not handled according to the provision. B.16 - Liquidated damages can be assessed for failure to maintain a complaint and appeal system as required in Section 2.19.
		CRA Attachment VIII requires the MCOs to submit documentation for review and/or approval by TennCare during readiness review and/or during operations: 65. Appeal and complaint policies and procedures that ensure compliance with Section 2.19.	
		Some of these requirements are evaluated as part of the Annual	TennCare requires that each MCC submit a plan of

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
		Quality Survey (AQS)[iii], an EQRO mandatory activity.	correction (POC) for any element not meeting 100% compliance. 4.20.2.2.7 B.2 – Liquidated damages can be assessed for failure to complete or comply with corrective action plans as required by TENNCARE.
42 CFR 438.230 Subcontractural Relationships and Delegation	The contracts with the MCOs contain subcontract requirements in section 2.26 and addresses the requirement that the MCOs must 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). This section also addresses subcontract relationships and delegation, legal responsibility, prior approval, subcontracts for behavioral health services, subcontract for assessments and plans of care, subcontract with Fiscal Employer Agent (FEA), standards, quality of care, interpretation/translation services and limited English proficiency (LEP) provisions, children in state custody, assignability, daims processing, HIPAA requirements, compensation for UM activities, and notice of subcontractor termination.	2.26.3 requires the MCOs to obtain prior approval from TennCare for subcontracts and revisions of subcontracts.	
		Some of these requirements are deemed met by the NCQA Accreditation Survey. For specific information, see Attachment A: State Requirements Deemed Met by NCQA Accreditation Survey- Subcontractual Relationships and Delegation.	4.20.2.2.7 B.4 – Liquidated damages can be assessed for failure to submit NCQA Accreditation Report within 10 days of receipt.

Quality Measurement and Improvement

As stated in section I.B, three additional goals of the Quality Strategy are as follows: to provide quality care to enrollees, to assure enrollees' satisfaction with services and to improve health care for program enrollees. Section I.B also lists the accompanying objectives to assess attainment of these goals. The following section addresses the standards that have been established in the MCO contracts for quality measurement and improvement, how TennCare determines whether the MCOs are in compliance with the contract requirements, and disincentives for nonperformance.

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
42 CFR 438.236 Practice Guidelines	In 2.8.1.2, the contracts require that the MCOs utilize evidence-based clinical practice guidelines that have been formally adopted by the MCO's QM/QI committee or other clinical committee with each Disease Management (DM) program (Maternity Care Management, Diabetes, CHF, Asthma, CAD, COPD, Bipolar Disorder, Major Depression, and Schizophrenia). The guidelines must include a requirement to conduct a mental health and substance abuse screening. The DM programs for bipolar disorder, major depression, and schizophrenia must include the use of evidence-based practice for co-occurring disorders. In 2.8.7.2, the contracts also require the MCOs to establish measurable benchmarks and goals for each DM program and to evaluate the programs using these benchmarks and goals. These benchmarks and goals should include: performance measured against at least two important clinical aspects of the guidelines associated with each DM program.	2.30.5.2 requires the MCOs to submit an annual Disease Management Report for each of the DM programs that contain information about the use, updating and dissemination of clinical practice guidelines for each DM program and includes benchmarks and goals as described in Section 2.8.7.	4.20.2.1.1 – Liquidated damages can be assessed for each day that a report or deliverable is late, incorrect, or deficient.
		Some of these requirements are evaluated as part of the Annual Quality Survey (AQS)[iii], an EQRO mandatory activity.	TennCare requires that each MCC submit a plan of correction (POC) for any element not meeting 100% compliance. 4.20.2.2.7 B.2 – Liquidated damages can be assessed for failure to complete or comply with corrective action plans as required by TENNCARE.
		Some of these requirements are	4.20.2.2.7 B.4 – Liquidated

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
		deemed met by the NCQA Accreditation Survey. For specific information, see Attachment A: State Requirements Deemed Met by NCQA Accreditation Survey- Practice Guidelines.	damages can be assessed for failure to submit NCQA Accreditation Report within 10 days of receipt.
42 CFR 438.240 Quality Assessment and Performance Improvement Program - 42 CFR 438.240(a) Program	The contracts with the MCOs address requirements for the Quality Management/Quality Improvement (QM/QI) program in section 2.15.1 and 2.15.2. Section 2.15.1.1 requires the program to be written and to be consistent with the current NCQA Standards and Guidelines for the Accreditation of HPs. Section 2.15.1.1.1 requires the program to address physical health, behavioral health, and long-term care. Section 2.15.1.1.7 requires the MCO to evaluate the program annually and to update the program as appropriate.	2.30.11.1 requires the MCOs to annually submit the following Quality Management/Quality Improvement Reports including, but not limited to: QM/QI Program Description, Associated Work Plan, and Annual Evaluation.	4.20.2.1.1 – Liquidated damages can be assessed for each day that a report or deliverable is late, incorrect, or deficient.
		CRA Attachment VIII requires the MCOs to submit documentation for review and/or approval by TennCare during readiness review and/or during operations: 40. QM/QI policies and procedures to ensure compliance with Section 2.15.	
		Some of these requirements are evaluated as part of the Annual Quality Survey (AQS)[iii], an EQRO mandatory activity.	TennCare requires that each MCC submit a plan of correction (POC) for any element not meeting 100% compliance. 4.20.2.2.7 B.2 – Liquidated damages can be assessed for

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
			failure to complete or comply with corrective action plans as required by TENNCARE.
		Some of these requirements are deemed met by the NCQA Accreditation Survey. For specific information, see Attachment A: State Requirements Deemed Met by NCQA Accreditation Survey-Program.	4.20.2.2.7 B.4 – Liquidated damages can be assessed for failure to submit NCQA Accreditation Report within 10 days of receipt.
42 CFR 438.240(c) Performance Measurement	In 2.15.6.1, the contracts require the MCOs to annually complete all HEDIS measures designated by NCQA as relevant to Medicaid. The only exclusion from the complete Medicaid HEDIS data set is dental measures. The MCO is required to contract with an NCQA certified HEDIS auditor to validate the processes of the MCO in accordance with NCQA requirements.	2.15.6.1 requires the MCOs to annually submit audited HEDIS results to TennCare, NCQA, and TennCare's EQRO.	4.20.2.2.7 B.3 - Liquidated damages can be assessed for failure to submit audited HEDIS and CAHPS results annually by June 15.
		This requirement is evaluated by the Performance Measure Validation[iv], an EQRO mandatory activity.	
		This requirement is also evaluated by the HEDIS/CAHPS Report: A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs)[v], an EQRO contractual activity.	
	In 2.15.6.2, the contracts require the MCOs to annually conduct CAHPS surveys including the CAHPS adult survey, CAHPS child survey and the CAHPS children with chronic	2.15.6.2 requires the MCOs to annually submit survey results to TennCare, NCQA, and TennCare's EQRO.	4.20.2.2.7 B.3 - Liquidated damages can be assessed for failure to submit audited HEDIS and CAHPS results

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
	conditions survey. The MCO is required to enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys.		annually by June 15.
		This requirement is evaluated by the HEDIS/CAHPS Report: A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs)[v], an EQRO contractual activity.	
42 CFR 438.240(d) Performance Improvement Projects	In 2.15.3, the contracts require each MCO to conduct two clinical and three nonclinical performance improvement projects (PIPs) relevant to the enrollee population. One of the two clinical PIPs must be relevant to one of the behavioral health disease management programs for bipolar disorder, major depression, or schizophrenia. Two of the three nondinical PIPs must be in the area of long-term care.	2.30.11.2 requires the MCOs to submit an annual Report on Performance Improvement Projects to TennCare.	4.20.2.1.1 – Liquidated damages can be assessed for each day that a report or deliverable is late, incorrect, or deficient.
		This requirement is evaluated by the Performance Improvement Project Validation[vi], an EQRO mandatory activity.	
42 CFR 438.242 Health Information Systems	The contracts with the MCOs contain information system requirements in section 2.23. The MCOs are required to have information management processes and information systems that enable them to meet TennCare and federal reporting requirements. This section includes requirements for: general provisions; data and document management; system and data integration; encounter data provision	2.30.17 requires submission of information system reports including, but not limited to: Systems Refresh Plan, Encounter Data Files, Systems Availability and Performance Report, Business Continuity and Disaster Recovery Plan.	2.23.13 addresses corrective actions, liquidated damages, and sanctions related to information systems.

Federal Requirements	State Standards	State Monitoring	MCO Sanctions
	(encounter submission and processing); eligibility and enrollment data exchange; system and information security and access management; systems availability, performance and problem management; system user and technical support; system testing and change management; information systems documentation; reporting; and statewide data warehouse and community health record.		

[i] QSource conducts a quarterly provider data validation survey. The purpose of this activity is to determine the accuracy of the provider data files submitted by the TennCare Managed Care Contractors (MCCs) and to use the results as a proxy to determine the extent to which providers are available and accessible to TennCare enrollees. For this activity, MCCs include Managed Care Organizations (MCOs) and the Dental Benefits Manager (DBM). The following data elements from the provider files were identified for validation by TennCare and QSource: contract status with MCC, provider address, provider specialty/behavioral health service code, panel status (open/closed), services to children under 21, services to adults 21 and older, primary care services (MCOs/DBM), and prenatal services (MCOs). Based on contractual requirements, additional information related to the availability of routine and urgent care services is also collected.

[ii] The Annual Network Adequacy and Benefit Delivery Review (ANA) is conducted by Health Services Advisory Group (HSAG), a subcontractor for QSource, at the direction of the Tennessee Department of Commerce and Insurance (TDCI). The DBM and each MCO is evaluated to determine if it has an adequate provider network to ensure the effective and efficient delivery of healthcare to enrollees. The review also examines the completeness of each health plan's communication with its enrollees and providers regarding TennCare-covered services. The ANA includes: analyses of the distribution, availability, and assignment of providers to TennCare enrollees; review of credentialing/recredentialing and contracting policies and procedures; examination of each health plan's provider manual and enrollee handbook; review of a sample of credentialing/recredentialing files and provider contracts; determination of the number of appointments and access complaints; analysis of the distribution of providers and service facilities.

[iii] QSource conducts an Annual Quality Survey (AQS) of each Managed Care Organization (MCO) and the Dental Benefits Manager (DBM). The purpose of the AQS is to determine the extent to which each TennCare MCC is in compliance with the TennCare Contractor Risk Agreement (CRA), and the quality process (QP) standards and performance activities (PAs) derived from them. The AQS also evaluates compliance with: QP standards for the John B. Consent Decree, Grier Revised Consent Decree, Newberry Dispute Resolution, and non-discrimination; PAs derived from the John B. Consent Decree, Grier Revised Consent Decree, Newberry Dispute Resolution; 42 CFR Parts 417.106, 430,433, 434, and 438; other quality standards established by the state of Tennessee. QSource

follows *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs), Final Protocol Version 1.0, February 11, 2003* to complete the review.

[iv] Performance Measure Validation for the MCOs is conducted by HSAG, subcontractor to QSource. The audit includes detailed review of a select set of two HEDIS measures required for reporting by TennCare. HSAG is an organization licensed by NCQA to perform HEDIS audit reviews. HSAG conducts an independent audit of HEDIS data from each MCO consistent with the current volume of NCQA's HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5. The auditor's examination includes procedures to obtain reasonable assurance the Final Audit Report presents fairly, in all material respects, the MCO's performance with respect to the HEDIS Technical Specifications. This activity is not required for the DBM.

[v] QSource compiles the annual *HEDIS/CAHPS Report: A Comparative Analysis of Audited Results from TennCare Managed Care organizations (MCOs).* The report includes a statewide performance section in which statewide weighted rates calculated from all reporting MCOs are compared to national averages and statewide rates for the previous reporting period. An individual plan performance section is also included in the report. This section allows for cross-comparison of results across the state's MCOs. In this section, HEDIS results are color-coded according to national percentiles and CAHPS results are color-coded according to comparison with the statewide average.

[vi] Annually, Performance Improvement Project (PIP) Validation of one or more PIPs completed by each MCO, is conducted on behalf of QSource by HSAG in accordance with CMS's *Validating Performance Improvement Projects, a Protocol for Use in Conducting External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002*.

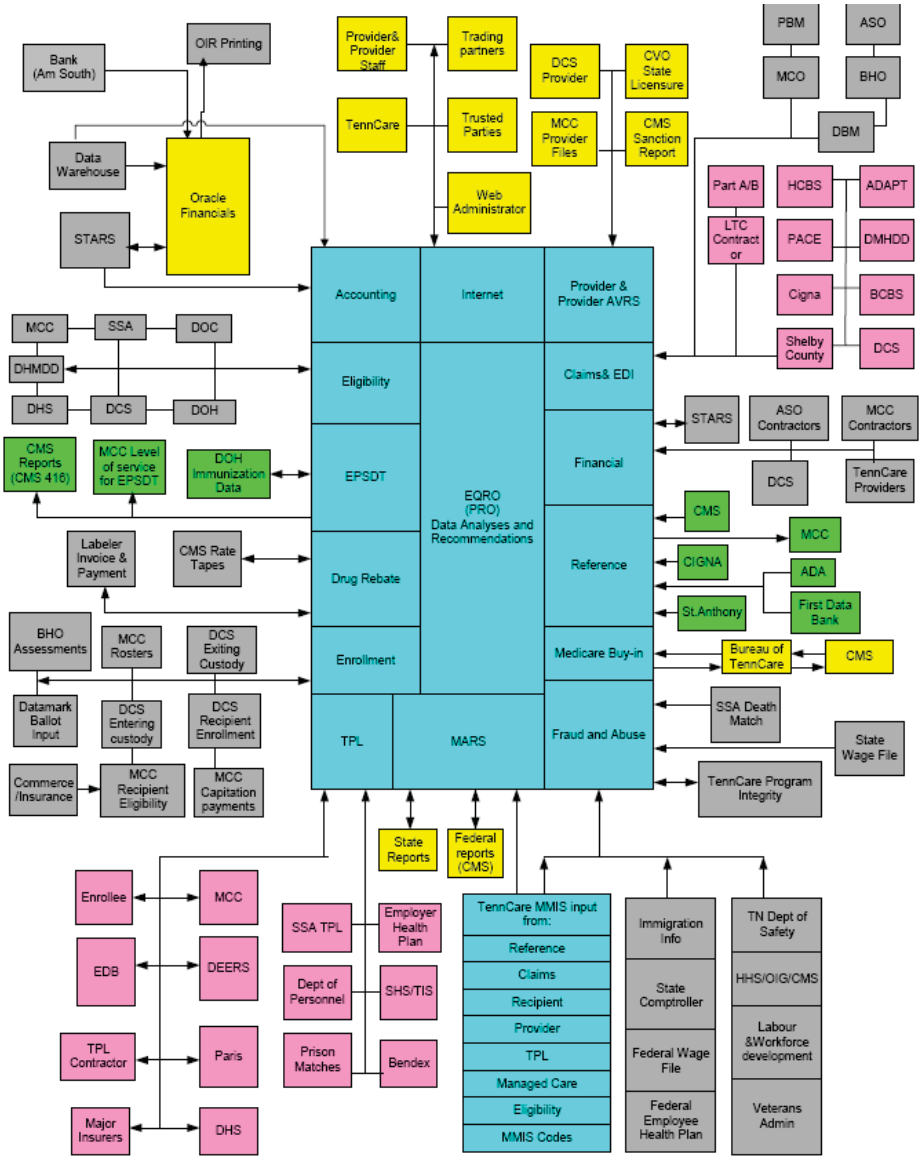
II.C Evolution of Health Information Technology

Information system to support initial and ongoing operation and review of the State's quality strategy objectives and progress toward performance targets

The TennCare Management Information System (TCMIS) supports the operation of TennCare and supports evaluation of progress toward targets for quality strategy objectives. One of the strategy objectives relies on data obtained from TCMIS. The strategy objective is 4.4 – By the end of each demonstration year, the state will achieve a total statewide EPSDT screening ratio of at least 80%.

TCMIS Interface Diagram

This diagram depicts the specific entities with which TennCare exchanges data.



Since July 1, 2009, TennCare has contracted with Electronic Data Systems (EDS) for operation and enhancement of the TennCare Management Information System (TCMIS). In September of 2009, EDS became HP Enterprise Services.

The current contract with HP Enterprise Services requires specific assessments of the TCMIS. The required assessments include Management and Administrative Reporting (MAR) review and ICD 10 design. HP Enterprise Services will review and assess the current MAR processes and provide recommendations for improving MAR as well as other TCMIS business analytics, decision support and dashboard capabilities for key business processes. HP Enterprise Services will also review the proposed changes to ICD coding in version 10, Procedural Coding System (PCS) and identify the changes needed in the TCMIS to accommodate them.

In addition to specific assessments, the current contract requires HP Enterprise Systems to perform specific enhancements to the TCMIS including:

1. **Capability Maturity Model Integration (CMMI)** – This Enhancement requires HP Enterprise Services to lead the effort in raising the TennCare capability maturity level.
2. **Technology Modernization** - This Enhancement requires HP Enterprise Services to support the Bureau's upgrade of specific hardware and software suites approaching end of life.
3. **Project Management Office (PMO)** - This Enhancement requires HP Enterprise Services to create a PMO for coordinating the multiple aspects and projects within the TCMIS.
4. **Commercial Off The Shelf (COTS) Dashboard** – This Enhancement is to establish the use of a COTS dashboard software product (such as Crystal Xcelsius), that shall be used to report performance metrics and operations indicators.
5. **COTS Documentation Software** - HP Enterprise Services shall secure and operate COTS documentation software with enhanced content management features and enhance Filenet, to be an enterprise-wide content management solution.
6. **Enhanced Testing Environment** – HP Enterprise Services shall develop multiple integrated test environments with subsequent promotion to a full system test environment and finally promoted to a regression test environment prior to a production release.
7. **Business Process Improvement** – This Enhancement requires HP Enterprise Services to develop a complete and detailed business process model of the Bureau and Contractor business processes, and that this process modeling shall include Activity Based Costing.
8. **Long-Term Care (LTC) CHOICES** - This Enhancement requires HP Enterprise Services to support the Bureau's implementation of the LTC CHOICES project.

<u>Progress towards Health Information Exchange (HIE)</u>

Tennessee continues to advance the adoption and meaningful use of health information technology (HIT) and health information exchange (HIE) to drive improvements in patient healthcare outcomes. It is anticipated that these advancements will not only enable vital, secure, decision-ready information to be available to clinicians at the point of care, but will also empower patients by making critical health information available to them. HIT and HIE is necessary to build Tennessee's health care delivery

foundation to improve both individual and population health. Substantial progress has been made to develop the infrastructure and capabilities for HIT and HIE at the state, regional, and institutional levels, the result of which is a dynamic environment enabling Tennessee to be at the forefront of delivering better health care. Tennessee is building its commitment to statewide HIE on quality and value, multi-sector collaboration, and sustainability. The Office of eHealth Initiatives, in the Tennessee Department of Finance and Administration, is the single coordinating authority for HIE in Tennessee and provides leadership, guidance, and operational support for e-Health efforts throughout the state.

Tennessee's statewide HIE framework consists of three categories of services:

- Core Services to help organizations locate, positively identify, and determine how to exchange information securely across organization boundaries
- Enterprise services to help organizations meet the federal criteria and state requirements for the meaningful use of certified EHR technologies
- Value-added services for inclusion within the statewide HIE framework based on the feasibility, cost, and value of the proposed service.

Currently clinical summary information is being exchanged through three operational Health Information Organizations (HIOs) and on a limited basis elsewhere in the state. Many geographic areas of the State are not currently served by HIOs and steps are being taken to initiate a number of local HIOs in these gaps. Among the first web-services proposed for the statewide HIE program is the development of a set of services that would allow HIOs and State departments to both create and consume a Continuity of Care Document (CCD). Many stakeholders view this as a key requirement for statewide HIE and for meaningful use as a means to enhance the coordination of care.

In Tennessee, a number of state-level databases are currently available to authorized users through the eHealth Network, including registries for immunization, licensure renewal and verification, and domestic violence. In addition, we are assessing the viability of using the eHealth Network to facilitate access to registries for cancer, controlled substances, newborn screening, and traumatic brain injury. As HIE capabilities continue to expand, Tennessee will explore opportunities to use the eHealth Network to build chronic disease registries for conditions like diabetes, stroke, etc.

Much progress has also been achieved in the area of electronic prescribing and Tennessee's Office of e-Health Initiatives has approved 1,961 healthcare providers and more than 420 treatment sites in its Tennessee as Physician Connectivity Grant recipients. Now expired, the Grant program required recipients to electronically prescribe for two years and has been a critical factor in Tennessee's HIE success. According to data compiled by Surescripts, a national electronic prescribing clearinghouse, the total percentage of prescriptions routed electronically in Tennessee has been: 0.45 percent in 2006, 1.14 percent in 2007, and 4.02 percent in 2008. Another measure of the use of electronic prescribing capabilities is the percentage of physicians who route their prescriptions electronically. The percentage of Tennessee providers who were routing electronic prescriptions was 1.74 percent in 2006, 6.45 percent in 2007, and 15.76 percent in 2008.

The Electronic Health Record (HER) Provider Incentive Program supports the adoption of Electronic Health Records (EHRs) by Eligible Professionals (EPs) and Eligible Hospitals (EHs) by providing financial incentives to providers that implement and demonstrate meaningful use of certified HER technology. Tennessee was the second state in the country to receive approval for implementation of the EHR Provider Incentive Program. As of May 2011, a total of 61 Acute Care hospitals, 24 Dentists, 664 physicians, 25 certified nurse midwives, 414 nurse practitioners, and 25 physicians assistants have applied to TennCare for the EHR incentive program. Tennessee is currently second in number of EPs/EHs who have applied to participate in the EHR Incentive Program and first in terms of the number who have been verified for participation. We look forward to the attestation process beginning April 4, 2011 where the eligible registrants will begin providing us their Medicaid encounter data so that we can verify the information in our system and make payments accordingly.

III. Improvement/Interventions

Implementation of interventions by the State specific to each strategic objective

TennCare has implemented a number of initiatives to support the goals of the TennCare Quality Strategy: assure appropriate access to care for enrollees, provide quality care to enrollees, assure enrollee satisfaction with services, and improve health care for program enrollees. These initiatives, in turn, support the attainment of the Quality Strategy objectives.

NCQA Health Plan Accreditation

Tennessee was the first state in the nation to mandate that all of its MCOs become accredited by the National Committee for Quality Assurance (NCQA). NCQA is an independent, 501(c)(3) non-profit organization that assesses and scores MCO performance in the areas of quality management and improvement, utilization management, provider credentialing and recredentialing, and members' rights and responsibilities. This process leaves only those MCOs providing the highest quality of care and service to provide for enrollees. All of TennCare's MCOs were initially accredited in 2006. In 2009, two of the original MCOs underwent the resurvey process and both MCOs maintained accreditation. In addition, a new MCO in Middle Tennessee completed the initial survey process and obtained accreditation. By the end of 2009, all TennCare MCOs were NCQA accredited. TennCare MCOs are contractually required to maintain accreditation once it is obtained, and Reaccreditation will occur in 2012.

In conjunction with accreditation, MCOs are required to annually submit a full set of audited measures from the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to NCQA. NCQA uses the results to reevaluate the organization's performance on specified HEDIS/CAHPS measures, and may change the organization's accreditation status based on the results.

Integrated Operations - Medical and Behavioral Healthcare

TennCare began integrating behavioral and medical health care delivery for Middle Tennessee members in 2007 with the implementation of two new MCOs. TennCare continued the process with the execution

of new MCO contracts in West Tennessee in November 2008 and East Tennessee in January 2009. In September 2009, behavioral health services for TennCare Select enrollees were transferred to BlueCross BlueShield of Tennessee (BCBST). TennCare Select operates statewide and serves enrollees such as foster children, children receiving SSI benefits and nursing facility or ICF-MR residents under age 21. It also serves as the back-up MCO should there be capacity problems with any of the other MCOs. This transition for TennCare Select completes TennCare's phased implementation of a fully-integrated service delivery model.

TENNderCARE

TennCare's Early Periodic Screening Diagnosis and Treatment (EPSDT) Program, TENNderCARE, aggressively reaches out to enrollees and informs them of the availability of services provided by the MCOs that are contracted by TennCare. To strengthen outreach efforts, TennCare has contracted with the Tennessee Department of Health to provide a comprehensive outreach program to all 95 Tennessee counties. The program is designed to inform families of the benefits of preventive health services, encourage families to utilize TENNderCARE services and to assist families with the scheduling of appointments. The TENNderCARE outreach program has two core elements: (1) a child enrollee call center and (2) a community-based outreach program. Also, TennCare provides marketing materials to state agencies, public schools, and mental health centers.

Statewide MCO Collaborative

In addition, MCOs and staff from TennCare and the Department of Health participate in a Managed Care Contractor (MCC) Collaborative. Meetings are held on a quarterly basis to identify innovative methods of providing TENNderCARE outreach to Youth under the age of 21 with a focus on teens. Through the collaborative, the MCCs decide on topics of special interest to adolescents for the quarterly teen newsletters. Each quarter an MCO is assigned the responsibility of writing articles for the newsletters and the DBM provides an article each quarter. The MCOs are responsible for printing and distributing the teen newsletters to their members between the ages of 15-20.

Emergency Room Diversion Grants

On April 15, 2008 Tennessee received $4,472,240 in Medicaid Emergency Room Diversion Grants for three projects for a two-year period. This initiative began in all three Grand Regions of the state: the Volunteer State Health Plan (VSHP) Partnership, the Haywood County Clinic, and the Nashville Medial Home Connection. The intent was to develop alternative service delivery systems to prevent the use of hospital emergency departments for primary and non-urgent care. Grant funding was extended for an additional year. The grant concludes in April 2011 with two sites completing the project: VSHP Partnership in the East region and the Haywood County Clinic in the West region. The objective of each site is to treat patients whose medical needs do not meet the intensity of receiving emergency department services and to facilitate the relationship with Primary Care Providers. Since December 2008 through the end of 2010, VSHP Partnership at the Erlanger-Pediatric Clinic has treated 14,813 patients, with 64% being Medicaid recipients. From June 2009 through the end of 2010, the Haywood County Clinic has treated 2,206 patients, with 52% being Medicaid recipients.

Pay-for-Performance Quality Incentive Payment

TennCare offered the first pay-for-performance quality incentive payments to the MCOs in 2006 and has continued to offer quality incentive payments annually since then. In 2010, TennCare offered quality incentive payments for six physical health HEDIS measures to the MCOs in the East, Middle, and West regions and to TennCare Select. In addition, TennCare offered quality incentive payments for three behavioral health HEDIS measures to the MCOs in the East, Middle, and West regions. MCOs were eligible for incentive payment if they demonstrated significant improvement from baseline for the specified measures or met a specified goal. Significant improvement was determined by using NCQA's minimum effect size change methodology. In 2010, AmeriChoice met the criteria for three quality incentive payments, Amerigroup met the criteria for four quality incentive payments, and VSHP met the criteria for nine quality incentive payments. TennCare plans to continue the pay-for-performance quality incentive payment program in 2011 and beyond.

Disease Management Programs

Each TennCare MCO provides ten (10) Disease Management (DM) programs for their TennCare members. Each MCO is required to provide disease management programs for Asthma, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Diabetes, Maternity and Obesity as well as Bipolar Disorder, Major Depression and Schizophrenia. The programs educate, coach, and support individuals or their care givers in assuming responsibility for their health status. The empowered member can resolve disease specific knowledge gaps, take action to reduce acute episodes requiring emergent or inpatient care, and improve their quality of life and health outcomes. At this time, all TennCare MCOs provide "Opt Out" Disease Management Programs. In an 'Opt Out" program, members are considered as participants and are enrolled in the program upon identification of eligibility and remain until the member actively notifies the health plan of their desire to opt-out. Disease management programs emphasize education to promote self management strategies, healthy lifestyles, medication adherence, and regular preventive visits to a primary care physician and or specialist. Each MCO has dedicated staff to provide disease management interventions. The type and intensity of Disease Management intervention provided is related to the severity of the condition and predictive future health risks of the member. Interventions range from providing general education about conditions to intense interventions including individualized care plans.

TennCare Health Plan Meetings

TennCare's External Quality Review Organization, QSource, conducts three meetings a year that are attended by TennCare and its MCCs. Each meeting is organized around a specific quality improvement (QI) topic and features keynote presentations, panel discussion and breakout sessions. QSource arranges for continuing education opportunities to be offered for at least one quarterly meeting per year.

IV. Strategy Effectiveness

Planned evaluations

TennCare plans to reevaluate the Quality Strategy objectives annually by December 31. Following this evaluation, TennCare will either continue with the current objectives or will choose new objectives. If TennCare chooses to continue with the current objectives, new targets may be set as appropriate. The table below summarizes TennCare's 2010 evaluation of the strategy objectives. 2010 HEDIS/CAHPS results are compared to the 2010 Medicaid National Average. Change has been determined from the baseline rates.

Quality Strategy Objectives				
Goals	**Objectives**	**2010 Statewide Rate**	**2010 National Average**	**Change from Baseline Statewide Rate to 2010 Statewide Rate**
1. Assure appropriate access to care for enrollees.	1.1 By 2013, the statewide weighted HEDIS rate for adults' access to preventive/ambulatory health services will increase to 75% for enrollees 20-44 years old and the rate for enrollees 45-64 years old will be maintained at 79% or above. **Baseline 2007: 70% 20-44 year olds; 74% 45-64 year olds**	a. 20-44 years old-79.50% b. 45-64 years old-79.89%	a. 80.38% b. 85.27%	**a. Increase – 9.5%** **b. Increase – 5.89%**
	1.2 By 2013, the statewide weighted HEDIS rate for children and adolescents' access to PCPs will increase to 90% for enrollees 7-11 years old and 86% for enrollees 12-19 years old. **Baseline 2007: 87% for 11 year olds; 82% for 12-19 year olds**	a. 7-11 years old-91.43% b. 12-19 years old-87.22%	a. 90.23% b. 87.85%	**a. Increase – 4.43% (objective met)** **b. Increase – 5.22% (objective met)**

Quality Strategy Objectives				
Goals	**Objectives**	**2010 Statewide Rate**	**2010 National Average**	**Change from Baseline Statewide Rate to 2010 Statewide Rate**
	1.3 By 2013, 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). **Baseline 2007: 94% Heads of Household; 97% Children**	a. Heads of household-92% b. Children-97%	NA-Not a HEDIS/CAHPS Rate	a. 2% decrease b. Same
2. Provide quality care to enrollees.	2.1 By 2013, the statewide weighted HEDIS rate for adolescent well-care visits will increase to 41%. **Baseline 2007: 35%**	41.1%	47.64%	**Increase – 6.1% (objective met)**
	2.2 By 2013, the statewide weighted HEDIS rate for timeliness of prenatal care will be maintained at 82% or above. **Baseline 2007: 78%**	81.06%	83.33%	**Increase – 3.06%**
	2.3 By 2013, the statewide weighted HEDIS rate for breast cancer screening will increase to 50%. **Baseline 2007: 44%**	38.45%	52.31%	Decrease – 5.55%
	2.4 By 2013, the statewide weighted HEDIS rate for cervical cancer screening will	61.30%	65.66%	Decrease – 1.7%

Quality Strategy Objectives				
Goals	**Objectives**	**2010 Statewide Rate**	**2010 National Average**	**Change from Baseline Statewide Rate to 2010 Statewide Rate**
	increase to 68%. **Baseline 2007: 63%**			
	2.5 By 2013, providers of EPSDT screening services will document the delivery of 95% of the required seven components of an EPSDT screen. **Baseline 2007: 89%**	94.0%	NA-Not a HEDIS/CAHPS measure	**Increase – 5%**
3. Assure enrollees' satisfaction with services.	3.1 By 2013, 95% of TennCare enrollees will be satisfied with TennCare. **Baseline 2007: 90%**	94%	NA-Not a HEDIS/CAHPS rate	**Increase – 4%**
	3.2 By 2013, the statewide average for adult CAHPS getting needed care-always or usually will increase to 82%. **Baseline 2007: 78%**	76.6%	76% (national benchmark)	Decrease – 1.4%
	3.3 By 2013, the statewide average for child CAHPS getting care quickly-always or usually will increase to 81%. **Baseline 2007: 79%**	88.78%	86% (national benchmark)	**Increase - 9.78% (objective met)**
4. Improve health care for program enrollees.	4.1 By 2013, the statewide weighted HEDIS rate for HbA1c testing will be maintained at 73% or above. **Baseline 2007: 68%**	77.93%	80.61%	**Increase – 9.93% (objective met)**

Quality Strategy Objectives				
Goals	**Objectives**	**2010 Statewide Rate**	**2010 National Average**	**Change from Baseline Statewide Rate to 2010 Statewide Rate**
	4.2 By 2013, the statewide weighted HEDIS rate for controlling high blood pressure will increase to 55%. **Baseline 2007: 50%**	53.67%	55.22%	**Increase – 3.67%**
	4.3 By 2013, the statewide weighted HEDIS rate for follow-up after hospitalization for mental illness will be maintained at 51% for follow-up within 7 days of discharge and 72% for follow-up within 30 days of discharge. **Baseline 2010: 37.93% for 7 day and 61.24% for 30 day**	a. 7 day-37.93% b. 30 day-61.24%	a. 42.69% b. 60.04%	**Due to changes in MCOs, 2010 will become the baseline for this measure**
	4.4 By the end of each demonstration year, the state will achieve a total statewide EPSDT screening rate of at least 80%. **Baseline 2007: 77%**	99%	Not a HEDIS/CAHPS measure	**Increase – 22% (objective met)**
	4.5 By 2013, the statewide weighted HEDIS rate for antidepressant medication management will be maintained at 63% for acute phase and 48% for continuation phase. **Baseline 2010: 50.11%**	a. Acute-50.11% b. Continuation-32.03%	a. 49.65% b. 32.95%	**Due to changes in MCOs, 2010 will become the baseline for this measure**

Quality Strategy Objectives				
Goals	**Objectives**	**2010 Statewide Rate**	**2010 National Average**	**Change from Baseline Statewide Rate to 2010 Statewide Rate**
	acute phase; 32.03% for continuation phase			
	4.6 By 2013, the statewide weighted HEDIS rate for follow-up care for children prescribed ADHD medication will be maintained at 36% for initiation and 46% for continuation and maintenance. **Baseline 2010: 34.29% initiation; 44.15% continuation**	a. Initiation-34.29% b. Continuation-44.15%	a. 36.45% b. 41.71%	**Due to changes in MCOs, 2010 will become the baseline for this measure**

Reporting requirements for MCOs to State

Data Source

MCO

The majority of the Quality Strategy objectives require statewide weighted HEDIS rates or statewide CAHPS averages based on MCO HEDIS/CAHPS results. These MCO HEDIS/CAHPS results are submitted to TennCare annually by the MCOs in mid-June. From the individual MCO results, the EQRO calculates the statewide weighted HEDIS rates and the statewide CAHPS averages in the annual HEDIS/CAHPS Report: A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs). This report is typically available in October.

TennCare

One of the strategy objectives is a statewide average based on MCO results obtained from the annual EPSDT Medical Record Review conducted by TennCare's Division of Quality Oversight. The review determines the extent to which medical providers are in compliance regarding the documentation of the

delivery of the seven components of the Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) exam. The medical record review is conducted annually in March or April. The completed report is typically available in May or June.

One of the strategy objectives is based on the TENNderCare screening ratio. This ratio is calculated by utilizing MCO encounter data submissions in accordance with specifications for the CMS-416 report. TennCare determines the statewide TENNderCare screening ratio annually in April.

University of Tennessee Knoxville-Center for Business and Economic Research

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. The report, The Impact of TennCare: A Survey of Recipients allows comparison between responses from all households and households receiving TennCare. The completed report is typically available in August.

Planned frequency of reporting Quality Strategy updates to CMS

Annually, in January, TennCare plans to review the Quality Strategy and provide a report to CMS by April 1 of each year that will include information on the implementation and effectiveness of the strategy. A revised strategy will be provided whenever significant changes occur in the TennCare Program.

V. Conclusions

Successes considered best practices

The following MCO promising practices have been identified for 2010:

Performance Measure Validation

- A strong commitment to and knowledge of the HEDIS reporting process.
- Each year, the MCOs efforts have become more sophisticated and coordinated, despite their geographically diverse staff.
- The use of NCQA-certified HEDIS reporting software, ensuring compliance with measure algorithms and the accurate production of HEDIS results.
- Claims data that is increasingly aligned across MCO business lines and/or regions. Internal processes helped ensure that claims were processed completely and accurately in the face of these changes.

Performance Improvement Projects

- Well-founded study topics based on high-volume and/or high-risk conditions
- Quality improvement strategies and processes based on data-driven causal/barrier analysis
- Continuous quality improvement for monitoring and modifying interventions.

- A foundation for comparing study results and tracking progress with the potential to affect member health, functional status or satisfaction

Annual Network Adequacy and Benefit Delivery Review

- Adherence to the network access and availability requirements established by TennCare. The majority of TennCare MCOs met or exceeded network requirements.
- Appropriate policies and procedures to ensure that qualified providers were accepted into the network. Credentialing and recredentialing files were well organized and information was easily accessible. The credentialing policies maintained by the MCOs were consistent with industry standards.
- Communication of existing benefits via member and provider handbooks. The MCOs also provided evidence that members and providers were notified of benefit changes via additional written materials, newsletters or notifications posted on health plan websites.

Annual Quality Survey

- *Substantial* or *Total Compliance* ratings across virtually all quality process standards and performance activities.
- Strong outreach, particularly for members age 20 and younger. The health plans continued making new member calls even though they were no longer required based on the high screening rates cited above.
- A commitment to care coordination. Examples included referrals to the Department of Children's Services for high emergency department utilization, internal assessments of physical-behavioral service integration and statewide collaboratives.

HEDIS/CAHPS 2010

Continuing the trend from the previous two years, improved statewide performance was noted in child health measures with some exceeding the HEDIS 2010 Medicaid National Average. Specifically, there was an increase in rates from HEDIS 2008 to HEDIS 2010 for:

- Childhood Immunization Status- all antigens demonstrated an increase
- Lead Screening in Children
- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection
- Well-Child Visits in the First 15 months of Life (6 or more visits)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
- Adolescent Well-Care Visits

Although Chronic Disease Management was previously identified as an area for improvement, gains continue to be made in the following HEDIS measures:

- Cholesterol Management for Patients with Cardiovascular Conditions
- Comprehensive Diabetes Care

- Controlling High Blood Pressure
- Annual Monitoring for Patients on Persistent Medications
- Medical Assistance with Smoking and Tobacco Use Cessation (Advising Smokers and Tobacco Users to Quit and Discussing Cessation Medications)

HEDIS 2010 marks the first year of statewide reporting of Behavioral Health measures following integration of medical-behavioral health services among TennCare's MCOs. Antidepressant Medication Management (Effective Acute Phase Treatment) was higher than the 2010 Medicaid National Average.

Ongoing challenges for the State in improving the quality of care for Medicaid beneficiaries

Over the last few years some of the Managed Care Contractors have changed. The most recent change occurred in 2010 with the Dental Benefits Manager changing from Doral to Delta Dental. As is always the case when major changes occur, there is a period of transition that can be challenging. The Bureau of TennCare has worked closely with each new contractor to assure that services are continued without interruption and that enrollees are not inconvenienced. Close monitoring will continue to occur in the future through reporting mechanisms, on-site visits, meetings and conference calls.

Recommendations by the State for ongoing Medicaid quality improvement activities in the State

- **Continue the CHOICES Special Study:** In July 2009, CMS approved an amendment to the TennCare waiver that allows MCOs to coordinate all of the care a TennCare member receives, which will now include medical, behavioral and long-term care. Implementation of CHOICES for the Middle Grand Region MCOs occurred March 1, 2010 and the East and West Grand Region MCOs August 1, 2010. TennCare is requiring the MCOs to participate in a CHOICES Special Study focusing on the topic of rebalancing the long-term care system. CMS *Protocols for Conducting Performance Improvement Projects* and the Money Follows the Person (MFP) Demonstration Grant were used as resources to develop the study topic and indicators. In 2010, workgroups were held with the MCOs to finalize the sources for data collection and methodology. 2011 marks the first year of reporting activities for the CHOICES Special Study.
- **Rotate Performance Improvement Project Validation Study Topics:** Performance Improvement Project (PIP) study topics will continue to be rotated for validation to ensure Managed Care Contractors (MCC) are universally applying sound methodologies to all PIPs. The rotation process was instituted because it seemed more attention to detail was paid to those projects that were going to be validated.
- **Enhance monitoring of integration of physical and behavioral health services:** Coordination of services between physical and behavioral health providers of care will continue to be monitored carefully.
- **Continuation of collaborative workgroups:** The Division of Quality Oversight has established collaborative workgroups that include representatives for each MCO, the EQRO, and other TennCare contractors as appropriate. At this time there are three active workgroups. Other groups will be established as needs are identified. The groups and their current areas of focus are as follows:

  - Diabetes Collaborative – ways to increase HEDIS rates for retinal eye exams
  - Maternity Collaborative - outreach to pregnant women. Previously this group has addressed smoking cessation
  - EPSDT – outreach to teens
- **Establish performance measures for other activities conducted by the MCOs.** The Division is currently implementing performance measures for Disease Management Programs.
- **Place an increased emphasis on data collection for racial and ethnic disparities.** The MCCs are required, by October 1, 2011, to provide the Bureau of TennCare with a plan that describes how they intend to collect data in accordance with the HHS initiative to implement a multifaceted health disparities data collection strategy.

Appendix A: State Requirements Deemed Met by NCQA Accreditation Survey [i]

Access to Care

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
42 CFR 438.206 Availability of Services	*CRA § 2.11.1.5.1-.4 (E/W, Middle and 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, medical, behavioral health, or long-term care, or treatment options, including any alternative treatment 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.
	CRA § 2.12.9.18, .20 and .50 (E/W, Middle and TCS)	**QI 3A Practitioner Contracts and QI 3C Provider Contracts**
	All provider agreements executed by the CONTRACTOR, and all provider agreements executed by subcontracting entities or organizations, shall…meet the following requirements: Provide that TENNCARE, DHHS OIG, Office of the Comptroller of the Treasury, OIG, TBI MFCU, and DOJ, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to this Agreement including, but not limited to medical records, billing records, financial	**QI 3A Practitioner Contracts** Contracts with practitioners specifically require that: 1. Practitioners cooperate with QI activities 2. The organization has access to practitioner medical records, to the extent permitted by state and federal law 3. Practitioners maintain the confidentiality of member information and records **QI 3C Provider Contracts** Contracts with organization providers specifically require that: 1. Providers cooperate with QI activities 2. The organization has access to provider medical records, to the extent permitted by state and federal law

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. Include a statement that HIPAA does not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to, OIG, TBI MFCU, DHHS OIG and DOJ. Provide that any authorized state or federal agency or entity, including, but not limited to TENNCARE, OIG, TBI MFCU, DHHS OIG, DOJ, Office of the Comptroller of the Treasury, may use these records and information for administrative, civil or criminal investigations and prosecutions; Provide for the participation and cooperation in any internal and external QM/QI, monitoring, utilization review, peer review and/or appeal procedures established by the CONTRACTOR and/or TENNCARE; Require safeguarding of information about enrollees according to applicable state and federal laws and regulations…	3. Providers maintain the confidentiality of member information and records
	CRA § 2.18.1.1 and .4, and 2.18.4.3 and .4 (E/W, Middle and TCS)	**UM 3A Access to Staff**

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	The CONTRACTOR shall operate a toll-free telephone line (member services information line) to respond to member questions, concerns, inquiries, and complaints from the member, the member's family, or the member's provider. The CONTRACTOR shall ensure that the member services information line is staffed adequately to respond to members' questions, at a minimum, from 8 a.m. to 5 p.m., in the time zone applicable to the Grand Region being served (for the Middle Grand Region, the applicable time zone shall be Central Time), Monday through Friday, except State of Tennessee holidays. The CONTRACTOR shall develop provider service line policies and procedures that address staffing, training, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards. The CONTRACTOR shall ensure that the provider service line is staffed adequately to respond to providers' questions at a minimum from 8 a.m. to 5 p.m., in the time zone applicable to the Grand Region being served (for the Middle Grand Region, the applicable time zone shall be Central Time), Monday through Friday, except State of Tennessee holidays.	The organization provides the following communication services for members and practitioners. 1. Staff are available at least eight hours a day during normal business hours for inbound calls regarding UM issues 2. Staff can receive inbound communication regarding UM issues after normal business hours 3. Staff can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon 4. Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues 5. Staff or a toll-free number are available to accept collect calls regarding UM issues 6. Staff are accessible to callers who have questions about the UM process
	CRA § 2.18.3 and 2.18.2-2.18.3 (E/W, Middle and TCS)	**QI 4A Cultural Needs and Preferences and RR 4B Interpreter Services**
	As required by 42 CFR 438.206, 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 CONTRACTOR shall provide interpreter and translation services free of charge to members. Interpreter services should be available in the form of	**QI 4A Cultural Needs** The organization assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary. **RR 4B Interpreter Services** The organization provides interpreter or bilingual services within its Member Services Department and telephone function based on the linguistic needs of its members.

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	in-person interpreters, sign language or access to telephonic assistance, such as the ATT universal line.	
42 CFR 438.208 Coordination and Continuity of Care	*CRA § 2.9.4.1.1-.2 (E/W, Middle and TCS)*	**QI 10C Continued Access to Practitioners**
	Except as provided below regarding members who are in their second or third trimester of pregnancy, the CONTRACTOR shall provide continuation of such provider for up to ninety (90) calendar days or until the member may be reasonably transferred to another provider without disruption of care, whichever is less. For members in their second or third trimester of pregnancy, the CONTRACTOR shall allow continued access to the member's prenatal care provider and any provider currently treating the member's chronic or acute medical or behavioral health condition or currently providing long-term care services, through the postpartum period.	If the practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows. 1. Continuation of treatment through the lesser of the current period of active treatment, or for up to 90 calendar days for members undergoing active treatment for a chronic or acute medical condition 2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy
	CRA § 2.9.4.1 (E/W, Middle and TCS)	**QI 10D Transition to Other Care**
	The CONTRACTOR shall actively assist members with chronic or acute medical or behavioral health conditions, members who are receiving long-term care services, and members who are pregnant in transitioning to another provider when a provider currently treating their chronic or acute medical or behavioral health condition, currently providing their long-term care services, or currently providing prenatal services has terminated participation with the CONTRACTOR. For CHOICES members, this assistance shall be provided by the member's care coordinator/care coordination team.	The organization assists with a member's transition to other care, if necessary, when benefits end.
42 CFR 438.210 Coverage and Authorization of Services	*CRA § 2.7.1.2-.3 (E/W, Middle and TCS)*	**UM 12A Policies and Procedures and UM 12C Organization's Authorized Representative**
	...The CONTRACTOR shall base coverage decisions for emergency services on the severity of the symptoms at the time of presentation and shall cover emergency	**UM 12A Policies and Procedures** The organization's emergency services policies and procedures require coverage of emergency services in the following

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	services where the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. The CONTRACTOR shall not impose restrictions on coverage of emergency services more restrictive than those permitted by the prudent layperson standard. The CONTRACTOR shall provide coverage for inpatient and outpatient emergency services, furnished by a qualified provider, regardless of whether the member obtains the services from a contract provider, that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard. These services shall be provided without prior authorization in accordance with 42 CFR 438.114. The CONTRACTOR shall pay for any emergency screening examination services conducted to determine whether an emergency medical condition exists and for all emergency services that are medically necessary until the member is stabilized.	situations. 1. To screen and stabilize the member without prior approval, where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed 2. If an authorized representative, acting for the organization, authorized the provision of emergency services **UM 12C Organization's Authorized Representative** The organization covers emergency services approved by an authorized representative.
	CRA § 2.8.4 (E/W, Middle and TCS)	**QI 8B Program Content**
	Each DM program shall include the development of treatment plans, as described in NCQA Disease Management program content, that serve as the outline for all of the activities and interventions in the program. At a minimum the activities and interventions associated with the treatment plan shall address condition monitoring, patient adherence to the treatment plan, consideration of other co-morbidities, and condition-related lifestyle issues. For CHOICES members, appropriate elements of the treatment plan shall be individualized and integrated into the member's plan of care to facilitate better management of the member's condition.	The content of the organization's programs addresses the following for each condition. 1. Condition monitoring 2. Patient adherence to the program's treatment plans 3. Consideration of other health conditions 4. Lifestyle issues, as indicated by practice guidelines (e.g., goal-setting techniques, problem solving)
	CRA § 2.8.2.1, 2.8.1.4 and 2.8.1.4.2 (E/W, Middle and TCS)	**QI 8C Identifying Members for DM Programs and QI 8D Frequency of Member Identification**

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	The CONTRACTOR shall have a systematic method of identifying and enrolling eligible members in each DM program, including CHOICES members, through the same processes used for identification of non-CHOICES members and the CHOICES care coordination process. The CONTRACTOR shall develop and maintain DM program descriptions. These program descriptions shall include…the following: Member identification strategies, which shall not exclude CHOICES members, including dual eligible CHOICES members.	**QI 8C 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 case management or UM process, if applicable 6. Member and practitioner referrals **QI 8D Frequency of Member Identification** The organization systematically identifies members who qualify for each of its DM programs. (Scored at 100% if done monthly; at 80% if done quarterly; 20% if done every 6 months and 0% if less frequently.)
	CRA §2.8.2.2 (E/W, Middle and TCS)	**QI 8E Providing Members with Information**
	The CONTRACTOR shall operate its disease management programs using an "opt out" methodology, meaning that disease management services shall be provided to eligible members unless they specifically ask to be excluded.	The organization provides eligible members with the following written information about the program. 1. How to use the services 2. How members become eligible to participate 3. How to opt in or opt out
	CRA § 2.8.3 (E/W, Middle and TCS)	**QI 8F Interventions Based on Assessment**
	As part of the DM programs, the CONTRACTOR shall classify eligible members into stratification levels according to condition severity or other clinical or member-provided information which, for members enrolled in the CHOICES program shall also include stratification by the type of setting in which long-term care services are delivered, i.e., nursing facility, community-based residential alternative, or home-based. The DM programs shall tailor the program content and education activities for each stratification level. For CHOICES members, this shall include targeted interventions based on the setting in which the member resides.	The organization provides interventions to members based on assessment.

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	CRA § 2.8.7.2, 2.8.7.2.4 and 2.8.7.2.5 (E/W, Middle and TCS)	**QI 8G Eligible Member Participation**
	The CONTRACTOR shall establish measurable benchmarks and goals for each DM program and shall evaluate the programs using these benchmarks and goals. The calculations for the benchmarks and goals should include non-CHOICES members only. These benchmarks and goals shall include: The passive participation rates (as defined by NCQA) and the number of individuals participating in each level of each of the DM programs; Member adherence to treatment plans.	The organization annually measures member participation rates.
	CRA § 2.8.6 (E/W, Middle and TCS)	**QI 8H Informing and Educating Practitioners**
	As part of the DM programs, the CONTRACTOR shall educate providers regarding the guidelines and shall distribute the guidelines to providers who are likely to treat enrollees with the DM conditions. This includes, but is not limited to, PCPs and specialists involved in treating that particular condition. The CONTRACTOR shall also provide each PCP with a list of their patients enrolled in each DM program upon the member's initial enrollment and at least annually thereafter. The CONTRACTOR shall provide specific information to the provider concerning how the program(s) works. The DM's provider education shall be designed to increase the providers' adherence to the guidelines in order to improve the members' conditions.	The organization provides practitioners with written information about the program that includes the following. 1. Instructions on how to use disease management services 2. How it works with a practitioner's patients in the program
	CRA § 2.8.7.1 (E/W, Middle and TCS)	**QI 8J Satisfaction With Disease Management**
	The CONTRACTOR shall evaluate member satisfaction with the DM services (as described by NCQA) by systematically analyzing feedback from members and analyzing member complaints and inquiries at least annually. The feedback on satisfaction shall be specific to DM programs.	The organization annually evaluates satisfaction with its disease management services by: 1. Obtaining member feedback 2. Analyzing member complaints and inquiries

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	CRA § 2.14.1.1 (E/W, Middle and TCS)	**UM 1A Written Program Description and UM 1D Annual Evaluation**
	The CONTRACTOR shall develop and maintain a utilization management (UM) program. As part of this program the CONTRACTOR shall have policies and procedures with defined structures and processes. The UM program shall assign responsibility to appropriate individuals including a designated senior physician and shall involve a designated behavioral health care practitioner in the implementation of behavioral health aspects of the program and a designated long-term care professional in the implementation of the long-term care aspects of the program. The UM program shall be supported by an associated work plan and shall be evaluated annually and updated as necessary.	**UM 1A Written Program Description** The organization's UM program description includes the following. 1. A written description of the program structure 2. Behavioral healthcare aspects of the program 3. Involvement of a designated senior physician in UM program implementation implementation 4.Involvement of a designated behavioral healthcare practitioner (BHP) in the implementation of the behavioral healthcare aspects of the UM program 5. The program scope and process used to determine benefit coverage and medical necessity 6. Information sources used to determine benefit coverage and medical necessity **UM 1D Annual Evaluation** The organization annually evaluates and updates the UM program as necessary.
	CRA § 2.14.1.1 (E/W, Middle and TCS)	**UM 1B Physician Involvement and UM 1B Physician Involvement**
	The CONTRACTOR shall develop and maintain a utilization management (UM) program. As part of this program the CONTRACTOR shall have policies and procedures with defined structures and processes. The UM program shall assign responsibility to appropriate individuals including a designated senior physician and shall involve a designated behavioral health care practitioner in the implementation of behavioral health aspects of the program and a designated long-term care professional in the implementation of the long-term care aspects of the program. The UM program shall be supported by an associated work plan and shall be evaluated annually and updated as necessary.	**UM 1B Physician Involvement** A senior physician is actively involved in implementing the organization's UM program. **UM 1C Behavioral Health Involvement** A BHP is actively involved in implementing the behavioral health aspects of the UM program.

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	CRA § 2.14.1.7 and 2.14.1.9 (E/W, Middle and TCS)	**UM 4F Affirmative Statement About Incentives**
	…The CONTRACTOR shall not place maximum limits on the length of stay for members requiring hospitalization and/or surgery. The CONTRACTOR shall 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 member and his/her medical history. The CONTRACTOR shall consider individual member characteristics in the determination of readiness for discharge. This requirement is not intended to limit the ability of the CONTRACTOR to use clinical guidelines or criteria in placing tentative limits on the length of a prior authorization or pre-admission certification. The CONTRACTOR shall assure, consistent with 42 CFR 438.6(h), 42 CFR 422.208 and 422.210, that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member.	The organization distributes a statement to all members and to all practitioners, providers and employees who make UM decisions, affirming the following. 1. UM decision making is based only on appropriateness of care and service and existence of coverage 2. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care 3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization
	CRA § 2.14.1.6 (E/W, Middle and TCS)	**UM 4A 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	The organization has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions 2. Specifying the type of personnel responsible for each level of UM decision-making

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	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 § 2.14.1.1 and 2.14.1.6 (E/W, Middle and TCS)	**UM 4B Use of Practitioners for UM Decisions, UM 4C Practitioner Review of Non-BH Denials, and UM 4D Practitioners Review of BH Denials**
	The CONTRACTOR shall develop and maintain a utilization management (UM) program. As part of this program the CONTRACTOR shall have policies and procedures with defined structures and processes. The UM program shall assign responsibility to appropriate individuals including a designated senior physician and shall involve a designated behavioral health care practitioner in the implementation of behavioral health aspects of the program and a designated long-term care professional in the implementation of the long-term care aspects of the program. The UM program shall be supported by an associated work plan and shall be evaluated annually and updated as necessary. 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	**UM 4B Use of Practitioners for UM Decisions** The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: 1. Education, training or professional experience in medical or clinical practice 2. A current license to practice without restriction **UM 4C Practitioner Review of Non-BH Denials** The organization ensures that a physician, or other health care professional, as appropriate, reviews any non-behavioral health denial of care based on medical necessity. **UM 4D Practitioners Review of BH Denials** The organization ensures that a physician, appropriate behavioral health practitioner or pharmacist, as appropriate, reviews any behavioral health denial of care based on medical necessity.

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	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 § 2.14.1.1.6 (E/W, Middle and TCS)	**UM 4 E Use of Board-Certified Consultants**
	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.	The organization has written procedures for using board-certified consultants and evidence that it uses these procedures to assist in making medical necessity determinations.
	CRA § 2.14.1.4.1-.5 (E/W, Middle and TCS)	**UM 2A UM Criteria**
	The UM program shall have criteria that: Are objective and based on medical, behavioral health and/or long-term care evidence, to the extent possible; Are applied based on individual needs; Are applied based on an assessment of the local delivery system; Involve appropriate practitioners in developing, adopting and reviewing them; and Are annually reviewed and up-dated as appropriate.	The organization: 1. Has written UM decision-making criteria that are objective and based on medical evidence 2. Has written policies for applying the criteria based on individual needs 3. Has written policies for applying the criteria based on an assessment of the local delivery system 4. Involves appropriate practitioners in developing, adopting and reviewing criteria 5. Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	CRA § 2.14.1.1 (E/W, Middle and TCS)	**UM 6A Information for UM Decision Making**
	The CONTRACTOR shall develop and maintain a utilization management (UM) program. As part of this program the CONTRACTOR shall have policies and procedures with defined structures and processes. The UM program shall assign responsibility to appropriate individuals including a designated senior physician and shall involve a designated behavioral health care practitioner in the implementation of behavioral health aspects of the program and a designated long-term care professional in the implementation of the long-term care aspects of the program. The UM program shall be supported by an associated work plan and shall be evaluated annually and updated as necessary.	For at least 12 months, the organization has had in place a written description that identifies the information needed to support UM decision making.
	CRA § 2.14.2.1 (E/W, Middle and TCS)	**UM 7A Notification of Reviewer Availability, UM 7B Discussing a Denial With a Reviewer, and UM 7E Discussing a BH Denial With a Reviewer**
	…The policies and procedures shall provide for consultation with the requesting provider when appropriate…	**UM 7A Notification of Reviewer Availability** The organization notifies practitioners: 1. The organization's policy for making an appropriate practitioner reviewer available to discuss any UM denial decision 2. How to contact a reviewer. **UM 7B Discussing a Denial With a Reviewer** The organization provides practitioners with the opportunity to discuss any non-behavioral health UM denial decision with a physician or other appropriate reviewer. **UM 7E Discussing a BH Denial With a Reviewer** The organization provides practitioners with the opportunity to discuss any behavioral health UM denial decision with a physician, appropriate behavioral health or pharmacist reviewer.
	CRA § 2.14.1.10 (E/W, Middle and TCS)	**UM 11A Assessing Satisfaction With the UM Process**

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	…The CONTRACTOR shall assess provider/office staff satisfaction with UM processes to identify areas for improvement.	The organization's annual assessment of satisfaction with the UM process includes: 1. Collecting and analyzing data on member satisfaction for the identification of improvement opportunities 2. Collecting and analyzing data on practitioner satisfaction for the identification of improvement opportunities 3. Taking action designed to improve member satisfaction based on its assessment of member data 4. Taking action designed to improve practitioner satisfaction based on its assessment of practitioner data

Structure and Operations

Federal Requirements	2010 State Standards	2010 NCQA Standards
42 CFR 438.218 **Enrollee Information**	*CRA § 2.17.4.1, 2.17.4.7 and 2.17.4.7.25 (E/W, Middle and TCS)*	**RR 1A Statement of Members' Rights and Responsibilities and RR 2A Distribution of Rights Statement to Members and Practitioners**
	The CONTRACTOR shall develop a member handbook based on a template provided by TENNCARE, and update it periodically (at least annually). Upon notice to TENNCARE of material changes to the member handbook, the CONTRACTOR shall make appropriate revisions and immediately distribute the revised handbook to members and providers. Each member handbook shall, at a minimum, be in accordance with the following guidelines: Shall include written policies on member rights and responsibilities, pursuant to 42 CFR 438.100 and NCQA's Standards and Guidelines for the Accreditation of MCOs	**RR 1A Statement of Members' Rights and Responsibilities** The organization has a written policy that states its commitment to treating members in a manner that respects their rights, and its expectations of members' responsibilities. **RR 2A Distribution of Rights Statement to Members and Practitioners** The organization distributes its member rights and responsibilities statement to members and participating practitioners.
42 CFR 438.224 **Confidentiality**	*CRA § 2.27.2, 2.27.2.8, .13, .15-.17, .22 and .24 (E/W, Middle and TCS);*	**RR 6A Adopting Written Policies**
	In accordance with HIPAA regulations, the CONTRACTOR shall, at a minimum: Make available to TENNCARE enrollees the right to	The organization adopts written PHI policies and procedures that address: 1. Information included in notification of privacy practices

Federal Requirements	2010 State Standards	2010 NCQA Standards
	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; Create and adopt policies and procedures to periodically audit adherence to all HIPAA regulations, and for which CONTRACTOR acknowledges and promises to perform, including but not limited to, the following obligations and actions: Implement all appropriate administrative, technical and physical safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this Agreement and, including but not limited to, confidentiality requirements in 45 CFR Parts 160 and 164; Set up appropriate mechanisms to limit use or disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure; Create and implement policies and procedures to address present and future HIPAA regulation requirements as needed to include: use and disclosure of data; de-identification of data; minimum necessity access; accounting of disclosures; patients rights to amend, access, request restrictions; and right to file a complaint; Adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by CONTRACTOR employees and other persons performing work for the CONTRACTOR to have only minimum necessary access to personally identifiable data within their organization; Be responsible for informing its enrollees of their privacy rights in the manner specified under the regulations.	2. Access to PHI 3. The process for members to request restrictions on use and disclosure of PHI 4. The process for members to request amendments to PHI 5. The process for members to request an accounting of disclosures of PHI 6. Internal protection of oral, written and electronic information across the organization
	CRA § 2.27.2 and 2.27.2.8 (E/W, Middle and TCS)	**RR 6C Authorization**

Federal Requirements	2010 State Standards	2010 NCQA Standards
	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.
	CRA § 2.27.2, 2.27.2.17 and .18 (E/W, Middle and TCS)	**RR 6D Communication of PHI Use and Disclosure**
	In accordance with HIPAA regulations, the CONTRACTOR shall, at a minimum: Create and implement policies and procedures to address present and future HIPAA regulation requirements as needed to include: use and disclosure of data; de-identification of data; minimum necessity access; accounting of disclosures; patients rights to amend, access, request restrictions; and right to file a complaint; Provide an appropriate level of training to its staff and enrollees regarding HIPAA related policies, procedures, enrollee rights and penalties prior to the HIPAA implementation deadlines and at appropriate intervals thereafter.	Upon member enrollment and annually thereafter, the organization informs members of its policies and procedures regarding the collection, use and disclosure of member PHI. Communication includes: 1. The organization's routine use and disclosure of PHI 2. Use of authorizations 3. Access to PHI 4. Internal protection of oral, written and electronic PHI across the organization 5. Protection of information disclosed to plan sponsors or to employers
42 CFR 438.230 Subcontractural Relationships and Delegation	*CRA § 2.26.1. and 2.26.1.1 (E/W, Middle and TCS)*	**CR (Credentialing)12, RR (Rights and Responsibilities) 8, UM (Utilization Management)15, and/or QI (Quality Improvement)13 D Predelegation Evaluation**
	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	For delegation agreements that have been in effect for less than 12 months, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Federal Requirements	2010 State Standards	2010 NCQA Standards
	delegated.	
	CRA § 2.26.1.2 (E/W, Middle and TCS)	**CR (Credentialing)12, RR (Rights and Responsibilities) 8, UM (Utilization Management)15, and/or QI (Quality Improvement)13 A Written Delegation Agreement**
	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.	There is a written delegation document: 1. Is mutually agreed upon 2. Describes the responsibilities of the organization and the delegated entity 3. Describes the delegated activities 4. Requires at least semiannual reporting to the organization 5. 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.
	CRA § 2.26.1.3 (E/W, Middle and TCS)	**CR (Credentialing)12, RR (Rights and Responsibilities) 8, UM (Utilization Management)15, and/or QI (Quality Improvement)13 E Annual Evaluation**
	The CONTRACTOR shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review, on at least an annual basis, consistent with NCQA standards and state MCO laws and regulations.	For delegation arrangements in effect for 12 months or longer, the organization annually evaluated delegate performance against NCQA standards for delegated activities.
	CRA § 2.26.1.4 (E/W, Middle and TCS)	**CR (Credentialing)12, RR (Rights and Responsibilities) 8, UM (Utilization Management)15, and/or QI (Quality Improvement)13 G Opportunities for Improvement**
	The CONTRACTOR shall identify deficiencies or areas for improvement, and the CONTRACTOR and the subcontractor shall take corrective action as necessary…	For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization has identified and followed up on opportunities for improvement, if applicable.

Quality Measurement and Improvement

Federal Requirements	2010 State Standards	2010 NCQA Standards
42 CFR 438.236 **Practice Guidelines**	*CRA § 2.8.1.2 (E/W, Middle and TCS)*	**QI 9A Factor 2 Adoption and Distribution of Guidelines**
	Each DM program shall utilize evidence-based clinical practice guidelines (hereafter referred to as the guidelines) that have been formally adopted by the CONTRACTOR's Quality Management/Quality Improvement (QM/QI) committee or other clinical committee and patient empowerment strategies to support the provider-patient relationship and the plan of care…The guidelines shall include a requirement to conduct a mental health and substance abuse screening. The DM programs for bipolar disorder, major depression, and schizophrenia shall include the use of the evidence-based practice for co-occurring disorders.	The organization ensures that practitioners are using relevant clinical practice guidelines by: 2. Establishing the clinical basis for the guidelines
	CRA § 2.15.4 (E/W, Middle and TCS)	**QI 9A Factor 3 Adoption and Distribution of Guidelines**
	The CONTRACTOR shall utilize evidence-based clinical practice guidelines in its disease management programs. The guidelines shall be reviewed and revised at least every two (2) years or whenever the guidelines change.	The organization ensures that practitioners are using relevant clinical practice guidelines by: 3. Updating the guidelines at least every two years
	CRA § 2.8.6 (E/W, Middle and TCS)	**QI 9A Factor 4 Adoption and Distribution of Guidelines**
	As part of the DM programs, the CONTRACTOR shall educate providers regarding the guidelines and shall distribute the guidelines to providers who are likely to treat enrollees with the DM conditions. This includes, but is not limited to, PCPs and specialists involved in treating that particular condition. The CONTRACTOR shall also provide each PCP with a list of their patients enrolled in each DM program upon the member's initial enrollment and at least annually thereafter. The CONTRACTOR shall provide specific information to the provider concerning how the program(s) works. The DM's provider education shall be designed to increase	The organization ensures that practitioners are using relevant clinical practice guidelines by: 4. Distributing the guidelines to the appropriate practitioners.

Federal Requirements	2010 State Standards	2010 NCQA Standards
	the providers' adherence to the guidelines in order to improve the members' conditions.	
42 CFR 438.240(a) Program	*Contractor Risk Agreement (CRA) § 2.15.1.1(1-6), 2.15.1.3 and 2.15.2.1 (E/W, Middle and TCS)*	**QI 1A Quality Improvement Program Structure**
	The CONTRACTOR shall have a written Quality Management/Quality Improvement (QM/QI) program that clearly defines its quality improvement structures and processes and assigns responsibility to appropriate individuals. This document shall include a separate section on CHOICES care coordination and must include all of the elements listed below. This QM/QI program shall use as a guideline the current NCQA Standards and Guidelines for the Accreditation of MCOs and shall include the CONTRACTOR's plan for improving patient safety. This means at a minimum that the QM/QI program shall: Address physical health, behavioral health, and long-term care services; Be accountable to the CONTRACTOR's board of directors and executive management team; Have substantial involvement of a designated physician and designated behavioral health practitioner; Have a QM/QI committee that oversees the QM/QI functions; Have an annual work plan; Have resources – staffing, data sources and analytical resources – devoted to it. As part of the QM/QI program, the CONTRACTOR shall collect information on providers' actions to improve patient safety and make performance data available to providers and members. The CONTRACTOR shall have a QM/QI committee which shall include medical, behavioral health, and long-term care staff and contract providers (including medical, behavioral health, and long-term care	The organization's QI program description includes the following. 1. A written description of the QI program structure 2. Behavioral healthcare aspects of the program 3. Patient safety is specifically addressed in the program description 4. The QI program is accountable to the governing body 5. A designated physician has substantial involvement in the QI program 6. A designated behavioral healthcare practitioner is involved in the behavioral healthcare aspects of the QI program 7. A QI committee oversees the QI functions of the organization 8. The specific role, structure and function of the QI committee and other committees, including meeting frequency, are addressed in the program description 9. An annual work plan 10. A description of resources that the organization devotes to the QI program

Federal Requirements	2010 State Standards	2010 NCQA Standards
	providers). This committee shall analyze and evaluate the results of QM/QI activities, recommend policy decisions, ensure that providers are involved in the QM/QI program, institute needed action, and ensure that appropriate follow-up occurs. This committee shall also review and approve the QM/QI program description and associated work plan prior to submission to TENNCARE…	
	CRA § 2.15.2.1 (E/W, Middle and TCS)	**QI 2A QI committee Responsibilities**
	The CONTRACTOR shall have a QM/QI committee which shall include medical, behavioral health, and long-term care staff and contract providers (including medical, behavioral health, and long-term care providers). This committee shall analyze and evaluate the results of QM/QI activities, recommend policy decisions, ensure that providers are involved in the QM/QI program, institute needed action, and ensure that appropriate follow-up occurs. This committee shall also review and approve the QM/QI program description and associated work plan prior to submission to TENNCARE…	1. Recommends policy decisions 2. Analyzes and evaluates the results of QI activities 3. Ensures practitioner participation in the QI program through planning, design, implementation or review 4. Institutes needed actions 5. Ensures follow-up, as appropriate
	CRA § 2.15.2.2 (E/W, Middle and TCS)	**QI 2B QI committee Minutes**
	The QM/QI committee shall keep written minutes of all meetings. A copy of the signed and dated written minutes for each meeting shall be available on-file after the completion of the following committee meeting in which the minutes are approved and shall be available for review upon request and during the annual on-site EQRO review and/or NCQA accreditation review.	QI committee meeting minutes reflect all committee decisions and actions, and are signed and dated.
	CRA § 2.15.1.2 (E/W, Middle and TCS)	**QI 2C Informing Practitioners and Members**
	The CONTRACTOR shall make all information about its QM/QI program available to providers and members.	The organization annually makes information about its QI program available to the following groups. 1. Members

Federal Requirements	2010 State Standards	2010 NCQA Standards
		2. Practitioners
	CRA § 2.15.1.1.7 (E/W, Middle and TCS)	**QI 1B Annual Evaluation**
	…The QM/QI program shall: Be evaluated annually and updated as appropriate.	There is an annual written evaluation of the QI program that includes the following information. 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis of the results of QI initiatives, including barrier analysis 4. Evaluation of the overall effectiveness of the QI program, including progress toward influencing networkwide safe clinical practices

[i] Based on the 2010 NCQA Standards and Guidelines for the Accreditation of Health Plans and the Contractor Risk Agreements dated March 1, 2010. The "CONTRACTOR" refers to the Managed Care Organization who has entered into agreement with the Bureau of TennCare.