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, 2013

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 Draft Annual Report for Demonstration Year 11 (July 1, 2012, through June 30, 2013). This report is being submitted in accordance with STC 48 of the Demonstration agreement that was in place throughout the reporting period.

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) 11

(7/1/2012 – 6/30/2013)

Executive Summary

During Demonstration Year (DY) 11, the Bureau of TennCare continued to pursue its mission of maintaining an exemplary system of high quality health care for eligible Tennesseans within a sustainable and predictable budget.

Key events of DY 11 included the following:

- Renewal of the TennCare demonstration through June 30, 2016.
- Resolution of the *John B.* lawsuit, which ended 12 years of litigation resulting from a 1998 Consent Decree.
- Beginning the exploration of new systems of payment that could be effective in driving better coordination of care and better patient outcomes.
- Implementing the higher payment for certain primary care providers mandated by the Affordable Care Act.
- Awarding of new Pharmacy Benefits Management and Dental Benefits Management contracts.

Three Demonstration Amendments were proposed during DY 11:

- Amendment 17, outlining proposed benefit reductions, was subsequently withdrawn when the Tennessee General Assembly approved a new one-year extension of the hospital assessment fee.
- Amendment 18, requesting the addition of Assisted Care Living Facility (ACLF) services to the list of benefits available to enrollees in CHOICES 3, was put on hold at the end of DY 11, awaiting new Home and Community Based Services (HCBS) regulations to be issued by CMS.
- Amendment 19, requesting the addition of a $1.50 co-payment on generic drugs for those enrollees who are now subject to a $3.00 co-payment on brand name drugs, was approved after the end of DY 11.

Program enrollment was relatively flat over DY 11.

Enrollees continued to exhibit a high level of satisfaction with the program. Results from the annual Beneficiary Satisfaction Survey, which is conducted each year by the Center for Business and Economic Research at the University of Tennessee, revealed that the current level of beneficiary satisfaction is 93 percent, one of the highest levels in the 20 years the survey has been conducted.

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

I. Accomplishments

Renewal of the TennCare Demonstration. 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.

Near the end of DY 10, the State submitted to CMS an application to renew the TennCare Demonstration for a three-year period lasting from July 1, 2013, through June 30, 2016. The two parties negotiated the terms of the renewal throughout the first half of DY 11, examining such issues as the removal of obsolete eligibility groups and the need to reword certain Special Terms and Conditions (STCs) of the Demonstration agreement for greater clarity.[1] On December 31, 2012, CMS notified the Bureau that a three-year renewal of the TennCare Demonstration had been approved. The State accepted CMS's terms and proposed certain technical corrections to the approval documents prepared by CMS. By June 7, 2013, the corrections had been incorporated into the new Demonstration agreement.

Payment Reform. On February 21, 2013, CMS awarded the Division of Health Care Finance and Administration (HCFA)—in which TennCare is located organizationally—a $756,000 State Innovation Model (SIM) grant. The purpose of the grant is to develop a proposal to use innovative purchasing strategies to hold health care providers accountable for both cost and quality of care by pinpointing and rewarding the best-performing providers in accordance with nationally-recognized quality metrics. The proposal must identify potential evidence-based payment and service delivery models and evaluate how one or more of these models could best be used in Tennessee. HCFA may apply for a second round of federal funding to implement its proposed payment innovation strategy.

In the months that followed the award, HCFA initiated a stakeholder engagement campaign directed at Managed Care Organizations and other insurance payers interested in working on payment reform, as well as providers and representatives of other interest groups in Tennessee. The first meeting with leading insurance companies BlueCross BlueShield of Tennessee, UnitedHealthcare, Wellpoint/Amerigroup, and Cigna took place on May 15, 2013, followed one week later by the first meeting with such provider stakeholders as the Tennessee Hospital Association, the Tennessee Medical Association, and the Tennessee Academy of Family Physicians.

This project is intended to support Governor Haslam's Tennessee Payment Reform Initiative, a program designed to channel health care dollars into outcomes-based payment and service delivery models. The Payment Reform Initiative will be a focal point of DY 12, during which finalization of the strategy will occur, and implementation is expected to begin. In preparation for these activities, TennCare joined Catalyst for Payment Reform, a national organization dedicated to "new systems of payment that promote affordability, advance clinical quality and foster prevention, coordination, safety and better patient outcomes."

[1] All STC references in this Draft Annual Report are to those in effect during DY 11, and not to those that took effect on July 1, 2013, as part of the new Demonstration Approval Period.

Additional information about the Catalyst for Payment Reform may be found online at http://www.catalyzepaymentreform.org, while details of the Tennessee Payment Reform Initiative are available at http://www.tn.gov/HCFA/forms/WhitePaper.pdf.

Recognition of TennCare. In August 2012, Mercy Community Healthcare, a non-profit provider of medical care to disadvantaged individuals in Williamson County, honored TennCare with a Certificate of Recognition. The award commended the Bureau's "outstanding dedication in collaborative partnership to provide health care services to the underserved in Tennessee." Dr. Jeanne James, TennCare's Medical Director at the time, accepted the certificate on behalf of the Bureau.

The stated mission of Mercy Community Healthcare, which has treated patients since 1999, is to "reflect the love and compassion of Jesus Christ by providing excellent healthcare for all and support to their families."[2]

Award for Chief Information Officer. On December 11, 2012, the Information Technology Management Association (ITMA) honored TennCare Chief Information Officer Brent Antony as Outstanding IT Director for 2012.

The ITMA is an organization whose stated mission is to "provide a forum for . . . Information Systems Management professionals to share information relating to their environment and State government" with the ultimate goal of "identifying common concerns, arriving at a consensus, and working toward their resolution."[3] In bestowing the award, ITMA recognized Mr. Antony for having made the most significant contribution to the organization based on the agency's strategic plan.

Antony, who oversaw all aspects of the Bureau's information technology systems management from 2005 until his departure from TennCare in February 2013, was distinguished twice within the field of information technology in as many years. In June 2011, he was named by eMids Technologies and Healthcare Payer News as one of eleven top executives and thought leaders in the healthcare information technology industry.

II. Project Status

Amendments to the TennCare Demonstration. The Bureau submitted three Demonstration Amendments during DY 11.

Demonstration Amendment 17. 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, DY 9, and DY 10 (and

[2] See the organization's "About Us" page, which is located online at http://mercycommunityhealthcare.org/about-us/. At the time the award was given, the provider operated under the name "Mercy Children's Clinic," but its subsequent designation as a Federally Qualified Health Center enabled the program to begin treating adults as well.

[3] See the "Information Technology Management Association" profile contained within The State of Tennessee 2009-2010 Information Systems Statewide Plan, an online document located at http://www.state.tn.us/finance/oir/prd/stplan.pdf.

proposed to CMS as Demonstration Amendments 9, 12, and 15, respectively, before being withdrawn) were revived during DY 11 in the form of Demonstration Amendment 17. This proposed amendment—which was submitted to CMS on February 4, 2013—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 non-pregnant adults and non-institutionalized adults.

Following the Tennessee General Assembly's passage of the Annual Coverage Assessment Act of 2013, the Bureau of TennCare notified CMS by letter dated April 26, 2013, that the benefit eliminations and reductions proposed in Amendment 17 would not be needed in State Fiscal Year 2014.

Demonstration Amendment 18. On March 7, 2013, TennCare proposed to add Assisted Care Living Facility (ACLF) services for individuals in CHOICES 3 when certain criteria (including cost neutrality) were met. The CHOICES 3 group comprises individuals who do not meet the Level of Care criteria for Nursing Facility (NF) services, but who have been found to be at risk for institutionalization. ACLF services are already available for persons in CHOICES 2, which consists of enrollees who meet the NF Level of Care criteria but who receive Home and Community Based Services (HCBS) as a safe and cost-effective alternative to institutional care.

In responding to the State's request for Amendment 18, CMS proposed modifications that would require adherence to HCBS regulations that have not been published in their final form. The State requested that the amendment be pended until the final regulations had been published so that the State could decide whether to move forward with Amendment.

Additional information about the Bureau's compliance with federal HCBS requirements is presented in the Attachments to this report. Attachment A comprises the operational procedures for reserving slots in CHOICES 2 for certain individuals being discharged from a Nursing Facility or an acute care setting. Attachment B details the steps taken by TennCare to ensure compliance with federal regulations governing the provision of HCBS.

Demonstration Amendment 19. On April 26, 2013, TennCare submitted Demonstration Amendment 19 to CMS. Amendment 19 proposed a $1.50 co-payment for covered generic medications to be charged to those TennCare enrollees who already had a $3.00 co-pay on brand name drugs.[4] This measure, which the Bureau intended to implement on October 1, 2013, had not been approved by CMS as of the end of DY 11.

John B. **Lawsuit.** The *John B.* lawsuit addressed the adequacy of services provided by TennCare to children under the age of 21. *John B*. was a consent decree filed in 1998 that had been the subject of ongoing litigation since 2000. In February 2012, District Judge Thomas A. Wiseman, Jr. ruled in favor of the State by dismissing the case on the grounds that TennCare had successfully established compliance with "all the binding provisions of the Consent Decree."[5] In response, the Plaintiffs filed a Notice of Appeal with the United States Court of Appeals for the Sixth Circuit on March 9, 2012.

[4] Items to which the co-pay would not apply include those services identified as exempt in federal regulations.
[5] John B. v. Emkes. U.S. District Court for the Middle District of Tennessee at Nashville. Order, pages 1-2. February 14, 2012.

A three-judge panel of the Sixth Circuit heard oral arguments on the appeal on October 5, 2012. Plaintiffs and Defendants subsequently filed supplemental briefs on the subject of TennCare's periodicity schedule, a timeline identifying the points in a child enrollee's life when the State must provide health screenings.[6]

On March 14, 2013, the Sixth Circuit issued a unanimous opinion upholding Judge Wiseman's decision to dismiss the *John B.* case. The 27-page ruling examined all of the arguments advanced by the Plaintiffs in their March 2012 appeal and classified each as either a "misstate[ment of] the bases of the [district] court's decision" or "simply meritless."[7] The concluding passage of the Sixth Circuit's decision offered a definitive consideration of the matter:

> The district court's handling of this case after our remand last year was exemplary. The court conducted an exhaustive evidentiary hearing, reviewed 345 pages of proposed findings of fact and conclusions of law from the parties, and familiarized itself with thousands of pages of evidence already in the record. And on the basis of all of that evidence, the court found, in a thorough and carefully reasoned opinion, that TennCare had vastly improved its delivery of services to enrollees, and indeed become a national leader in its compliance with the Medicaid statute. The court's conclusions were sound. Its judgment is affirmed.[8]

Although the Plaintiffs in the suit had the option of pursuing the matter to the United States Supreme Court, the deadline for filing an appeal of the Sixth Circuit's ruling—June 12, 2013—passed without incident. The Plaintiffs' decision not to take further action left Judge Wiseman's order vacating the consent decree undisturbed and, as a result, concluded the litigation.

Dual Demonstration Proposal. Late in DY 10, TennCare submitted a proposal to the Medicare-Medicaid Coordination Office (MMCO) for a Financial Alignment Demonstration (FAD) to consolidate services for individuals who are dually eligible for Medicare and TennCare. The proposal was called "TennCare PLUS" and would have assigned responsibility for a comprehensive package of Medicare and Medicaid benefits to each member's TennCare Managed Care Organization to ensure proper coordination of services.

During the months that followed, as additional guidance was issued by the MMCO, Bureau management began to have several concerns about the project, including the methodology by which Tennessee health plans would be reimbursed, key policy decisions that could impede the effectiveness of the project, and delays that would make it difficult, if not impossible, for the State to achieve success within the prescribed timeframes. On December 21, 2012, therefore, the Bureau withdrew its proposal. However, TennCare remains determined to improve the quality and cost-effectiveness of care for dual eligibles in Tennessee and implemented the following strategy in DY 11.

Recognizing that there were opportunities for improvement in the MIPPA (Medicare Improvements for Patients and Providers Act) agreements that are required for TennCare and the Dual Eligible Special

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[6] TennCare's periodicity schedule is available online at http://www.tn.gov/tenncare/tenndercare/screeningsched.shtml.

[7] John B. v. Emkes. U.S. Court of Appeals for the Sixth Circuit. Opinion, page 2. March 14, 2013. The full text of the Opinion is available online at http://www.ca6.uscourts.gov/opinions.pdf/13a0068p-06.pdf.

[8] Ibid, page 27.

Needs Plans (or "D-SNPs") providing Medicare services to TennCare enrollees, the Bureau added enhanced coordination requirements and new eligibility/enrollment exchange processes to these agreements, with the qualification that any D-SNP unable to meet the requirements would no longer be approved to operate as a D-SNP in Tennessee in 2014. TennCare strengthened language in the MCO contracts as well.

All of the Tennessee D-SNPs except one satisfied readiness review requirements and went live with new coordination agreements on May 13, 2013. That D-SNP was required to submit acceptable corrective action plans for outstanding issues in order to execute an amendment that would allow it to continue to operate as a D-SNP in Tennessee in 2014.

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[9] to replace outdated, often paper-based approaches to medical record-keeping with electronic systems that meet rigorous certification criteria and that can improve health care delivery and quality. The federal government provides 100 percent of the funding for the incentive payments and 90 percent of the program's administrative costs.

Tennessee's EHR program remained robust during DY 11 by continuing to distribute payments to some providers while educating others on the advantages of participation. Highlights from the year included the following:

- Payments to providers who had adopted, implemented, or upgraded to certified EHR technology capable of meeting "meaningful use" standards (referred to variously as "first-year" or "Year 1" payments) neared a cumulative total of $125 million by June 30, 2013.
- Payments to providers who had demonstrated meaningful use of certified EHR technology for a minimum period of ninety consecutive days ("second-year" or "Year 2" payments) tallied more than $20 million in DY 11 alone.
- More than 1,500 Tennessee providers received incentive payments during DY 11.
- The conclusion of Calendar Year 2012 marked two years since Tennessee's EHR program had begun accepting attestations from providers, an accomplishment that only ten other states could claim at the time.

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 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 (including provider training videos) throughout DY 11 to address the topics with which providers had most difficulty.

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

[9] 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).

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.

Table 1
Enrollment Counts for DY 11

State Plan and Demonstration Populations	Total No. of TennCare Enrollees			
	Jul - Sep 2012	Oct - Dec 2012	Jan - Mar 2013	Apr - Jun 2013
EG1 Disabled, Type 1 State Plan eligibles	137,701	136,384	135,215	133,692
EG1 Disabled and EG9 H-Disabled, Type 2 Demonstration Population	309	369	339	351
EG2 Over 65, Type 1 State Plan eligibles	39	50	50	37
EG2 Over 65 and EG10 H-Over 65, Type 2 Demonstration Population	0	0	0	0
EG3 Children, Type 1 State Plan eligibles	695,237	700,828	696,874	658,669[10]
EG4 Adults, Type 1 State Plan eligibles	281,982	285,536	276,834	289,416
EG4 Adults, Type 2 Demonstration Population[11]	0	0	0	0
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	143,001	140,887	136,225	133,701
EG6E Expan Adult, Type 3 Demonstration Population	1,724	1,638	1,473	1,630
EG7E Expan Child, Type 3 Demonstration Population	255	247	177	151
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	20,120	21,153	19,165	19,309
EG12E Carryover, Type 3, Demonstration Population	Not available	2,594	5,753	6,067
TOTAL	1,280,368	1,289,686	1,272,105	1,243,023

[10] Although STC 55.a.(iii) had defined EG3 Children as "age 18 or younger," some 19-year-olds were erroneously placed in this category in previous quarters. Correction of the mistake accounted for a slightly smaller population of EG3 Children during the April-June 2013 quarter (and a modest rise in the population of EG4 Adults).

[11] This eligibility group—individuals between 19 and 64 years old who are medically needy rollovers—was removed from the Demonstration agreement that was to take effect at the beginning of DY 12 (i.e., on July 1, 2013).

III. Quantitative and Case Study Findings

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

During DY 11, CBER published a summary of the results of the most recent survey entitled "The Impact of TennCare: A Survey of Recipients 2012." Although the findings of a single survey must be viewed in context of long-term trends, several results from the September 2012 report were noteworthy:

- The estimated number of "uninsured" Tennesseans (577,813) reached its lowest point since 2008.
- The percentage of respondents classifying themselves as "uninsured" (9.2 percent) reached its lowest point since 2005.
- 93 percent of respondents covered by TennCare expressed satisfaction with the quality of care they had received. This level of satisfaction was one of the highest in the program's history.
- The vast majority of respondents covered by TennCare reported that they sought initial medical care for themselves (89 percent) and for their children (97 percent) at a doctor's office or clinic instead of at the hospital. These figures are significant because seeking initial medical care at the emergency room (in the absence of an emergency) is clearly less cost-effective than seeking this care at a doctor's office or clinic.

In summary, the report notes, "TennCare continues to receive positive feedback from its recipients, indicating the program is providing medical care in a satisfactory manner and up to the expectations of those it serves." The report is presented in Attachment D and is available online at http://cber.bus.utk.edu/tncare/tncare12.pdf.[12]

HEDIS/CAHPS Report. The annual report of HEDIS/CAHPS data—entitled "Comparative Analysis of Audited Results from TennCare MCOs"—was published on January 3, 2013. The full name for HEDIS is Healthcare Effectiveness Data Information Set, and the full name for CAHPS is Consumer Assessment of Health Plans Surveys. This report, which is presented in Attachment E and posted on the TennCare website at http://www.tn.gov/tenncare/forms/hedis12.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 2011 Medicaid National Average. Higher success rates were achieved in all of the following categories:

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
- Immunization for Adolescents

[12] In compliance with STC #49, the Bureau submitted the Beneficiary Survey to CMS on September 14, 2012.

- Lead Screening in Children
- Appropriate Testing for Children with Pharyngitis
- Children and Adolescents' Access to Primary Care Practitioners
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Improvement was also observed in such categories as Cholesterol Management for Patients with Cardiovascular Conditions, Controlling High Blood Pressure, and Comprehensive Diabetes Care, as well as in categories with special relevance to women's health, like Cervical Cancer Screening and Chlamydia Screening.

HEDIS 2012 was the third 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 2011 were achieved in such categories as Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase, and Follow-Up After Hospitalization for Mental Illness.

Additional information about TennCare's 2012 HEDIS/CAHPS report is available online at http://news.tn.gov/node/10114.

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 2011, FY 2012, and FY 2013 are presented in Table 2.

Table 2
Key Indicators Tracked by TennCare FYs 2011-2013

METRIC	FY 2011	FY 2012	FY 2013
Member Months (FTE)	**1,206,067**	**1,226,313**	**1,227,788**
COST INDICATORS			
PMPM – Physician	**$110**	**$114**	**$107**
PMPM – Facilities	**$102**	**$105**	**$112**
PMPM – Rx (before rebate)	**$53**	**$56**	**$53**
UTILIZATION MEASURES			
Hospital Days/1000	**483**	**475**	**498**
Hospital Admissions (excluding mental health events)/1000	**121**	**121**	**110**
ER Visits/1000	**847**	**844**	**870**
Prescriptions/1000	**10,670**	**10,576**	**10,683**

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 11.

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.
    - 2013 Measure—In Calendar Year 2012, 100 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.
    - 2013 Measure—In Fiscal Year 2013, the MCCs reported a compliance rate of 99 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

Higher Reimbursement for Primary Care. One provision of the Affordable Care Act (ACA) with which all Medicaid programs must comply is an enhanced reimbursement rate for certain providers delivering primary care services during Calendar Years 2013 and 2014. Section 1202 of ACA, entitled "Payments to Primary Care Physicians," requires Medicaid agencies to pay certain primary care providers for identified primary care services at a rate no lower than the one at which primary care physicians are reimbursed under Medicare Part B. Medicaid providers eligible for the higher levels of reimbursement are those whose primary specialty falls within one of the following categories:

- Family medicine
- General internal medicine
- Pediatric medicine
- Related subspecialties

The Bureau of TennCare submitted a State Plan Amendment (#13-001) outlining its compliance with Section 1202 of ACA to CMS on March 27, 2013. Following a two-month period of negotiations, CMS approved the Amendment on May 29, 2013. While eligible claims could not be paid at the enhanced rate until CMS had issued its approval, retroactive reimbursement began automatically, requiring no further action by providers on claims that had already been submitted. TennCare Managed Care Organizations (MCOs), furthermore, were scheduled to begin paying primary care providers the higher rate for current dates of service on August 1, 2013.

Eligibility Determination System. With the advent of ACA and its emphasis on consolidation of eligibility determination functions, TennCare was required to build a new TennCare Eligibility Determination System (called "TEDS") that would be used to manage eligibility determination functions for both TennCare and CoverKids, Tennessee's Children's Health Insurance Program. TennCare was also required to in-source staffing for performance of eligibility determinations. On November 9, 2012, TennCare announced its intent to award the contract for the new TennCare Eligibility Determination System to Northrop Grumman. TennCare received five qualified proposals to the RFP, and Northrop was the winning bidder.

One of the central benefits envisioned in the new system is that historically paper-based and/or in-person transactions—such as applications for benefits and the reporting of changes—will be able to be conducted through an online portal. Although a basic online application currently exists, the new system will contain a rules engine capable of making eligibility determinations in real time or near real time.

To help ensure that the transition to a new system is seamless, TennCare awarded an Independent Verification and Validation contract to Cognosante, LLC in June 2013. This contractor will be responsible for monitoring the development and implementation of the system and reporting concerns and findings to TennCare and CMS.

Pharmacy Benefits Management Transition. With the contract between TennCare and Pharmacy Benefits Manager (PBM) Catamaran scheduled to conclude during DY 11, the State issued a Request for Proposals (RFP) for a new PBM on August 3, 2012. Following a competitive bidding process in which

three companies submitted proposals, the Bureau announced on November 6, 2012, that Magellan Health Services would succeed Catamaran, which had held the role since 2008.

In compliance with the terms of its contract with TennCare, Magellan initiated a six-month period of "readiness review" in December 2012. During that time, priorities included the following:

- Establishing a pharmacy network;
- Building a claims processing system and loading it with enrollee information and with edits specific to TennCare's preferred drug list, prior authorization program, and clinical/quantity requirements;
- Creating a call center and a website to assist patients and providers; and
- Contracting with drug manufacturers for supplemental rebates.

Before being named TennCare's PBM, Magellan had managed pharmacy benefits for more than eight million individuals. From June 1 through June 30, 2013 (the company's first full month of operations for the Bureau), Magellan paid 932,777 claims, a volume in line with typical TennCare pharmacy claims activity. Although typical transition difficulties arose during June, the Bureau worked closely with the PBM to clarify expectations and to devise solutions as appropriate.

TennCare's contract with Magellan lasts through May 31, 2016, and contains an option for two one-year extensions.

Dental Benefits Management Transition. As Magellan Health Services' term as Pharmacy Benefits Manager commenced in full, the transition to a new Dental Benefits Manager (DBM) had just gotten underway. DentaQuest USA Insurance Company emerged from the competitive bidding process as TennCare's new DBM on April 24, 2013, and—as of the end of DY 11—was scheduled to replace Delta Dental of Tennessee on October 1, 2013.

Like Magellan, DentaQuest was awarded a three-year contract containing options for two one-year extensions. While all previous contracts between TennCare and its DBMs were "Administrative Services Only" (or "ASO") contracts, the contract executed by the parties in May 2013 is a partial risk-bearing contract.

Although DentaQuest's preliminary responsibilities included building an adequate network of dentists and administering dental benefits for more than 750,000 children enrolled in TennCare, the company's experience managing dental benefits for more than 16 million recipients in 26 states represented a positive indication of the company's ability to succeed with projects of similar scope. Additional information about the DBM transition is available on TennCare's website at http://news.tn.gov/node/10664.

Quality Improvement Strategy. As required by federal law,[13] federal regulation,[14] and the State's Demonstration agreement with CMS,[15] TennCare has developed a strategy for evaluating and improving the quality and accessibility of care offered to enrollees through the managed care network. The Bureau submitted its annual update of the strategy—entitled "2012 Quality Assessment and Performance

[13] 42 U.S.C. § 1396u-2(c)(1)(A)
[14] 42 C.F.R. § 438.202
[15] STC 45.c. of the TennCare Demonstration.

Improvement Strategy and Quality Strategy: Annual Update Report"—to CMS on August 1, 2012. In addition to laying out the measures of quality assurance already in place, the report outlined TennCare's goals and objectives for the year ahead. The Strategy, which was approved by CMS on October 22, 2012, is available online at http://www.tn.gov/tenncare/forms/qualitystrategy2012.pdf and as Attachment F of this report.

New Chief Medical Officer. On January 28, 2013, Vaughn Frigon, M.D. joined TennCare's Executive Staff in the role of Chief Medical Officer. He fills the position left vacant when Dr. Wendy Long assumed a dual role as TennCare's Deputy Director and Chief of Staff.

Dr. Frigon, who is originally from Virginia, graduated from the United States Military Academy at West Point and served in the United States Army Infantry as a platoon leader during the first Persian Gulf War. After attending medical school at the University of Tennessee's College of Medicine in Memphis, he completed both an Orthopedic Surgery residency at Tulane University, and the Health Care MBA program at Vanderbilt University's Owen Graduate School of Management.

Dr. Frigon is board certified by the American Board of Orthopaedic Surgery and practiced orthopedics for 12 years. He also worked as the Lead Medical Director for the Unum Insurance Company in Chattanooga for the five-year period preceding his arrival at TennCare. The diversity of his professional experience—military service, providing care in rural communities with significant Medicaid populations, helping manage a corporate insurance program—has already proven to be a valuable asset for the Bureau, as demonstrated by his productive involvement in such matters as the Payment Reform Initiative and the PBM and DBM transitions.

New General Counsel. John G. (Gabe) Roberts assumed responsibility as General Counsel for TennCare and the Health Care Finance and Administration (HCFA) staff on April 4, 2013.

Mr. Roberts, who hails from Jackson, Mississippi, received degrees from the University of Mississippi's E. H. Patterson School of Accountancy and Vanderbilt University Law School. He is a licensed Certified Public Accountant and, prior to attending law school, worked in the Memphis, Tennessee, office of Ernst & Young as an auditor of both publicly traded and privately held Tennessee companies.

Mr. Roberts came to HCFA from the Nashville, Tennessee, law firm Sherrard & Roe, where his primary practice areas included general corporate law, mergers and acquisitions, and private equity investment transactions. While at Sherrard & Roe, his business law practice intersected regularly with the health care industry and regulatory environment. His unique perspective borne by the diversity of his professional experiences aids the Bureau in a variety of contexts.

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,

Regulation	Topic	Actions
		development of the plan of care and 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 for—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-

Regulation	Topic	Actions
		03-03-.06 entitled *Technical and Financial 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 11

TennCare maintained compliance with all Special Terms and Conditions during Demonstration Year 11. Specific actions are detailed below.

STCs #6 and 7: The State submitted three Demonstration Amendments.

- Amendment 17, dealing with possible program reductions if the hospital assessment fee were not renewed by the Tennessee General Assembly, was submitted on February 4, 2013, and withdrawn on April 26, 2013, after the fee had been renewed.
- Amendment 18, dealing with the provision of Assisted Community Living Facility services to persons in CHOICES Group 3, was submitted on March 7, 2013. This amendment was put "on hold" by CMS and the State on June 26, 2013, pending the release of new CMS rules on HCBS waiver services.
- Amendment 19, dealing with the imposition of a $1.50 copay on generic drugs for those enrollees who have a $3.00 copay for brand name drugs, was submitted on April 26, 2013, and approved by CMS after the end of the DY on July 16, 2013.

STC #8: The State submitted a request to extend the Demonstration on June 29, 2012. The request was approved by CMS on December 31, 2012. The State requested technical corrections in the approval materials on January 31, 2013. CMS approved the technical corrections on June 7, 2013.

STC #15: Public notice concerning Waiver Amendments was provided to Tennessee newspapers as follows:

- Waiver Amendment 17: December 26, 2012
- Waiver Amendment 18: February 6, 2013
- Waiver Amendment 19: March 25, 2013

STC #21: Two open enrollments for the Standard Spend Down program were conducted during the DY, one on September 13, 2012, and the second on March 21, 2013.

STC #25: TennCare's MEQC Review Plan for FFY 2013 was submitted to CMS on July 27, 2012. TennCare's MEQC Report for FFY 2011 was submitted to CMS on the same day.

STC #31: TennCare's "Cost-Effective Alternatives" policy, BEN 08-001 outlines services TennCare MCOs may provide as cost-effective alternatives to covered Medicaid services. 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.

STC #34.e.iii(A): The operational procedures for determining individuals for whom CHOICES Group 2 reserve capacity slots are to be held are included as Attachment A. The State originally submitted these procedures to CMS on February 2, 2010.

STCs #35-37: On January 1, 2013, the State implemented the cost-sharing provisions outlined in its cost-sharing compliance plan, which was submitted to CMS on October 1, 2010, and approved by CMS on April 18, 2012.

STC #45.a: The State submitted signed Contractor Risk Agreement (CRA) contract amendments to CMS as detailed in the following table:

Submission Date	7/17/2012	9/7/2012	11/30/2012	1/4/2013	5/1/2013
Middle TN CRA Amendment No.	12	--	13	14	15
East/West TN CRA Amendment No.	9	--	10	11	12
TennCare Select Contract Amendment No.	28	29	30	31	32

STC #45.b: A description of the steps taken to ensure compliance with the HCBS regulations identified in this STC is included as Attachment B. The State submitted this description to CMS with the last Draft Annual Report.

STC #45.c: The State submitted the "2012 Quality Assessment and Performance Improvement Strategy and Quality Strategy Update Report" on August 1, 2012. The State received notification of CMS's approval of the QIS on October 22, 2012.

STC #45.d.iii: The State submitted electronic copies of the CHOICES point-in-time baseline data to CMS on September 27, 2012, and June 26, 2013.

STC #45.d.iv: The State reported on data and trends of the designated CHOICES data elements in the Quarterly Progress Reports submitted on August 31, 2012, and November 30, 2012.

STC #47: The State submitted quarterly progress reports on August 30, 2012, November 30, 2012, February 28, 2012, and May 31, 2012.

STC #48: The State submitted a draft Annual Report on October 31, 2012. CMS has not commented on the draft Annual Report.

STC #49: The State submitted to CMS a report of the Beneficiary Survey results on September 14, 2012.

STC #51: Enrollment information was reported to CMS in each Quarterly Report. On August 22, 2012, as requested by CMS, the State submitted reworked enrollment data that had been due with the Quarterly Report for the January-March 2012 quarter.

STC #54: Member months were reported to CMS in each Quarterly Report. On August 22, 2012, as requested by CMS, the State submitted reworked member month data that had been due with the Quarterly Report for the January-March 2012 quarter.

Section XIV: The State submitted to CMS an updated version of the Operational Protocol on November 19, 2012.

ATTACHMENT D

THE IMPACT OF TENNCARE: A SURVEY OF RECIPIENTS 2012

THE IMPACT OF TENNCARE

A Survey of Recipients, 2012

Prepared by
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September 2012

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The Impact of TennCare: A Survey of Recipients, 2012

Method

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

The University of Tennessee Social Work Office of Research and Public Service conducted the survey by telephone between May and July 2012. 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 dual frame approach began in 2011. The additional cell phone sampling allowed the surveyors to reach a segment of the population that could not be reached in prior years because it only has a cell phone. Five calls were made to each residence, at staggered times, to minimize nonrespondent bias. The design chosen was a "Household Sample," and the interview was conducted with the head of the household. When Hispanic households were reached, a translator would call the household at a later time to conduct the survey.

Approximately 52.0 percent of those who answered their phone through the random digit dialing technique and 50.9 percent of those who answered their phone 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, 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 had 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, we make comparisons to findings from the earlier surveys.

[1] In the random digit dialing sample, there were 4,803 completed surveys and 4,431 refusals. In the cell phone sample, there were 200 completed surveys and 193 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.

TABLE 1: Head of Household Age and Household Income

Age-Householders	Proportion in 2012 Survey (Percent)	Proportion in ACS* (Percent)	Deviation (Percent)
Under 25	2.3	4.9	2.6
25-44	22.3	34.4	12.1
45-64	54.6	39.1	-15.5
65+	20.8	21.6	0.8

Household Income Level	Proportion in 2012 Survey (Percent)	Proportion in ACS* (Percent)	Deviation (Percent)
<10000	9.2	9.3	0.1
10,000-14,999	9.3	7.0	-2.3
15,000-19,999	8.9	6.7	-2.2
20,000-29,999	13.2	12.4	-0.8
30,000-39,999	10.6	11.7	1.1
40,000-49,999	9.0	10.0	1.0
50,000-59,999	7.8	8.3	0.5
60,000-99,999	17.8	20.6	2.8
100,000+	14.2	14.0	-0.2

*Census Bureau, 2008-2010 American Community Survey 3-year Estimates

Estimates for Insurance Status

Estimates for the number of Tennesseans who are uninsured are presented below (Table 2). These statewide estimates are extrapolated from the weighted sample. The estimated 577,813 uninsured represent 9.2 percent of the 6,303,437 Tennessee residents.[3] This is the lowest total of uninsured since the 2008 estimate, and it is the lowest percent of uninsured since the 2005 estimate. The uninsured rate for children is 2.7 percent, a slight increase from last year's rate of 2.4 percent. The rate for adults decreased from the 2011 rate of 12.0 percent (Table 2a) to its current rate of 11.2 percent.

TABLE 2: Statewide Estimates of Uninsured Populations (1993–2012)

	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	2012
State Total	608,234	566,633	616,967	618,445	604,222	577,813
Percent	10.0	9.3	10.0	9.9	9.5	9.2

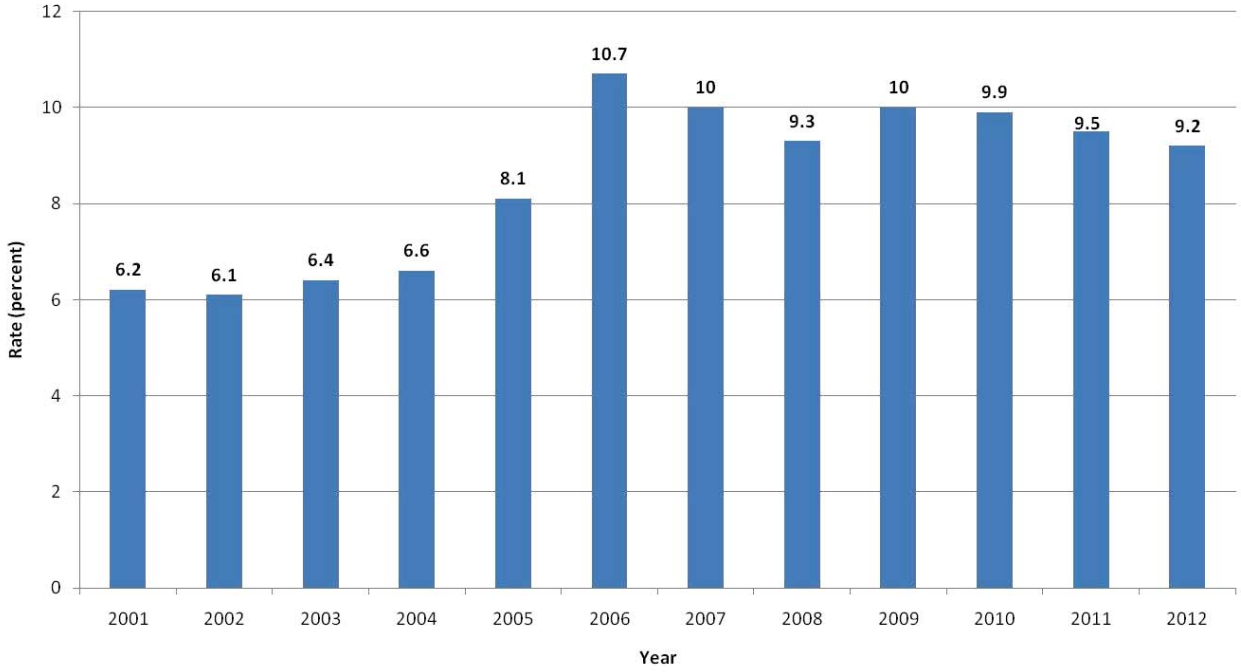
TABLE 2a: Uninsured Tennesseans by Age (1999–2012)

	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	2012
Under 18 Total	82,484	70,096	72,258	54,759	57,912	35,743	40,700
Under 18 Percent	5.7	4.8	4.9	3.7	3.9	2.4	2.7
18+ Total	566,955	538,138	494,375	562,208	560,532	568,479	537,113
18+ Percent	12.1	11.7	10.6	11.9	12.0	12.0	11.2

[3] Population estimates are found using United States Census Bureau, 2008-2010 American Community Survey. In prior years (1993-2009), population figures were gathered from the "Interim State Population Projections," also part of the United States Census Bureau.

FIGURE 1: Rate of Uninsured Populations (2001-2012)



Reasons for Failure to Obtain Medical Insurance

The underlying reported reasons for a lack of insurance have changed little over the period since TennCare was implemented in 1994, though the percentages have shifted somewhat. The major reason that people report remaining uninsured is their perception that they cannot afford insurance (Table 3). In 2012, 88 percent indicate that this is a major reason for not having insurance, the same portion as in 2011. 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 4).[4] The group least likely to consider cost a major barrier to having insurance is the $50,000+ group, with only 71 percent claiming affordability as a major barrier for not having insurance. The $40,000 bracket experienced an increase from 80 percent claiming affordability as a major barrier to not having insurance to 91 percent, a percentage that is more in line with the previous 5 years. The lowest income bracket continues to claim affordability is less of a barrier to having insurance, dropping from 89 percent in 2011 to 87 percent in 2012. While financial pressures continue to limit people from obtaining coverage, 9 percent indicate that they just did not get around to securing it, and 7 percent indicate that a major reason is that they do not need insurance. (Table 3)

TABLE 3: Reasons for Not Having Insurance (1997–2012) (Percent)

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

[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. Therefore, the change may not reflect the shifts in the underlying population.

TABLE 4: "Cannot Afford" Major Reason for No Insurance: By Income (2005–2012) (Percent)

Household Income	2005	2006	2007	2008	2009	2010	2011	2012
Less than $10,000	90	92	93	97	96	96	89	87
$10,000 - $14,499	82	96	95	97	96	95	90	94
$15,000 - $19,999	91	87	93	88	93	88	90	91
$20,000 - $29,999	81	90	89	96	92	94	89	92
$30,000 - $39,999	78	76	90	88	90	87	83	85
$40,000 - $49,999	64	84	88	93	92	92	80	91
$50,000+	67	68	76	81	80	76	92	71

Evaluations of Medical Care and Insurance Coverage

The ratings remain high for TennCare quality of medical care, with almost 70 percent of heads of households rating their care "good" or "excellent" and 80 percent rating their children's care "good" or "excellent." Tennesseans' overall perception (including both TennCare and non-TennCare medical care recipients) of the quality of care they and their children have been receiving has been relatively stable in recent years but is up considerably since inception of the program. Overall perception of children's medical care dipped slightly from 2011 to 2012, with 87 percent giving children's medical care a "good" or "excellent" rating in 2012, a 2 percentage point decrease from 2011. Ratings of medical care quality for the TennCare head of household population gradually increased from TennCare's inception in 1994 to 2005; in 2012, the perceived medical care quality for TennCare heads of household equaled the 2010 rate with 24 percent rating it "excellent;" 69 percent rate their quality as "good" or "excellent" (higher than in 2010), while 22 percent rate their quality as "fair." Perceptions of quality of medical care for their children remain high in 2012, with only 20 percent rating the quality of care as "fair" or "poor." The portion rating the quality of their children's care "excellent" decreased to its lowest point since 2008, though it is much higher than before 2009. Eighty percent of TennCare heads of household still rate their children's care as "excellent" or "good." Ratings for quality of children's medical care are slightly lower for TennCare recipients than for total populations.

TABLE 5: Quality of Medical Care Received by Heads of Households (2004–2012) (Percent)

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

TABLE 6: Quality of Medical Care Received by Children of Heads of Households (2004–2012) (Percent)

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

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 7), with 93 percent responding "somewhat satisfied" or "very satisfied," exceeding the satisfaction level reported by Medicaid recipients in 1993 by 11 percent.[5] The satisfaction levels are consistent with the satisfaction levels in the last several years. The highest level of satisfaction, 95 percent, was reported in 2011.

TABLE 7: Percent Indicating Satisfaction with TennCare (2000–2012) (Percent)

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

[5] We used a three point scale, and respondents could indicate "very satisfied," "somewhat satisfied," or "not satisfied."

Behavior Relevant to Medical Care

Each respondent was asked a series of questions regarding his or her behavior when seeking medical care (Table 8). The proportion of TennCare heads of households reporting initially seeking care at hospitals in 2012 is slightly higher than it was in 2011, increasing from 8 percent to 10 percent. The portion of TennCare households reporting initially seeking medical care for their children from hospitals decreased to 3 percent in 2012, a drop of 6 percentage points from 2011, offset in part by a 2 percentage point increase in patients who report initially seeking medical care at a doctor's office. (Table 9)

However, a decreasing share of TennCare adults report initially seeking care at a doctor's office; in 2011, the share was 80 percent versus 75 percent in 2012. The decrease was offset by an increasing share of TennCare adults who report initially seeking care with visits to clinics and hospitals. For all heads of households, the choice of venue for initial care was essentially unchanged from 2011, with 82 percent reporting initially seeking care from a doctor's office.

TABLE 8: Head of Household: Medical Facilities Used When Medical Care Initially Sought (2004–2012) (Percent)

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

TABLE 9: Children: Medical Facilities Used When Medical Care Initially Sought (2004–2012) (Percent)

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

TennCare recipients continue to report seeing physicians on a more frequent basis than the average Tennessee household. Seventy-eight percent of TennCare heads of households (versus 58 percent of all heads of households) report seeing a physician at least every few months (Table 10). This figure remained the same for TennCare adults from 2011 to 2012 but only 67 percent of adults on TennCare saw a physician this often in 1997. Only 73 percent of TennCare children visit physicians at that same frequency (Table 11). This represents a slight increase in visits for children, where 71 percent reported they visited a doctor at least every few months in 2011.

TABLE 10: Frequency of Visits to Doctor for Head of Household (2004–2012) (Percent)

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

TABLE 11: Frequency of Visits to Doctor for Children (2004–2012) (Percent)

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

Appointments

The reported time required to obtain an appointment is comparable to the 2011 findings, with slightly more respondents reporting being able to make an appointment for the same day or the next day. The percent of TennCare recipients reporting obtaining a doctor's appointment on the same day that the request is made or the next day increased slightly to 41 percent in 2012, a 1 percentage point increase from 2011. The proportion of TennCare heads of household being able to obtain an appointment within one week slightly decreased to 66 percent, a 4 percentage point decrease from 2011. The number reporting having to wait longer than three weeks is 18 percent (Table 12). TennCare recipients are waiting 58 minutes on average to see their physicians once they reach the office (Table 13). This is similar to wait times in previous years.

TABLE 12: Time between Attempt to Make Appointment and First Availability of Appointment: TennCare Heads of Household (2004–2012) (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?	2004	2005	2006	2007	2008	2009	2010	2011	2012
Same day	20	21	22	22	21	18	20	21	20
Next day	17	17	27	20	17	23	19	19	21
1 week	33	31	22	30	27	25	29	30	25
2 weeks	11	10	10	8	10	9	11	10	14
3 weeks	3	5	4	4	4	4	4	4	2
Over 3 weeks	15	16	16	15	22	20	17	16	18

TABLE 13: Wait for Appointments: TennCare Heads of Household (2004–2012) (Minutes)

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

TennCare Plans

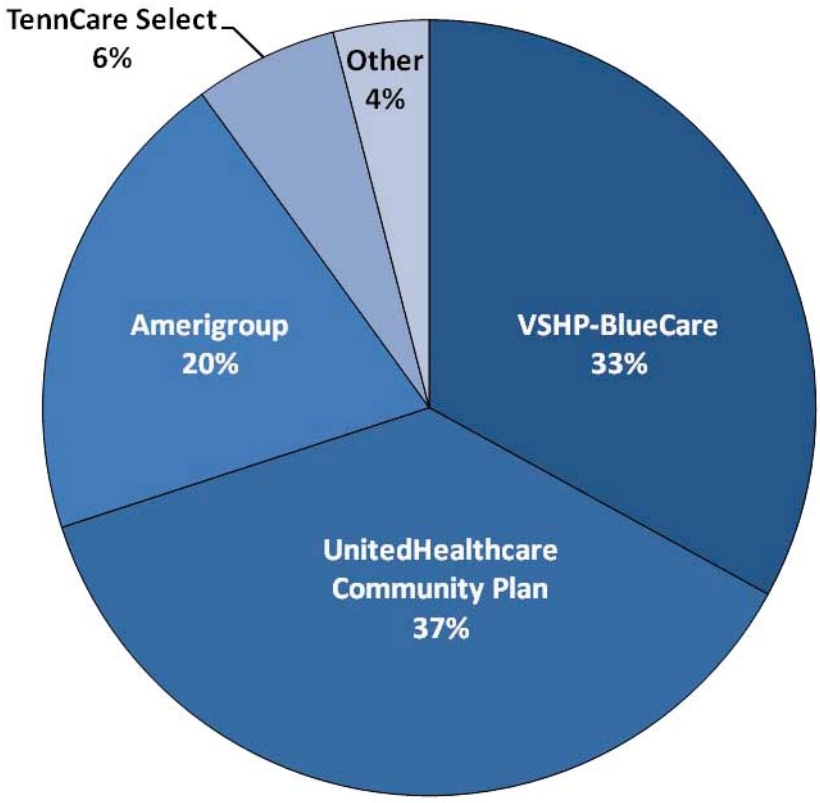
The largest number of TennCare recipients (37 percent) report being signed up with UnitedHealthcare Community Plan as their TennCare MCO. Volunteer State Health Plan (BlueCare) also accounts for a large percentage of the TennCare recipients (33 percent). Amerigroup accounts for another 20 percent, while 6 percent are represented by TennCare Select. Four percent report being represented by other plans, though there are no other active TennCare plans (Table 14).[6]

TABLE 14: Reported TennCare Plan (2005–2012) (Percent)

What company manages your TennCare plan?	2005	2006	2007	2008	2009	2010	2011	2012
Active Plans								
Amerigroup					8	10	16	20
TennCare Select	21	18	6	7	10	8	8	6
UnitedHealthcare Community Plan (formerly AmeriChoice)					26	37	41	37
VSHP – BlueCare					41	36	32	33
Inactive Plans								
Access Med Plus	1		2	3	<1			
Better Health Plans	2	3	1	1	<1			
Blue Cross / Blue Shield	36	31	35	37				
John Deere (Heritage)	9	6	7	4	1			
Omnicare (Affordable)	6	9	7	5	2			
Preferred Health Partner	10	11	8	6	2			
Premier Behavioral		1		<1				
Tennessee Behavioral			<1					
TLC (Memphis Managed Care)	13	11	7	9	2			
Universal Care		1	1	1				
Vanderbilt Health Plan	1	1	<1					
VHP Community Care		1		<1				
Windsor Health Plan of TN, Inc.			<1	<1				
Xantus Health Plan			<1					
Other	1	6	22	27	7	7	4	4

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

FIGURE 2: Reported TennCare Plan (2012)



In 2012, an increased share of TennCare households reported receiving information from MCOs (enrollment card, a list of rights and responsibilities, and name of MCO assigned). Sixty-two percent recall receiving an enrollment card, a one percentage point increase from 2011 (Table 15). Six percent of respondents indicated that they changed plans, a one percentage point increase from 2011. A greater proportion of respondents than in 2011 reported receiving both a list of rights and responsibilities and the name of the assigned MCO, though receiving a list of rights and responsibilities increased the most (12 percentage points). The preferred method for receiving information about TennCare remains through the mail, with 80 percent reporting this is the best way they obtain TennCare information (Table 16).

TABLE 15: Households Receiving TennCare Information from Plans (2005–2012) (Percent)

Please indicate whether or not you or anyone in your household has received each of the following regarding TennCare	2005	2006	2007	2008	2009	2010	2011	2012
An enrollment card	70	73	78	78	77	74	61	62
Information on filing grievances	26	41	46	41	41	43	29	
Information on filing appeals[7]								73
A list of rights and responsibilities	71	78	77	73	75	74	68	80
Name of MCO to whom assigned	79	82	81	79	79	79	76	79

TABLE 16: Best Way to Get Information about TennCare (2005–2012) (Percent)

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

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

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 and are able to see a physician without excessive travel or waiting time. Tennessee's 9.2 percent rate of uninsured in 2012 is a slight decrease from 9.5 percent in 2011 and is the lowest since 2005. Still, the rate is much higher than those experienced before 2006. The total uninsured population is approximately 577,813, including about 40,700 children, a slight rise from last year's number of 35,743 uninsured children.

In 2012, recipients expressed high overall satisfaction with TennCare, with 93 percent claiming satisfaction with the program. This is the third highest level of satisfaction since the program began. The satisfaction rate remains dramatically higher (32 percentage points) than the rate in the program's first year. Additionally, fewer of those in the lowest income group claim affordability as a major barrier to getting insurance than at inception. TennCare continues to receive positive feedback from its recipients, indicating the program is providing medical care in a satisfactory manner and up to the expectations of those it serves.

ATTACHMENT E

2012 HEDIS/CAHPS REPORT: A COMPARATIVE ANALYSIS OF AUDITED RESULTS FROM TENNCARE MANAGED CARE ORGANIZATIONS

Comparative Analysis of Audited Results from TennCare MCOs

August 2012

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
CT ..... Computed Tomography
CWP ..... Appropriate Testing for Children With Pharyngitis
CY ..... Calendar Year
d.b.a. ..... doing business as
DMARD ..... Disease-Modifying Anti-Rheumatic Drug
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
HPV ..... Human Papillomavirus Vaccine for Female Adolescents

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
MMA ..... Medication Management for People With Asthma
MMR ..... Measles, Mumps and Rubella Vaccination
MPM ..... Annual Monitoring for Patients on Persistent Medications
MPT ..... Mental Health Utilization
MRI ..... Magnetic Resonance Imaging
MSC ..... Medical Assistance With Smoking and Tobacco Use Cessation
NA ..... Not Applicable
NCQA ..... National Committee for Quality Assurance
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
PMPY ..... Per Member Per 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. UnitedHealthcare-East in the Tennessee East Grand Region

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

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

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

VZV.....Chicken Pox Vaccination

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

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

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

Executive Summary

Medicaid managed care organizations (MCOs) 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 2012 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 plan-specific results for the HEDIS 2012 Utilization Measures and HEDIS 2011 national benchmarks.

Background

HEDIS Measures–Domains of Care

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

The HEDIS rates presented in this report refer to data collected during the review period of the previous calendar year (CY), from January 1 to December 31. For HEDIS 2012 results, CY2011 was the review period. Similarly, the comparative data presented in this report from the HEDIS 2011 Medicaid Means and Percentiles reflect data procured during CY2010.

For HEDIS 2012, there were a total of 76 measures (Commercial, Medicare and Medicaid) across five domains of care:

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

The following brief descriptions of selected HEDIS measures were extracted from NCQA's *HEDIS 2012 Volume 2: Technical Specifications*, which includes additional information related to each measure. The measures presented in this report reflect data submitted from the following domains of care: Effectiveness of Care, Access/Availability of Care, Utilization and Relative Resource Use, and Experience of Care (**CAHPS Survey Results**).

Effectiveness of Care Measures

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

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

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

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 Utilization Measures are included in **Appendix A**.

Prevention and Screening

Adult BMI Assessment (ABA)

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

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

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

Childhood Immunization Status (CIS)

The percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates. HepA, RV, flu, and Combinations four through 10 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.

Human Papillomavirus Vaccine for Female Adolescents (HPV)

The percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.

Lead Screening in Children (LSC)

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

Breast Cancer Screening (BCS)

The percentage of women 40 to 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 to 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 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. This measure calculates a total rate as well as two age stratifications: 16- to 20- and 21- to 24-year-old women.

Respiratory Conditions

Appropriate Testing for Children With Pharyngitis (CWP)

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

Appropriate Treatment for Children With Upper Respiratory Infection (URI)

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

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

The percentage of adults 18 to 64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription. 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. The denominator may include multiple events for the same individual.

Use of Appropriate Medications for People With Asthma (ASM)

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

Medication Management for People With Asthma (MMA)

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

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

Cardiovascular Conditions

Cholesterol Management for Patients With Cardiovascular Conditions (CMC)

The percentage of members 18 to 75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) from January 1 to 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 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

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

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

Diabetes

Comprehensive Diabetes Care (CDC)

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

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

Musculoskeletal Conditions

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

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

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).

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

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 and treated with antidepressant medication, and remained on an antidepressant medication treatment. Two rates are reported:

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

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

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period (where members diagnosed with narcolepsy are excluded from the denominator if optional exclusions are applied). One of these visits must have been within 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 to 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 a practitioner with 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 (nine 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 six years of age and older who were hospitalized for treatment of selected mental health disorders and had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which the member received follow-up within seven days of discharge
- The percentage of discharges for which the member 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 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, four separate rates and a total are reported:

- Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blocker (ARB)
- Annual monitoring for members on digoxin

- Annual monitoring for members on diuretics
- Annual monitoring for members on anticonvulsants
- Total rate (the sum of the four numerators divided by the sum of the four denominators)

Measures Collected Through CAHPS Health Plan Survey

Medical Assistance With Smoking and Tobacco Use Cessation (MSC)

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

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

Access/Availability of Care Measures

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

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

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

- 20–44 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 six years who had a visit with a PCP during the measurement year, and members 7–19 years who had a visit with a PCP during the measurement year or the year prior. The MCO reports four separate percentages:

- 12–24 months
- 25 months–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 the following:

- *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 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 MCO's Member Services call centers (during operating hours) during the measurement year that were abandoned 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 MCO's Member Services call centers (during operating hours) during the measurement year that were answered by a live voice within 30 seconds.

Utilization and Relative Resource Use

Utilization

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

Adolescent Well-Care Visits (AWC)

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

Relative Resource Use

Relative Resource Use measures are detailed in a separate report upon request by TennCare.

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 the following:

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

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

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 2012, Volume 3: Specifications for Survey Measures.* MCO results from the CPA, CPC 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 CPA: *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 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 CPC: *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 CPC. Additionally, five CCC composites summarize satisfaction with basic components of care essential for successful treatment, management and support of children with chronic conditions. These topics are reflected in the following composite measures presented in this report:

1. Access to 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: 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 2012, 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 2011 and HEDIS 2012 measures as well as the HEDIS 2011 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 2011 and HEDIS 2012 are presented. The column titled 'Change 2011 to 2012' indicates whether there was an improvement (⬆) or a decline (⬇) in statewide performance for the measure from HEDIS 2011 to HEDIS 2012.

Table 2-1a. HEDIS 2012 State to National Rates: Effectiveness of Care Measures

Measure	Weighted State Rate		2011 Medicaid National Avg.	Change 2011 to 2012
	2011	2012		
Prevention and Screening				
Adult BMI Assessment (ABA)	18.95%	59.17%	42.2%	⬆
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC):				
BMI Percentile: 3–11 years	9.00%	39.57%	37.5%	⬆
12–17 years	10.99%	43.38%	36.8%	⬆
Total	**9.65%**	**40.91%**	**37.3%**	⬆
Counseling for Nutrition: 3–11 years	24.22%	58.43%	47.4%	⬆
12–17 years	20.79%	51.03%	41.3%	⬆
Total	**23.15%**	**56.30%**	**45.6%**	⬆
Counseling for Physical Activity: 3–11 years	18.75%	39.13%	35.6%	⬆
12–17 years	18.13%	40.29%	38.5%	⬆
Total	**18.58%**	**39.63%**	**36.7%**	⬆
Childhood Immunization Status (CIS):				
DTaP/DT	80.70%	79.52%	80.2%	⬇
IPV	94.84%	93.94%	90.8%	⬇
MMR	91.51%	90.05%	90.6%	⬇

Table 2-1a. HEDIS 2012 State to National Rates: Effectiveness of Care Measures				
Measure	Weighted State Rate		2011 Medicaid National Avg.	Change 2011 to 2012
	2011	2012		
HiB	91.40%	93.90%	90.3%	↑
HepB	93.83%	92.27%	90.1%	↓
VZV	91.74%	90.88%	90.0%	↓
PCV	82.08%	81.69%	79.4%	↓
HepA	40.57%	43.31%	36.5%	↑
RV	65.68%	66.23%	57.6%	↑
Influenza	38.14%	38.38%	43.6%	↑
Combination 2	74.21%	75.37%	74.1%	↑
Combination 3	70.28%	72.01%	69.9%	↑
Combination 4	36.24%	40.13%	31.6%	↑
Combination 5	52.58%	54.64%	47.2%	↑
Combination 6	32.11%	32.90%	36.4%	↑
Combination 7	28.34%	31.79%	23.8%	↑
Combination 8	18.45%	20.83%	19.0%	↑
Combination 9	26.63%	26.98%	27.8%	↑
Combination 10	15.57%	17.54%	15.2%	↑
Immunizations for Adolescents (IMA):				
Meningococcal	47.58%	60.34%	56.3%	↑
Tdap/Td	53.48%	76.12%	67.8%	↑
Combination 1	43.16%	58.66%	52.2%	↑
Human Papillomavirus Vaccine for Female Adolescents (HPV)*		15.07%		
Lead Screening in Children (LSC)	70.87%	71.65%	66.2%	↑
Breast Cancer Screening (BCS)	43.79%	42.68%	51.3%	↓
Cervical Cancer Screening (CCS)	67.29%	67.73%	67.2%	↑
Chlamydia Screening in Women (CHL):				
16–20 years	53.93%	54.48%	54.6%	↑
21–24 years	62.10%	62.52%	62.3%	↑
Total	**57.19%**	**57.75%**	**57.5%**	↑
Respiratory Conditions				
Appropriate Testing for Children With Pharyngitis (CWP)	72.05%	75.27%	64.9%	↑
Appropriate Treatment for Children With Upper Respiratory Infection (URI)	74.95%	74.21%	87.2%	↓
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)	21.51%	21.92%	23.5%	↑
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	30.68%	35.36%	31.3%	↑
Pharmacotherapy Management of COPD Exacerbation (PCE):				
Systemic corticosteriod	42.54%	45.55%	65.3%	↑
Bronchodilator	73.17%	72.13%	82.1%	↓

Table 2-1a. HEDIS 2012 State to National Rates: Effectiveness of Care Measures				
Measure	Weighted State Rate		2011 Medicaid National Avg.	Change 2011 to 2012
	2011	2012		
Use of Appropriate Medications for People With Asthma (ASM):				
5–11 years	93.80%	93.42%	91.8%	↓
12–18 years**		87.89%		
19–50 years**		59.16%		
51–64 years**		55.76%		
Total**		**85.29%**		
Medication Management for People With Asthma (MMA)*:				
Medication Complication 50%: 5-11 years		54.78%		
12–18 years		49.54%		
19–50 years		45.06%		
51–64 years		62.50%		
Total		**52.22%**		
Medication Complication 75%: 5-11 years		30.08%		
12–18 years		26.67%		
19–50 years		26.28%		
51–64 years		35.58%		
Total		**28.71%**		
Cardiovascular Conditions				
Cholesterol Management for Patients With Cardiovascular Conditions (CMC):				
LDL-C Screening	80.61%	82.65%	82.0%	↑
LDL-C Controlled (<100 mg/dL)	36.01%	39.23%	42.8%	↑
Controlling High Blood Pressure (CBP)	52.96%	55.99%	55.6%	↑
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	72.01%	75.06%	76.3%	↑
Diabetes				
Comprehensive Diabetes Care (CDC):				
HbA1c Testing	78.87%	80.55%	82.0%	↑
HbA1c Control (<7.0%)	34.64%	37.34%	34.7%	↑
HbA1c Control (<8.0%)	44.54%	48.08%	46.9%	↑
Retinal Eye Exam Performed	37.02%	37.64%	53.1%	↑
LDL-C Screening	74.73%	75.53%	74.7%	↑
LDL-C Controlled (<100 mg/dL)	29.22%	32.00%	34.6%	↑
Medical Attention for Nephropathy	73.19%	75.02%	77.7%	↑
Blood Pressure Control (<130/80 mm Hg)	35.56%	38.03%	38.7%	↑
Blood Pressure Control (<140/90 mm Hg)	55.03%	59.72%	60.4%	↑
Musculoskeletal Conditions				
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	57.88%	58.66%	70.1%	↑
Use of Imaging Studies for Low Back Pain (LBP)	67.88%	68.03%	75.5%	↑

Table 2-1a. HEDIS 2012 State to National Rates: Effectiveness of Care Measures				
Measure	Weighted State Rate		2011 Medicaid National Avg.	Change 2011 to 2012
	2011	2012		
Behavioral Health				
Antidepressant Medication Management (AMM):				
Effective Acute Phase Treatment	47.31%	47.12%	50.7%	↓
Effective Continuation Phase Treatment	28.23%	28.50%	34.4%	↑
Follow-Up Care for Children Prescribed ADHD Medication (ADD):				
Initiation Phase	39.11%	38.28%	38.1%	↓
Continuation and Maintenance Phase	47.00%	47.21%	43.9%	↑
Follow-Up After Hospitalization for Mental Illness (FUH):				
7-day follow-up	41.52%	45.73%	44.6%	↑
30-day follow-up	64.79%	66.83%	63.8%	↑
Medication Management				
Annual Monitoring for Patients on Persistent Medications (MPM):				
ACE Inhibitors or ARBs	89.75%	90.78%	86.0%	↑
Digoxin	91.00%	90.76%	89.7%	↓
Diuretics	89.97%	90.57%	85.5%	↑
Anticonvulsants	75.42%	75.00%	67.7%	↓
Total	**87.96%**	**88.78%**	**83.9%**	↑
Measures Collected Through CAHPS Health Plan Survey				
Medical Assistance With Smoking and Tobacco Use Cessation (MSC):				
Advising Smokers and Tobacco Users to Quit	71.76%***	72.12%***	73.63%	↑
Discussing Cessation Medications	38.13%***	38.84%***	42.69%	↑
Discussing Cessation Strategies	35.23%***	37.03%***	38.53%	↑

**First year measure*
***Increased the upper age limit to 64 and added new age stratifications*
**** 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 2012 State to National Rates: Effectiveness of Care Measure Where Lower Rates Indicate Better Performance				
Measure	Weighted State Rate		2011 Medicaid National Avg.	Change 2011 to 2012
	2011	2012		
Comprehensive Diabetes Care (CDC):				
HbA1c Poor Control (>9.0%)	47.85%	44.78%	44.0%	↑

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

Table 2-2a. HEDIS 2012 State to National Rates: Access/Availability of Care Measures

Measure	Weighted State Rate		2011 Medicaid National Avg.	Change 2011 to 2012
	2011	2012		
Adults' Access to Preventive/Ambulatory Health Services (AAP):				
20–44 years	80.28%	80.62%	81.2%	⬆
45–64 years	85.69%	86.34%	86.0%	⬆
Children and Adolescents' Access to Primary Care Practitioners (CAP):				
12–24 months	97.07%	97.14%	96.1%	⬆
25 months–6 years	89.91%	90.37%	88.3%	⬆
7–11 years	92.80%	93.14%	90.2%	⬆
12–19 years	88.63%	90.18%	88.1%	⬆
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET):				
Initiation of AOD Treatment: 13–17 years	63.61%	53.33%	44.7%	⬇
≥18 years	53.71%	42.54%	42.7%	⬇
Total	**54.45%**	**43.38%**	**42.9%**	⬇
Engagement of AOD Treatment: 13–17 years	37.37%	31.07%	19.9%	⬇
≥18 years	14.93%	12.34%	13.6%	⬇
Total	**16.61%**	**13.80%**	**14.2%**	⬇
Prenatal and Postpartum Care (PPC):				
Timeliness of Prenatal Care	83.12%	79.83%	83.7%	⬇
Postpartum Care	62.50%	61.06%	64.4%	⬇
Call Answer Timeliness (CAT)	91.39%	88.47%	82.7%	⬇

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 2012 State to National Rates: Access/Availability of Care Measure Where Lower Rates Indicate Better Performance

Measure	Weighted State Rate		2011 Medicaid National Avg.	Change 2011 to 2012
	2011	2012		
Call Abandonment (CAB)	0.78%	0.96%	2.9%	⬇

Table 2-3 summarizes results for the Utilization measures included in the Utilization and Relative Resource Domain of Care.

Table 2-3. HEDIS 2012 State to National Rates: Utilization Measures

Measure	Weighted State Rate		2011 Medicaid National Avg.	Change 2011 to 2012
	2011	2012		
Frequency of Ongoing Prenatal Care (FPC):				
≥ 81 percent	61.07%	58.29%	61.1%	↓
Well-Child Visits in the First 15 Months of Life (W15):				
6 or More Visits	55.75%	62.36%	60.2%	↑
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	71.80%	72.69%	71.9%	↑
Adolescent Well-Care Visits (AWC)	46.19%	45.95%	48.1%	↓

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 2011 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 and Access/Availability of Care domains and Utilization measures. **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 CPA as noted in **Tables 2-1a**.

Table 2-4. MCO HEDIS 2012 Rating Determination

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

Table 2-5a. HEDIS 2012 Plan-Specific Rates: Effectiveness of Care Measures								
Measure	Amerigroup	BlueCare -East	BlueCare -West	TennCare *Select*	UnitedHealthcare -East	UnitedHealthcare -Middle	UnitedHealthcare -West	HEDIS 2011 National Medicaid 50th Percentile
Prevention and Screening								
Adult BMI Assessment (ABA)	66.98%	56.45%	66.42%	52.55%	53.28%	61.56%	49.64%	47.6%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC):								
BMI Percentile: 3–11 years	38.21%	40.79%	56.83%	40.00%	31.71%	28.00%	41.11%	37.5%
12–17 years	41.54%	32.71%	66.43%	48.26%	35.48%	32.43%	50.81%	36.3%
Total	**39.21%**	**38.69%**	**60.10%**	**44.04%**	**32.85%**	**29.20%**	**44.04%**	**37.5%**
Counseling for Nutrition: 3–11 years	56.81%	53.95%	67.16%	51.43%	61.32%	57.00%	57.49%	53.3%
12–17 years	49.23%	38.32%	63.57%	48.76%	58.87%	45.95%	56.45%	46.7%
Total	**54.52%**	**49.88%**	**65.94%**	**50.12%**	**60.58%**	**54.01%**	**57.18%**	**51.1%**
Counseling for Physical Activity: 3–11 years	47.84%	40.46%	36.53%	32.86%	39.72%	39.33%	30.66%	39.4%
12–17 years	45.38%	33.64%	46.43%	38.31%	46.77%	37.84%	33.87%	42.8%
Total	**47.10%**	**38.69%**	**39.90%**	**35.52%**	**41.85%**	**38.93%**	**31.63%**	**40.6%**
Childhood Immunization Status (CIS):								
DTaP/DT	83.02%	80.78%	83.21%	78.10%	77.13%	78.35%	72.99%	81.7%
IPV	95.28%	93.67%	95.38%	92.70%	93.67%	92.94%	92.70%	92.3%
MMR	93.40%	91.48%	89.78%	90.75%	88.56%	89.05%	86.86%	91.9%
HiB	95.52%	94.16%	94.89%	92.46%	93.92%	92.70%	92.21%	91.0%
HepB	94.58%	91.97%	94.40%	91.48%	92.70%	88.08%	92.46%	91.8%
VZV	95.05%	91.24%	91.97%	91.00%	88.56%	90.75%	86.13%	91.3%
PCV	86.08%	82.48%	84.43%	82.00%	78.83%	82.97%	72.75%	81.3%
HepA	49.53%	42.58%	38.69%	46.23%	42.34%	49.15%	35.04%	36.4%
RV	70.75%	67.15%	65.94%	42.82%	65.69%	69.59%	60.58%	59.4%
Flu	53.54%	40.63%	21.41%	49.39%	42.09%	45.01%	23.36%	44.0%
Combination 2	81.13%	75.43%	80.29%	73.97%	74.70%	70.80%	69.10%	75.1%
Combination 3	78.07%	72.75%	76.16%	71.05%	71.53%	68.13%	64.23%	71.0%
Combination 4	46.93%	39.66%	38.20%	40.39%	40.15%	42.34%	31.87%	31.4%
Combination 5	61.79%	55.96%	57.66%	36.98%	54.50%	52.80%	46.47%	47.4%
Combination 6	48.58%	33.33%	20.19%	41.85%	36.50%	36.25%	19.22%	37.0%
Combination 7	38.21%	32.12%	28.71%	22.87%	31.87%	35.52%	24.09%	23.1%
Combination 8	30.90%	20.92%	11.68%	25.06%	22.38%	24.57%	12.41%	18.0%
Combination 9	41.75%	27.25%	16.79%	20.19%	28.95%	31.14%	15.09%	26.8%
Combination 10	26.18%	17.76%	10.22%	12.65%	18.00%	21.90%	10.46%	14.4%
Immunization for Adolescents (IMA):								
Meningococcal	66.98%	65.33%	58.88%	57.42%	56.93%	63.95%	48.42%	54.8%
Tdap/Td	82.90%	80.65%	72.26%	66.67%	77.86%	78.77%	66.67%	68.5%
Combination 1	65.81%	64.07%	57.42%	55.72%	54.99%	61.98%	45.99%	49.8%
Human Papillomavirus Vaccine for Female Adolescents (HPV)	16.59%	21.17%	12.41%	17.27%	14.36%	15.57%	7.79%	
Lead Screening in Children (LSC)	76.18%	74.94%	72.99%	69.34%	66.55%	68.33%	69.34%	72.2%
Breast Cancer Screening (BCS)	40.21%	46.75%	43.92%	35.77%	42.89%	42.07%	36.46%	52.4%
Cervical Cancer Screening (CCS)	67.12%	69.00%	70.76%	45.96%	59.84%	71.58%	66.58%	69.7%

Table 2-5a. HEDIS 2012 Plan-Specific Rates: Effectiveness of Care Measures								
Measure	Amerigroup	BlueCare -East	BlueCare -West	TennCare *Select*	UnitedHealthcare -East	UnitedHealthcare -Middle	UnitedHealthcare -West	HEDIS 2011 National Medicaid 50th Percentile
Chlamydia Screening in Women (CHL):								
16–20 years	53.13%	49.53%	61.99%	52.61%	50.17%	53.21%	59.31%	53.6%
21–24 years	59.81%	58.17%	70.48%	NA	56.84%	59.97%	67.17%	62.5%
Total	**55.83%**	**53.08%**	**65.77%**	**52.56%**	**52.70%**	**56.26%**	**62.71%**	**57.2%**
Respiratory Conditions								
Appropriate Testing for Children With Pharyngitis (CWP)	79.56%	72.13%	77.06%	73.52%	70.44%	78.27%	76.14%	68.1%
Appropriate Treatment for Children With Upper Respiratory Infection (URI)	77.63%	71.79%	71.16%	71.20%	69.78%	77.96%	75.36%	87.5%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)	20.52%	21.43%	22.14%	28.38%	20.34%	22.53%	25.52%	22.0%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	32.36%	36.13%	43.70%	NA	30.03%	33.87%	42.90%	30.5%
Pharmacotherapy Management of COPD Exacerbation (PCE):								
Systemic corticosteroid	41.34%	43.70%	41.37%	NA	49.27%	45.21%	50.35%	67.6%
Bronchodilator	69.79%	73.23%	71.32%	NA	71.47%	72.28%	75.29%	84.3%
Use of Appropriate Medications for People With Asthma (ASM):								
5–11 years	92.80%	96.89%	91.73%	92.90%	95.06%	90.89%	90.71%	92.3%
12–18 years*	88.14%	89.88%	87.84%	89.76%	89.25%	83.17%	85.74%	
19–50 years*	57.11%	56.56%	62.55%	84.42%	62.60%	54.53%	57.48%	
51–64 years*	50.00%	50.00%	62.50%	NA	61.33%	56.60%	51.79%	
Total*	**83.93%**	**88.36%**	**84.51%**	**91.05%**	**86.91%**	**80.99%**	**81.62%**	
Medication Management for People With Asthma (MMA):**								
Medication Complication 50%: 5–11 years	55.09%	60.32%	48.91%	61.79%	57.38%	51.66%	45.84%	
12–18 years	49.32%	53.77%	43.22%	59.22%	54.50%	45.14%	39.95%	
19–50 years	51.61%	49.35%	37.69%	60.00%	55.31%	39.77%	33.67%	
51–64 years	61.29%	NA	57.78%	NA	73.91%	63.33%	NA	
Total	**53.13%**	**57.25%**	**45.89%**	**60.70%**	**56.69%**	**48.54%**	**42.81%**	
Medication Complication 75%: 5–11 years	25.02%	35.07%	25.39%	38.87%	33.15%	29.01%	22.54%	
12–18 years	23.78%	30.25%	22.11%	36.65%	30.04%	24.12%	18.48%	
19–50 years	32.26%	28.43%	20.67%	35.38%	33.19%	25.48%	15.82%	
51–64 years	45.16%	NA	24.44%	NA	41.30%	33.33%	NA	
Total	**25.89%**	**33.00%**	**23.77%**	**37.81%**	**32.44%**	**27.32%**	**20.71%**	
Cardiovascular Conditions								
Cholesterol Management for Patients With Cardiovascular Conditions (CMC):								
LDL-C Screening	82.09%	83.21%	83.94%	NA	82.73%	82.48%	81.27%	82.5%
LDL-C Controlled (<100 mg/dL)	38.84%	43.55%	37.23%	NA	41.12%	40.15%	28.71%	44.0%

Table 2-5a. HEDIS 2012 Plan-Specific Rates: Effectiveness of Care Measures								
Measure	**Amerigroup**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**HEDIS 2011 National Medicaid 50th Percentile**
		-East	**-West**		**-East**	**-Middle**	**-West**	
Controlling High Blood Pressure (CBP)	63.36%	61.23%	61.04%	70.34%	52.07%	51.09%	46.23%	56.4%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	70.59%	81.43%	72.73%	NA	74.29%	79.73%	69.57%	79.3%
Diabetes								
Comprehensive Diabetes Care (CDC):								
HbA1c Testing	81.99%	80.09%	80.46%	76.57%	84.36%	81.15%	74.23%	82.2%
HbA1c Control (<7.0%)	35.77%	43.31%	39.44%	50.52%	37.57%	34.71%	28.51%	35.2%
HbA1c Control (<8.0%)	47.08%	54.19%	49.51%	54.81%	50.91%	45.26%	36.67%	47.4%
Retinal Eye Exam Performed	30.96%	44.08%	43.32%	58.58%	34.91%	36.15%	31.79%	52.8%
LDL-C Screening	75.67%	76.46%	74.59%	65.27%	76.61%	77.05%	72.05%	75.4%
LDL-C Controlled (<100 mg/dL)	33.65%	36.18%	32.41%	41.00%	29.70%	30.38%	27.82%	35.2%
Medical Attention for Nephropathy	77.73%	71.72%	77.85%	51.88%	76.73%	72.31%	77.05%	78.5%
Blood Pressure Control (<130/80 mm Hg)	40.28%	42.34%	37.46%	55.23%	37.94%	39.10%	27.31%	38.5%
Blood Pressure Control (<140/90 mm Hg)	62.09%	65.09%	57.65%	75.31%	60.97%	60.38%	47.44%	61.2%
Musculoskeletal Conditions								
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	55.44%	63.32%	61.75%	NA	63.45%	51.05%	53.70%	73.0%
Use of Imaging Studies for Low Back Pain (LBP)	70.47%	66.11%	69.52%	68.60%	62.47%	69.93%	70.56%	75.6%
Behavioral Health								
Antidepressant Medication Management (AMM):								
Effective Acute Phase Treatment	50.18%	44.31%	43.09%	52.38%	49.42%	46.56%	50.20%	50.1%
Effective Continuation Phase Treatment	30.96%	24.26%	25.55%	30.16%	32.04%	28.24%	32.33%	32.7%
Follow-Up Care for Children Prescribed ADHD Medication (ADD):								
Initiation Phase	61.33%	39.47%	31.85%	32.93%	40.28%	33.87%	29.22%	38.3%
Continuation and Maintenance Phase	72.38%	47.09%	42.27%	39.26%	46.39%	43.27%	39.06%	45.2%
Follow-Up After Hospitalization for Mental Illness (FUH):								
7-day follow-up	55.18%	35.08%	24.66%	35.10%	45.37%	52.99%	67.58%	45.1%
30-day follow-up	74.11%	63.21%	50.59%	57.48%	66.19%	73.28%	78.90%	66.6%
Medication Management								
Annual Monitoring for Patients on Persistent Medications (MPM):								
ACE Inhibitors or ARBs	88.30%	91.80%	91.76%	83.58%	91.64%	89.69%	90.97%	86.5%
Digoxin	91.25%	88.00%	94.79%	NA	92.98%	88.29%	90.32%	90.3%

Table 2-5a. HEDIS 2012 Plan-Specific Rates: Effectiveness of Care Measures								
Measure	Amerigroup	BlueCare		TennCare *Select*	UnitedHealthcare			HEDIS 2011 National Medicaid 50th Percentile
		-East	-West		-East	-Middle	-West	
Diuretics	88.08%	91.75%	91.22%	92.63%	91.83%	89.78%	89.39%	85.8%
Anticonvulsants	74.17%	77.70%	72.46%	74.64%	77.22%	73.72%	72.47%	68.6%
Total	**86.57%**	**89.97%**	**89.37%**	**78.60%**	**90.26%**	**87.93%**	**88.18%**	**84.2%**
Measures Collected Through CAHPS Health Plan Survey								
Medical Assistance With Smoking and Tobacco UseCessation (MSC)**								
Advising Smokers and Tobacco Users to Quit	78.55%	79.34%	66.67%	64.04%	74.80%	75.79%	65.67%	74.82%
Discussing Cessation Medications	43.15%	40.93%	33.98%	35.71%	41.86%	39.07%	37.21%	42.71%
Discussing Cessation Strategies	33.73%	43.44%	41.11%	46.43%	29.65%	33.82%	31.00%	38.14%

**For ASM age stratification changed for 2012 HEDIS; hence, there are no National data.*

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 2012 Plan-Specific Rates: Effectiveness of Care Measure Where Lower Rates Indicate Better Performance								
Measure	Amerigroup	BlueCare		TennCare *Select*	UnitedHealthcare			HEDIS 2011 National Medicaid 50th Percentile
		-East	-West		-East	-Middle	-West	
Comprehensive Diabetes Care (CDC):								
HbA1c Poor Control (>9.0%)	43.60%	39.18%	43.16%	40.17%	41.58%	48.21%	57.31%	42.6%

Table 2-6a. HEDIS 2012 Plan-Specific Rates: Access/Availability of Care Measures								
Measure	Amerigroup	BlueCare		TennCare *Select*	UnitedHealthcare			HEDIS 2011 National Medicaid 50th Percentile
		-East	-West		-East	-Middle	-West	
Adults' Access to Preventive/Ambulatory Health Services (AAP):								
20–44 years	80.52%	84.11%	79.89%	66.70%	80.01%	84.28%	74.25%	83.2%
45–64 years	84.51%	90.03%	84.09%	64.75%	86.90%	89.94%	80.25%	87.4%
Children and Adolescents' Access to Primary Care Practitioners (CAP):								
12–24 months	97.91%	97.94%	96.72%	94.34%	96.60%	97.83%	95.74%	97.0%
25 months–6 years	91.10%	92.16%	89.19%	91.00%	89.08%	91.55%	88.21%	89.6%
7–11 years	92.29%	94.19%	94.08%	93.36%	90.98%	93.55%	92.81%	91.3%
12–19 years	90.94%	92.60%	90.30%	88.07%	88.88%	91.08%	87.22%	89.7%

Table 2-6a. HEDIS 2012 Plan-Specific Rates: Access/Availability of Care Measures								
Measure	Amerigroup	BlueCare		TennCare *Select*	UnitedHealthcare			HEDIS 2011 National Medicaid 50th Percentile
		-East	-West		-East	-Middle	-West	
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET):								
Initiation of AOD Treatment: 13–17 years	48.13%	53.80%	56.85%	53.47%	58.62%	44.90%	62.19%	44.9%
≥18 years	38.29%	42.62%	39.27%	50.26%	48.65%	40.25%	45.53%	40.4%
Total	**38.87%**	**43.59%**	**40.31%**	**51.98%**	**49.23%**	**40.52%**	**46.54%**	**40.8%**
Engagement of AOD Treatment: 13–17 years	31.72%	36.01%	27.92%	28.01%	34.48%	27.11%	30.35%	19.4%
≥18 years	13.59%	12.28%	9.03%	16.93%	12.69%	13.82%	10.40%	13.3%
Total	**14.64%**	**14.32%**	**10.14%**	**22.84%**	**13.96%**	**14.61%**	**11.61%**	**14.5%**
Prenatal and Postpartum Care (PPC):								
Timeliness of Prenatal Care	89.42%	88.50%	77.92%	70.04%	79.56%	78.35%	60.58%	86.0%
Postpartum Care	63.22%	66.13%	61.54%	53.70%	62.53%	58.64%	52.55%	64.6%
Call Answer Timeliness (CAT)	91.55%	89.91%	89.77%	90.06%	86.78%	86.78%	86.78%	84.6%

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 2012 Plan-Specific Rates: Access/Availability of Care Measures Where Lower Rates Indicate Better Performance								
Measure	Amerigroup	BlueCare		TennCare *Select*	UnitedHealthcare			HEDIS 2011 National Medicaid 50th Percentile
		-East	-West		-East	-Middle	-West	
Call Abandonment (CAB)	0.71%	1.01%	1.04%	0.99%	0.99%	0.99%	0.99%	2.1%

Table 2-7. HEDIS 2012 Plan-Specific Rates: Utilization Measures								
Measure	Amerigroup	BlueCare		TennCare *Select*	UnitedHealthcare			HEDIS 2011 National Medicaid 50th Percentile
		-East	-West		-East	-Middle	-West	
Frequency of Ongoing Prenatal Care (FPC):								
≥81%	67.55%	72.52%	54.59%	42.80%	56.69%	53.28%	39.42%	64.4%
Well-Child Visits in the First 15 Months of Life (W15):								
6 or More Visits	65.35%	72.92%	50.36%	38.44%	72.63%	62.30%	51.34%	61.3%

Table 2-7. HEDIS 2012 Plan-Specific Rates: Utilization Measures								
Measure	Amerigroup	BlueCare		TennCare *Select*	UnitedHealthcare			HEDIS 2011 National Medicaid 50th Percentile
		-East	-West		-East	-Middle	-West	
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	76.15%	72.70%	71.96%	76.02%	72.81%	68.97%	73.10%	72.3%
Adolescent Well-Care Visits (AWC)	53.72%	42.09%	49.39%	50.36%	42.58%	42.85%	42.58%	46.1%

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 2011 National Medicaid CAHPS Benchmarking data were obtained from AHRQ's website: **www.cahps.ahrq.gov**.

Table 2-8. MCO 2012 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. 2012 CAHPS 4.0H Adult Medicaid Survey Results								
Amerigroup	BlueCare		TennCare Select	UnitedHealthcare			Statewide Average	2011 National Medicaid CAHPS Benchmarking
	-East	-West		-East	-Middle	-West		
1. Getting Needed Care (Always + Usually)								
80.92%	78.80%	77.87%	87.63%	74.84%	82.31%	76.86%	79.89%	78%
2. Getting Care Quickly (Always + Usually)								
81.14%	82.98%	83.16%	86.63%	82.82%	82.18%	81.52%	82.92%	81%
3. How Well Doctors Communicate (Always + Usually)								
88.22%	83.17%	89.03%	93.32%	90.23%	89.30%	87.35%	88.66%	89%
4. Customer Service (Always + Usually)								
NA	NA	NA	NA	75.53%	NA	NA	75.53%	81%
5. Shared Decision Making (Definitely Yes)								
58.16%	55.55%	62.69%	69.92%	60.38%	52.56%	59.72%	59.85%	

Table 2-9. 2012 CAHPS 4.0H Adult Medicaid Survey Results								
Amerigroup	BlueCare		TennCare Select	UnitedHealthcare			Statewide Average	2011 National Medicaid CAHPS Benchmarking
	-East	-West		-East	-Middle	-West		
6. Rating of All Health Care (9+10)								
49.20%	52.57%	56.37%	60.71%	50.80%	49.34%	55.16%	53.45%	80%
7. Rating of Personal Doctor (9+10)								
62.34%	59.71%	68.03%	70.70%	63.43%	59.14%	63.72%	63.87%	86%
8. Rating of Specialist Seen Most Often (9+10)								
62.68%	69.59%	65.49%	64.17%	64.18%	51.58%	71.21%	64.13%	85%
9. Rating of Health Plan (9+10)								
55.73%	60.91%	61.98%	66.13%	57.41%	56.24%	60.05%	59.78%	82%

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. 2012 CAHPS 4.0H Child Medicaid Survey Results (General Population)								
Amerigroup	BlueCare		TennCare *Select*	UnitedHealthcare			Statewide Average	2011 National Medicaid CAHPS Benchmarking
	-East	-West		-East	-Middle	-West		
1. Getting Needed Care (Always + Usually)								
78.15%	91.33%	NA	87.42%	84.45%	88.43%	81.10%	85.15%	79%
2. Getting Care Quickly (Always + Usually)								
88.96%	92.79%	88.86%	91.89%	91.06%	89.27%	87.92%	90.11%	87%
3. How Well Doctors Communicate (Always + Usually)								
93.47%	92.84%	94.32%	94.24%	93.45%	92.12%	90.98%	93.06%	92%
4. Customer Service (Always + Usually)								
NA	NA	NA	NA	NA	NA	NA	NA	80%
5.Shared Decision Making (Definitely Yes)								
69.97%	74.58%	73.62%	70.11%	66.57%	64.34%	54.88%	67.72%	
6. Rating of Personal Doctor (9+10)								
74.36%	76.14%	77.94%	73.54%	71.15%	74.31%	69.35%	73.83%	91%
7. Rating of Specialist Seen Most Often (9+10)								
64.91%	NA	NA	70.55%	75.68%	NA	NA	70.38%	89%
8. Rating of All Health Care (9+10)								
66.33%	68.99%	74.52%	66.12%	64.95%	64.32%	59.83%	66.44%	89%
9. Rating of Health Plan (9+10)								
70.52%	75.78%	75.93%	75.79%	65.93%	71.72%	65.78%	71.64%	89%

Table 2-11. 2012 CAHPS 4.0H Child Medicaid Survey Results (Children with Chronic Conditions)								
Amerigroup	BlueCare -East	BlueCare -West	TennCare *Select*	UnitedHealthcare -East	UnitedHealthcare -Middle	UnitedHealthcare -West	Statewide Average	2011 National Medicaid CAHPS Benchmarking
1. Getting Needed Care (Always + Usually)								
79.57%	87.26%	86.59%	86.10%	87.90%	86.26%	82.17%	85.12%	79%
2. Getting Care Quickly (Always + Usually)								
92.11%	92.92%	90.74%	92.42%	94.50%	92.64%	90.44%	92.25%	87%
3. How Well Doctors Communicate (Always + Usually)								
92.77%	93.71%	91.22%	95.00%	93.39%	93.58%	93.06%	93.25%	92%
4. Customer Service (Always + Usually)								
NA	NA	NA	83.33%	NA	NA	NA	83.33%	80%
5.Shared Decision Making (Definitely Yes)								
71.71%	74.37%	72.92%	73.85%	72.47%	68.34%	61.69%	70.76%	
6. Rating of Personal Doctor (9+10)								
76.33%	75.67%	77.42%	74.89%	72.80%	71.28%	75.44%	74.83%	91%
7. Rating of Specialist Seen Most Often (9+10)								
68.02%	73.66%	75.00%	71.84%	75.00%	68.09%	62.94%	70.65%	89%
8. Rating of All Health Care (9+10)								
69.72%	68.39%	71.52%	64.21%	61.33%	64.72%	57.48%	65.34%	89%
9. Rating of Health Plan (9+10)								
69.87%	74.48%	77.54%	73.68%	66.86%	67.59%	65.89%	70.84%	89%
10. Access to Specialized Services (Always + Usually)								
NA	NA	NA	78.75%	77.48%	80.28%	NA	78.84%	
11. Family-Centered Care: Personal Doctor or Nurse Who Knows Child (Yes)								
89.71%	91.08%	92.53%	91.99%	88.87%	90.37%	89.40%	90.56%	
12. Family-Centered Care: Coordination of Care (Yes)								
79.43%	81.34%	NA	78.88%	78.91%	82.22%	78.20%	79.83%	
13. Family-Centered Care: Getting Needed Information (Always + Usually)								
91.79%	88.69%	89.06%	91.38%	90.85%	90.09%	87.76%	89.95%	
14. Access to Prescription Medicines (Always + Usually)								
91.39%	94.59%	94.14%	90.37%	94.28%	93.59%	94.16%	93.22%	

APPENDIX A | 2012 HEDIS Additional Measures, Rates and Benchmarks

Utilization Measures

Added Initially in 2009 Reporting

Frequency of Selected Procedure (FSP)

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

Ambulatory Care (AMB)

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

- Outpatient Visits
- Emergency Department (ED) Visits

Inpatient Utilization – General Hospital/Acute Care (IPU)

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

- Total IP
- Medicine
- Surgery
- Maternity

Identification of Alcohol and Other Drug Services (IAD)

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

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

Mental Health Utilization (MPT)

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

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

Antibiotic Utilization (ABX)

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

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

Utilization Measures: Plan-Specific Rates / National Benchmarks

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

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures

Measure by Age / as Stated	Sex	Ameri group	BlueCare -East	BlueCare -West	TennCare *Select*	UnitedHealthcare -East	UnitedHealthcare -Middle	UnitedHealthcare -West	National Medicaid HEDIS 2011 Means and Percentiles Mean	P10	P25	P50	P75	P90
Frequency of Ongoing Prenatal Care (FPC):														
<21%	NA	4.57%	1.92%	5.96%	5.45%	7.79%	10.22%	13.63%	10.4%	1.8%	4.0%	7.7%	11.5%	19.1%
21–40%	NA	6.97%	4.15%	5.46%	10.12%	7.30%	8.27%	9.00%	6.9%	1.9%	2.9%	4.9%	8.8%	13.8%
41–60%	NA	7.69%	7.35%	13.15%	14.01%	8.76%	9.25%	17.27%	8.1%	4.0%	5.5%	7.0%	9.8%	14.2%
61–80%	NA	13.22%	14.06%	20.84%	27.63%	19.46%	18.98%	20.68%	13.6%	7.1%	10.6%	13.4%	16.8%	19.7%
≥81%	NA	67.55%	72.52%	54.59%	42.80%	56.69%	53.28%	39.42%	61.1%	34.7%	50.8%	64.4%	74.9%	81.8%
Well-Child Visits in the First 15 Months of Life (W15):														
0 Visits	NA	1.24%	1.04%	1.22%	8.52%	0.53%	1.37%	1.22%	2.2%	0.5%	0.8%	1.6%	2.7%	4.4%
1 Visits	NA	1.24%	2.34%	2.43%	4.14%	1.84%	1.91%	1.46%	2.2%	0.7%	1.2%	1.9%	2.7%	4.1%
2 Visits	NA	2.23%	1.30%	4.14%	4.87%	3.42%	4.10%	5.11%	3.3%	1.1%	2.1%	2.9%	4.5%	6.1%
3 Visits	NA	5.69%	4.17%	9.49%	9.25%	3.16%	5.46%	9.25%	5.7%	2.7%	3.8%	5.4%	7.3%	9.3%
4 Visits	NA	7.18%	7.55%	11.92%	14.84%	8.42%	7.65%	12.17%	10.1%	5.3%	7.4%	9.5%	12.2%	15.6%
5 Visits	NA	17.08%	10.68%	20.44%	19.95%	10.00%	17.21%	19.46%	16.1%	8.3%	11.9%	16.5%	19.8%	21.9%
6 or More Visits	NA	65.35%	72.92%	50.36%	38.44%	72.63%	62.30%	51.34%	60.2%	41.9%	52.2%	61.3%	68.9%	77.1%
Frequency of Selected Procedures (FSP)														
Bariatric weight loss surgery*: *Procedures /1,000 Member Years*														
0–19	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
20–44		0.00	0.01	0.00	0.00	0.01	0.01	0.01						
45–64		0.03	0.01	0.00	0.00	0.03	0.00	0.00						
0–19	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
20–44		0.03	0.02	0.02	0.00	0.05	0.04	0.01						
45–64		0.06	0.03	0.00	0.00	0.04	0.07	0.01						
Tonsillectomy: *Procedures /1,000 Member Years*														
0–9	M&F	0.91	1.39	0.70	1.48	1.29	0.98	0.64	0.8	0.4	0.6	0.8	1.0	1.2
10–19		0.45	0.73	0.28	0.31	0.62	0.55	0.42	0.4	0.1	0.3	0.4	0.5	0.6

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age / as Stated	Sex	Ameri group	BlueCare		TennCare *Select*	UnitedHealthcare			National Medicaid HEDIS 2011 Means and Percentiles					
			-East	-West		-East	-Middle	-West	Mean	P10	P25	P50	P75	P90
Hysterectomy—Abdominal (A) and Vaginal (V): *Procedures /1,000 Member Years*														
A 15–44	F	0.24	0.23	0.23	0.07	0.19	0.18	0.13	0.2	0.1	0.2	0.2	0.3	0.4
A 45–64		0.40	0.16	0.46	0.00	0.21	0.21	0.24	0.5	0.2	0.3	0.5	0.6	0.7
V 15–44	F	0.24	0.47	0.13	0.01	0.38	0.25	0.07	0.2	0.0	0.1	0.2	0.3	0.4
V 45–64		0.30	0.30	0.17	0.00	0.27	0.29	0.07	0.3	0.0	0.1	0.2	0.3	0.5
Cholecystectomy—Open (O) and Closed (C) / Laparoscopic: *Procedures /1,000 Member Years*														
O 30–64	M	0.06	0.04	0.12	0.45	0.04	0.05	0.05	0.0	0.0	0.0	0.0	0.1	0.1
O 15–44	F	0.02	0.02	0.01	0.06	0.00	0.01	0.02	0.0	0.0	0.0	0.0	0.0	0.0
O 45–64		0.06	0.07	0.06	0.00	0.08	0.00	0.07	0.1	0.0	0.0	0.1	0.1	0.1
C 30–64	M	0.44	0.49	0.37	3.35	0.55	0.51	0.31	0.4	0.1	0.2	0.3	0.4	0.5
C 15–44	F	1.01	1.21	0.67	1.37	1.25	1.03	0.54	0.8	0.5	0.6	0.8	1.0	1.2
C 45–64		0.73	1.20	0.79	2.78	1.15	0.71	0.70	0.7	0.3	0.5	0.7	0.8	1.1
Back Surgery: *Procedures /1,000 Member Years*														
20–44	M	0.50	0.49	0.18	0.23	0.44	0.51	0.10	0.3	0.1	0.2	0.3	0.5	0.6
	F	0.29	0.34	0.09	0.08	0.30	0.34	0.10	0.2	0.1	0.1	0.2	0.3	0.4
45–64	M	0.85	0.74	0.46	0.45	0.63	0.81	0.22	0.6	0.1	0.3	0.5	0.8	1.0
	F	0.84	0.62	0.45	0.00	0.74	1.01	0.38	0.6	0.1	0.3	0.5	0.7	1.0
Mastectomy: *Procedures /1,000 Member Years*														
15–44	F	0.03	0.03	0.03	0.00	0.03	0.05	0.02	0.0	0.0	0.0	0.0	0.0	0.0
45–64		0.36	0.71	0.66	0.35	0.35	0.54	0.12	0.2	0.0	0.1	0.1	0.2	0.3
Lumpectomy: *Procedures /1,000 Member Years*														
15–44	F	0.17	0.17	0.23	0.06	0.17	0.25	0.12	0.2	0.1	0.1	0.2	0.2	0.2
45–64		0.91	0.95	1.76	0.00	0.43	1.10	0.37	0.5	0.2	0.3	0.4	0.6	0.8
Ambulatory Care: Total (AMB)														
Outpatient Visits: *Visits/1,000 Member Months*														
<1	NA	786.33	879.87	726.34	969.34	737.02	726.66	588.24	727.7	509.1	671.2	761.7	820.3	882.1
1–9	NA	313.80	351.95	292.63	454.70	282.98	305.33	239.43	305.6	222.2	260.8	298.7	329.7	367.4
10–19	NA	247.70	300.32	239.94	300.88	228.73	235.29	177.09	231.4	166.5	202.1	225.7	259.6	294.1
20–44	NA	380.33	468.42	394.41	266.24	378.35	467.37	319.60	421.2	261.4	349.2	404.8	466.8	585.5
45–64	NA	659.19	809.26	671.09	287.60	650.71	825.19	541.79	589.3	418.8	493.0	588.3	672.8	745.8

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age / as Stated	Sex	Ameri group	BlueCare		TennCare *Select*	UnitedHealthcare			National Medicaid HEDIS 2011 Means and Percentiles					
			-East	-West		-East	-Middle	-West	Mean	P10	P25	P50	P75	P90
65–74	NA	460.34	351.94	338.46	244.90	782.56	789.34	543.46	531.2	159.1	333.3	517.4	659.5	798.9
75–84	NA	284.75	199.81	313.29	195.65	700.67	615.13	453.67	528.0	47.7	236.8	445.5	598.8	794.5
≥85	NA	114.89	231.16	129.53	333.33	524.21	400.58	353.82	653.0	0.0	175.1	360.8	500.0	739.7
Total	**NA**	**360.12**	**433.95**	**349.89**	**369.14**	**357.23**	**392.62**	**284.19**	**357.2**	**264.5**	**314.7**	**349.5**	**391.9**	**439.0**
ED Visits: *Visits/1,000 Member Months*														
<1	NA	91.52	121.56	118.42	104.79	122.53	94.16	106.65	91.1	61.2	81.1	92.9	105.0	120.0
1–9	NA	50.02	70.75	55.64	67.17	66.55	52.39	48.51	49.2	35.5	44.3	49.1	54.4	64.1
10–19	NA	49.23	69.49	44.15	61.83	65.97	52.27	41.11	41.4	28.2	35.2	41.2	47.0	54.4
20–44	NA	111.96	139.26	106.81	94.64	139.54	123.48	98.87	101.1	67.0	80.4	103.2	120.7	136.9
45–64	NA	89.01	115.53	101.07	54.06	104.21	103.61	87.25	78.0	42.7	62.3	82.9	96.0	107.0
65–74	NA	38.02	32.93	21.37	102.04	81.82	67.53	56.21	39.8	0.0	17.7	33.3	47.2	66.0
75–84	NA	16.87	8.28	14.36	130.43	67.40	49.49	48.24	33.2	0.0	13.4	23.0	38.5	58.8
≥85	NA	5.32	5.47	3.70	0.00	57.39	32.51	43.39	35.1	0.0	1.4	20.1	32.1	48.4
Total	**NA**	**70.50**	**95.40**	**71.84**	**66.60**	**91.68**	**77.10**	**65.33**	**62.0**	**44.4**	**55.7**	**63.3**	**70.5**	**76.6**
Inpatient Utilization—General Hospital/Acute Care: Total (IPU)														
Total Inpatient														
Discharges: *Discharges/1,000 Member Months*														
<1	NA	10.16	9.76	9.51	37.26	9.82	7.16	6.93	10.2	6.1	7.7	9.3	11.2	14.0
1–9	NA	1.20	1.64	1.48	8.67	1.40	1.11	1.31	2.1	1.2	1.4	1.8	2.2	2.7
10–19	NA	2.95	3.35	3.13	5.73	3.30	3.04	3.25	3.6	2.4	2.9	3.4	4.2	5.2
20–44	NA	14.96	14.78	15.03	38.67	14.39	15.71	14.97	21.9	11.3	13.8	18.4	25.1	35.3
45–64	NA	27.97	22.45	24.83	34.79	24.32	24.61	25.23	19.1	8.6	11.0	17.4	26.7	31.0
65–74	NA	18.40	21.49	20.09	198.98	32.05	34.17	29.07	19.1	0.0	1.5	15.4	21.8	32.2
75–84	NA	8.77	10.23	17.06	326.09	34.81	30.54	29.70	36.3	0.0	4.2	16.0	25.3	51.3
≥85	NA	5.32	13.28	8.88	2000.00	39.97	30.85	31.51	39.4	0.0	0.0	19.2	30.3	41.7
Total	**NA**	**7.54**	**7.96**	**7.48**	**9.83**	**8.53**	**7.77**	**7.81**	**8.1**	**5.6**	**6.4**	**7.9**	**9.0**	**10.7**
Days: *Days/1,000 Member Months*														
<1	NA	58.28	57.50	54.42	568.69	74.51	43.54	55.02	60.4	22.6	32.4	45.5	62.0	83.6
1–9	NA	3.86	5.24	5.12	55.35	4.64	3.69	4.66	6.6	3.4	4.3	5.5	6.7	7.8
10–19	NA	9.02	10.21	10.17	30.08	10.71	9.31	10.77	11.0	7.0	8.4	10.3	12.6	14.7

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures													
Measure by Age / as Stated	Sex	Ameri group	BlueCare		TennCare *Select*	UnitedHealthcare			National Medicaid HEDIS 2011 Means and Percentiles					
			-East	-West		-East	-Middle	-West	Mean	P10	P25	P50	P75	P90
20–44	NA	45.74	49.96	52.21	155.36	54.56	47.58	52.89	64.8	34.9	44.9	55.1	74.1	95.4
45–64	NA	145.61	128.76	155.60	249.85	142.94	120.66	163.97	98.2	32.5	45.0	92.2	131.2	161.3
65–74	NA	86.67	161.04	184.62	1204.08	196.59	173.94	189.53	95.1	0.0	0.0	74.5	118.1	194.5
75–84	NA	35.76	47.76	115.80	1804.35	204.85	130.75	174.16	231.3	0.0	17.9	86.5	143.3	433.0
≥85	NA	20.21	74.97	39.97	11000.00	207.28	144.23	251.55	284.3	0.0	0.0	97.9	162.5	300.0
Total	**NA**	**28.65**	**32.39**	**31.48**	**61.93**	**39.62**	**28.62**	**35.31**	**29.8**	**19.0**	**21.8**	**27.0**	**33.8**	**39.4**
Average Length of Stay: *Average # of Days*														
<1	NA	5.73	5.89	5.72	15.26	7.59	6.08	7.94	5.5	3.3	3.9	4.7	6.2	7.4
1–9	NA	3.21	3.20	3.45	6.38	3.31	3.32	3.57	3.0	2.3	2.6	2.9	3.4	3.9
10–19	NA	3.06	3.05	3.25	5.25	3.24	3.07	3.31	3.0	2.4	2.7	3.0	3.2	3.4
20–44	NA	3.06	3.38	3.47	4.02	3.79	3.03	3.53	3.0	2.6	2.7	3.1	3.3	3.5
45–64	NA	5.21	5.74	6.27	7.18	5.88	4.90	6.50	4.8	3.5	4.1	4.8	5.3	5.8
65–74	NA	4.71	7.49	9.19	6.05	6.13	5.09	6.52	5.4	3.0	4.1	5.1	6.3	7.1
75–84	NA	4.08	4.67	6.79	5.53	5.88	4.28	5.86	7.3	3.5	4.3	5.3	6.7	9.2
≥85	NA	3.80	5.65	4.50	5.50	5.19	4.68	7.98	9.9	3.4	4.3	5.2	6.4	10.4
Unknown	NA	NA	2.00	NA	NA	NA	NA	NA	5.1	1.8	2.0	3.0	3.7	15.0
Total	**NA**	**3.80**	**4.07**	**4.21**	**6.30**	**4.64**	**3.68**	**4.52**	**3.6**	**2.8**	**3.2**	**3.6**	**3.9**	**4.2**
Medicine														
Discharges: *Discharges/1,000 Member Months*														
<1	NA	8.59	8.69	8.38	28.33	8.08	5.81	5.06	8.3	4.7	6.2	7.8	9.1	11.3
1–9	NA	0.88	1.40	1.24	6.78	1.11	0.80	0.96	1.6	0.9	1.1	1.4	1.7	2.0
10-19	NA	0.68	0.80	0.78	3.58	0.81	0.67	0.69	1.1	0.6	0.7	0.9	1.1	1.5
20–44	NA	3.79	3.74	3.75	10.54	3.86	3.42	3.45	3.9	1.7	2.4	3.5	4.6	6.3
45–64	NA	19.34	16.66	18.54	23.20	16.04	15.70	16.56	12.6	4.5	6.2	11.7	18.0	22.2
65–74	NA	15.94	16.75	15.38	127.55	23.28	23.71	18.89	11.5	0.0	0.0	9.7	15.1	22.6
75–84	NA	6.07	7.31	16.16	217.39	27.40	23.69	20.31	28.6	0.0	2.5	10.7	18.2	27.6
≥85	NA	5.32	11.71	7.40	666.67	33.56	23.76	24.79	33.0	0.0	0.0	15.3	23.4	35.3
Total	**NA**	**3.25**	**3.59**	**3.27**	**5.97**	**3.98**	**3.00**	**3.10**	**3.3**	**1.4**	**2.2**	**3.0**	**3.7**	**4.8**

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures													
Measure by Age / as Stated	Sex	Ameri group	BlueCare		TennCare *Select*	UnitedHealthcare			National Medicaid HEDIS 2011 Means and Percentiles					
			-East	-West		-East	-Middle	-West	Mean	P10	P25	P50	P75	P90
Days: *Days/1,000 Member Months*														
<1	NA	40.63	47.68	36.52	314.12	51.09	26.61	19.57	40.9	17.3	23.0	28.4	39.5	48.8
1–9	NA	2.11	3.99	3.81	33.71	2.92	1.99	2.62	4.5	2.2	2.7	3.5	4.6	5.7
10–19	NA	1.92	2.68	2.54	18.52	2.72	2.33	2.42	3.3	1.4	1.9	2.7	3.6	5.0
20–44	NA	12.47	15.23	16.83	58.60	17.75	11.67	14.56	13.4	5.4	7.3	11.9	16.0	20.3
45–64	NA	77.12	81.60	99.05	131.90	73.89	60.84	76.44	55.5	13.5	22.0	46.7	76.7	87.5
65–74	NA	70.73	92.38	109.40	545.92	127.64	97.71	92.24	54.5	0.0	0.0	39.1	65.5	106.1
75–84	NA	24.29	35.09	113.11	1043.48	134.27	87.22	97.74	151.5	0.0	4.7	47.6	73.9	191.5
≥85	NA	20.21	65.99	34.79	1666.67	152.96	104.21	177.69	235.4	0.0	0.0	64.9	112.2	275.9
Total	**NA**	**11.89**	**15.71**	**14.88**	**34.67**	**18.17**	**10.98**	**13.09**	**12.3**	**4.4**	**6.8**	**11.0**	**13.6**	**18.2**
Average Length of Stay: *Average # of Days*														
<1	NA	4.73	5.49	4.36	11.09	6.32	4.58	3.87	4.6	3.0	3.3	3.9	4.6	5.6
1–9	NA	2.38	2.84	3.07	4.97	2.62	2.48	2.74	2.6	2.1	2.3	2.5	2.8	3.1
10–19	NA	2.84	3.36	3.25	5.17	3.35	3.46	3.53	3.0	2.3	2.5	2.9	3.3	3.7
20–44	NA	3.29	4.07	4.49	5.56	4.59	3.41	4.22	3.4	2.7	3.0	3.3	3.7	4.0
45–64	NA	3.99	4.90	5.34	5.69	4.61	3.88	4.62	4.0	2.9	3.4	3.9	4.4	4.7
65–74	NA	4.44	5.52	7.11	4.28	5.48	4.12	4.88	4.6	2.8	3.5	4.4	5.0	5.6
75–84	NA	4.00	4.80	7.00	4.80	4.90	3.68	4.81	6.1	2.4	3.4	4.1	5.3	6.3
≥85	NA	3.80	5.63	4.70	2.50	4.56	4.39	7.17	9.3	3.2	3.5	4.3	6.0	7.8
Unknown	NA	NA	2.00	NA	NA	NA	NA	NA	6.9	2.0	2.0	3.7	15.0	15.0
Total	**NA**	**3.66**	**4.38**	**4.54**	**5.81**	**4.56**	**3.66**	**4.22**	**3.6**	**2.8**	**3.2**	**3.5**	**3.8**	**4.0**
Surgery														
Discharges: *Discharges/1,000 Member Months*														
<1	NA	1.58	1.05	1.10	7.81	1.74	1.35	1.87	1.6	0.6	0.9	1.5	1.9	2.5
1–9	NA	0.32	0.21	0.21	1.72	0.29	0.31	0.35	0.4	0.2	0.3	0.4	0.5	0.6
10–19	NA	0.45	0.37	0.33	0.81	0.49	0.40	0.48	0.6	0.3	0.4	0.5	0.6	0.8
20–44	NA	1.97	1.38	1.25	5.86	2.27	2.06	1.90	2.2	1.3	1.7	2.1	2.6	3.1
45–64	NA	8.57	4.90	5.42	9.44	8.18	8.83	8.57	6.2	2.7	4.3	5.9	8.1	9.4
65–74	NA	2.45	3.63	3.85	56.12	8.77	10.46	10.18	7.5	0.0	0.0	4.7	6.9	11.7
75–84	NA	2.70	1.46	0.00	108.70	7.41	6.84	9.39	7.5	0.0	0.0	4.0	7.4	14.0
≥85	NA	0.00	1.17	1.48	1000.00	6.41	7.09	6.71	6.0	0.0	0.0	0.5	5.3	9.7
Total	**NA**	**1.42**	**1.03**	**0.91**	**1.71**	**1.86**	**1.55**	**1.58**	**1.5**	**0.7**	**0.9**	**1.3**	**1.8**	**2.2**

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures													
Measure by Age / as Stated	Sex	Ameri group	BlueCare		TennCare *Select*	UnitedHealthcare			National Medicaid HEDIS 2011 Means and Percentiles					
			-East	-West		-East	-Middle	-West	Mean	P10	P25	P50	P75	P90
Days: *Days/1,000 Member Months*														
<1	NA	17.65	9.67	16.76	234.45	23.41	16.92	35.44	16.5	4.0	7.7	13.4	21.5	29.1
1–9	NA	1.75	1.14	1.02	17.93	1.73	1.70	2.04	2.0	0.7	1.2	1.8	2.4	3.3
10–19	NA	2.69	1.76	1.74	5.85	2.76	2.02	3.15	2.5	1.2	1.6	2.1	2.7	3.4
20–44	NA	10.79	7.42	8.11	32.15	16.10	10.29	14.40	10.5	5.0	7.1	9.0	13.3	15.9
45–64	NA	68.27	37.30	45.08	90.03	68.78	59.08	87.26	41.1	14.0	21.3	38.9	56.1	72.1
65–74	NA	15.94	49.96	59.83	448.98	68.95	76.24	97.29	39.2	0.0	0.0	30.1	56.1	81.9
75–84	NA	11.47	9.75	0.00	760.87	70.57	43.52	76.42	78.5	0.0	0.0	28.2	53.8	120.0
≥85	NA	0.00	4.69	5.18	7000.00	54.32	40.02	73.86	44.5	0.0	0.0	4.3	37.9	72.1
Total	**NA**	**9.74**	**6.66**	**6.79**	**18.19**	**14.66**	**9.52**	**14.44**	**8.4**	**3.1**	**5.1**	**7.1**	**10.4**	**13.8**
Average Length of Stay: *Average # of Days*														
<1	NA	11.20	9.22	15.28	30.03	13.45	12.49	18.91	10.2	4.1	6.4	9.5	13.2	16.5
1–9	NA	5.53	5.40	4.85	10.44	5.97	5.52	5.84	4.8	2.7	3.7	4.5	5.8	7.2
10–19	NA	6.03	4.77	5.29	7.23	5.63	5.05	6.53	4.4	2.8	3.6	4.3	5.3	6.2
20–44	NA	5.46	5.39	6.50	5.48	7.10	4.98	7.56	4.6	3.1	3.9	4.6	5.4	6.0
45–64	NA	7.97	7.61	8.32	9.54	8.41	6.69	10.18	6.4	4.0	5.2	6.3	7.8	8.6
65–74	NA	6.50	13.77	15.56	8.00	7.86	7.29	9.56	7.3	3.0	5.1	7.2	9.0	10.9
75–84	NA	4.25	6.67	NA	7.00	9.53	6.36	8.14	8.6	3.3	5.2	7.2	10.0	13.6
≥85	NA	NA	4.00	3.50	7.00	8.48	5.65	11.00	8.6	3.0	5.5	7.3	10.5	13.6
Total	**NA**	**6.87**	**6.47**	**7.49**	**10.63**	**7.86**	**6.16**	**9.11**	**5.7**	**3.7**	**4.7**	**5.7**	**6.6**	**7.5**
Maternity (calculated using member months for members 10-64 years)														
Discharges: *Discharges/1,000 Member Months*														
10–19	NA	1.82	2.12	1.96	1.12	2.00	1.96	2.08	2.0	1.0	1.4	1.9	2.4	3.1
20–44	NA	9.20	9.37	9.77	20.72	8.26	10.22	9.62	15.7	6.7	7.9	10.9	18.7	27.8
45–64	NA	0.07	0.04	0.02	0.20	0.10	0.08	0.10	0.1	0.0	0.0	0.1	0.1	0.3
Total	**NA**	**4.83**	**5.04**	**5.16**	**2.94**	**4.29**	**5.47**	**5.07**	**6.1**	**3.1**	**4.1**	**5.3**	**7.6**	**10.7**
Days: *Days/1,000 Member Months*														
10–19	NA	4.40	5.38	4.99	3.10	5.23	4.96	5.20	5.3	2.6	3.8	5.2	6.5	7.7
20–44	NA	22.49	23.64	24.56	48.46	20.71	25.62	23.93	40.3	15.9	21.3	29.5	49.5	72.9
45–64	NA	0.21	0.11	0.05	0.59	0.26	0.74	0.27	0.4	0.0	0.1	0.2	0.5	1.0
Total	**NA**	**11.79**	**12.72**	**13.02**	**7.31**	**10.84**	**13.78**	**12.63**	**15.8**	**6.8**	**11.1**	**14.0**	**19.6**	**27.3**

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age / as Stated	Sex	Ameri group	BlueCare		TennCare *Select*	UnitedHealthcare			National Medicaid HEDIS 2011 Means and Percentiles					
			-East	-West		-East	-Middle	-West	Mean	P10	P25	P50	P75	P90
Average Length of Stay: *Average # of Days*														
10–19	NA	2.41	2.53	2.55	2.77	2.62	2.53	2.50	2.6	2.3	2.5	2.6	2.8	2.9
20–44	NA	2.44	2.52	2.52	2.34	2.51	2.51	2.49	2.6	2.2	2.5	2.6	2.7	2.9
45–64	NA	3.20	2.75	3.00	3.00	2.67	9.08	2.67	3.1	1.8	2.0	2.7	3.3	4.9
Unknown	NA	NA	NA	NA	NA	NA	NA	NA	2.3	1.8	1.8	2.0	3.0	3.0
Total	**NA**	**2.44**	**2.52**	**2.52**	**2.49**	**2.53**	**2.52**	**2.49**	**2.6**	**2.2**	**2.5**	**2.6**	**2.8**	**2.9**
Identification of Alcohol and Other Drug Services: Total (IAD)														
Any Services														
0–12	M	0.03%	0.08%	0.05%	0.24%	0.04%	0.05%	0.03%	0.1%	0.0%	0.0%	0.1%	0.1%	0.1%
	F	0.02%	0.04%	0.05%	0.12%	0.03%	0.03%	0.01%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%
	M&F	0.03%	0.06%	0.05%	0.19%	0.04%	0.04%	0.02%	0.1%	0.0%	0.0%	0.0%	0.1%	0.1%
13–17	M	2.59%	3.33%	1.98%	6.96%	3.08%	3.24%	1.99%	2.5%	0.9%	1.3%	2.1%	3.2%	5.2%
	F	1.39%	1.92%	0.92%	7.72%	1.89%	1.59%	0.92%	1.6%	0.6%	0.9%	1.4%	1.9%	2.5%
	M&F	1.99%	2.62%	1.44%	7.23%	2.48%	2.43%	1.45%	2.0%	0.7%	1.1%	1.7%	2.5%	3.9%
18–24	M	6.07%	4.69%	3.85%	4.57%	6.75%	7.10%	4.36%	6.2%	2.3%	3.6%	5.2%	8.1%	11.2%
	F	5.18%	6.53%	3.41%	4.14%	7.20%	6.01%	3.24%	4.6%	2.0%	3.3%	4.5%	6.0%	7.0%
	M&F	5.47%	5.96%	3.54%	4.42%	7.03%	6.36%	3.59%	5.1%	2.3%	3.3%	4.8%	6.6%	8.3%
25–34	M	10.72%	8.41%	10.46%	12.03%	11.41%	13.39%	10.18%	10.8%	4.6%	7.9%	9.6%	13.3%	19.1%
	F	8.09%	8.85%	6.11%	4.86%	9.99%	11.16%	5.52%	6.9%	4.0%	5.4%	6.5%	8.9%	10.7%
	M&F	8.66%	8.75%	6.71%	8.61%	10.34%	11.64%	6.23%	7.9%	4.4%	6.0%	7.1%	9.4%	12.8%
35–64	M	14.64%	10.51%	14.52%	10.34%	13.34%	16.24%	15.16%	12.4%	5.4%	8.1%	11.7%	15.4%	21.5%
	F	10.19%	6.84%	7.52%	2.63%	8.27%	13.61%	6.78%	7.8%	4.8%	5.6%	7.2%	8.8%	12.0%
	M&F	11.78%	8.04%	9.33%	6.03%	10.30%	14.49%	9.57%	9.5%	5.1%	6.4%	8.9%	11.1%	15.6%
≥65	M	2.54%	1.82%	1.63%	15.58%	3.98%	6.73%	7.03%	5.1%	0.0%	0.0%	0.4%	3.2%	7.1%
	F	2.42%	2.16%	1.44%	0.00%	1.39%	3.77%	1.65%	2.0%	0.0%	0.0%	0.0%	1.4%	2.7%
	M&F	2.47%	2.05%	1.50%	4.90%	2.24%	4.77%	3.29%	3.9%	0.0%	0.0%	0.5%	2.0%	4.1%
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**	**3.29%**	**2.93%**	**2.42%**	**3.17%**	**4.13%**	**3.86%**	**3.10%**	**3.4%**	**0.9%**	**1.7%**	**2.7%**	**4.1%**	**6.4%**
	F	**3.80%**	**3.94%**	**2.93%**	**2.95%**	**4.30%**	**5.17%**	**2.66%**	**3.1%**	**1.2%**	**2.0%**	**2.9%**	**4.0%**	**5.4%**
	M&F	**3.58%**	**3.51%**	**2.73%**	**3.09%**	**4.23%**	**4.61%**	**2.84%**	**3.3%**	**1.2%**	**1.9%**	**2.7%**	**4.4%**	**5.7%**

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures													
Measure by Age / as Stated	Sex	Amerigroup	BlueCare -East	BlueCare -West	TennCare *Select*	UnitedHealthcare -East	UnitedHealthcare -Middle	UnitedHealthcare -West	National Medicaid HEDIS 2011 Means and Percentiles Mean	P10	P25	P50	P75	P90
Inpatient														
0–12	M	0.00%	0.01%	0.00%	0.06%	0.01%	0.00%	0.00%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	F	0.00%	0.00%	0.01%	0.02%	0.01%	0.00%	0.00%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	M&F	0.00%	0.00%	0.01%	0.04%	0.01%	0.00%	0.00%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
13–17	M	0.43%	0.50%	0.49%	1.06%	0.51%	0.56%	0.57%	0.4%	0.1%	0.2%	0.4%	0.6%	0.8%
	F	0.38%	0.42%	0.22%	1.16%	0.48%	0.34%	0.30%	0.4%	0.1%	0.2%	0.3%	0.5%	0.7%
	M&F	0.40%	0.46%	0.35%	1.10%	0.49%	0.45%	0.43%	0.4%	0.1%	0.2%	0.4%	0.5%	0.8%
18–24	M	2.09%	1.29%	1.05%	1.28%	2.23%	1.82%	1.37%	1.3%	0.3%	0.7%	1.0%	1.8%	3.0%
	F	1.61%	2.69%	1.03%	1.46%	2.98%	1.77%	1.07%	1.5%	0.4%	0.9%	1.2%	2.0%	2.7%
	M&F	1.77%	2.26%	1.03%	1.35%	2.71%	1.79%	1.16%	1.5%	0.5%	0.9%	1.2%	1.9%	2.6%
25–34	M	3.11%	2.28%	3.14%	6.96%	3.75%	3.54%	3.21%	2.7%	0.7%	1.3%	2.3%	3.7%	4.9%
	F	2.40%	3.29%	1.46%	0.69%	3.72%	2.62%	1.77%	2.0%	0.7%	1.3%	1.8%	2.6%	3.2%
	M&F	2.55%	3.06%	1.69%	3.97%	3.72%	2.81%	1.99%	2.2%	0.9%	1.4%	2.0%	3.0%	3.7%
35–64	M	5.59%	4.58%	6.24%	7.67%	5.11%	5.19%	6.53%	4.1%	1.0%	1.8%	3.8%	5.9%	7.8%
	F	2.42%	2.38%	2.02%	1.58%	2.57%	2.73%	2.20%	2.3%	0.9%	1.3%	2.0%	2.9%	4.1%
	M&F	3.55%	3.10%	3.11%	4.27%	3.59%	3.56%	3.64%	3.0%	1.0%	1.4%	2.7%	4.0%	5.3%
≥65	M	1.27%	0.91%	1.63%	15.58%	2.30%	2.94%	4.92%	0.8%	0.0%	0.0%	0.0%	1.3%	2.6%
	F	0.81%	1.30%	1.08%	0.00%	0.36%	0.53%	0.41%	0.5%	0.0%	0.0%	0.0%	0.3%	1.0%
	M&F	0.99%	1.17%	1.25%	4.90%	1.00%	1.34%	1.79%	0.6%	0.0%	0.0%	0.0%	0.7%	1.7%
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**1.09%**	**0.95%**	**0.86%**	**0.69%**	**1.42%**	**1.08%**	**1.19%**	**0.9%**	**0.1%**	**0.4%**	**0.7%**	**1.4%**	**2.0%**
	F	**1.04%**	**1.43%**	**0.77%**	**0.60%**	**1.51%**	**1.17%**	**0.86%**	**0.9%**	**0.3%**	**0.5%**	**0.8%**	**1.2%**	**1.6%**
	M&F	**1.06%**	**1.23%**	**0.81%**	**0.66%**	**1.47%**	**1.13%**	**1.00%**	**0.9%**	**0.3%**	**0.5%**	**0.8%**	**1.3%**	**1.7%**
Intensive Outpatient / Partial Hospitalization														
0–12	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%	0.01%	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%	0.01%	0.01%	0.00%	0.00%	0.00%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
13–17	M	1.08%	1.36%	0.51%	1.83%	1.06%	1.10%	0.43%	0.3%	0.0%	0.0%	0.0%	0.3%	0.8%
	F	0.34%	0.59%	0.13%	2.79%	0.49%	0.41%	0.10%	0.1%	0.0%	0.0%	0.0%	0.2%	0.3%
	M&F	0.71%	0.98%	0.32%	2.18%	0.77%	0.76%	0.26%	0.2%	0.0%	0.0%	0.0%	0.3%	0.6%
18–24	M	0.98%	0.89%	0.40%	0.51%	1.21%	1.44%	0.44%	0.4%	0.0%	0.0%	0.1%	0.7%	1.2%
	F	0.75%	1.47%	0.34%	0.61%	1.39%	1.24%	0.29%	0.3%	0.0%	0.0%	0.1%	0.5%	1.0%
	M&F	0.82%	1.29%	0.36%	0.55%	1.33%	1.31%	0.34%	0.3%	0.0%	0.0%	0.1%	0.6%	1.0%

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures													
Measure by Age / as Stated	Sex	Ameri group	BlueCare		TennCare *Select*	UnitedHealthcare			National Medicaid HEDIS 2011 Means and Percentiles					
			-East	-West		-East	-Middle	-West	Mean	P10	P25	P50	P75	P90
25–34	M	1.35%	1.25%	0.90%	1.27%	1.54%	2.19%	1.11%	0.7%	0.0%	0.0%	0.2%	1.1%	2.2%
	F	0.98%	1.64%	0.72%	0.00%	1.81%	1.73%	0.68%	0.5%	0.0%	0.0%	0.2%	0.9%	1.3%
	M&F	1.06%	1.55%	0.74%	0.66%	1.75%	1.83%	0.75%	0.5%	0.0%	0.0%	0.2%	0.9%	1.6%
35–64	M	0.77%	0.59%	0.74%	0.33%	0.68%	1.26%	0.84%	0.7%	0.0%	0.0%	0.2%	1.0%	1.9%
	F	0.55%	0.54%	0.48%	0.26%	0.63%	1.03%	0.49%	0.5%	0.0%	0.0%	0.2%	0.7%	1.2%
	M&F	0.63%	0.55%	0.55%	0.29%	0.65%	1.11%	0.61%	0.6%	0.0%	0.0%	0.2%	0.8%	1.5%
≥65	M	0.00%	0.00%	0.00%	0.00%	0.10%	0.00%	0.00%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%
	F	0.00%	0.00%	0.00%	0.00%	0.00%	0.09%	0.00%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	M&F	0.00%	0.00%	0.00%	0.00%	0.03%	0.06%	0.00%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
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**	**0.42%**	**0.45%**	**0.23%**	**0.65%**	**0.48%**	**0.56%**	**0.26%**	**0.2%**	**0.0%**	**0.0%**	**0.1%**	**0.3%**	**0.6%**
	F	**0.39%**	**0.64%**	**0.27%**	**0.87%**	**0.63%**	**0.67%**	**0.25%**	**0.2%**	**0.0%**	**0.0%**	**0.1%**	**0.4%**	**0.7%**
	M&F	**0.40%**	**0.56%**	**0.25%**	**0.74%**	**0.56%**	**0.62%**	**0.25%**	**0.2%**	**0.0%**	**0.0%**	**0.1%**	**0.3%**	**0.6%**
Outpatient / ED														
0–12	M	0.03%	0.07%	0.04%	0.18%	0.04%	0.05%	0.03%	0.1%	0.0%	0.0%	0.0%	0.1%	0.1%
	F	0.01%	0.04%	0.04%	0.12%	0.03%	0.03%	0.01%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	M&F	0.02%	0.05%	0.04%	0.16%	0.03%	0.04%	0.02%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%
13–17	M	1.79%	2.40%	1.41%	5.05%	2.52%	2.42%	1.30%	2.4%	0.8%	1.2%	1.9%	3.1%	5.3%
	F	0.97%	1.46%	0.69%	6.34%	1.62%	1.20%	0.63%	1.6%	0.4%	0.7%	1.1%	1.7%	2.8%
	M&F	1.38%	1.93%	1.05%	5.52%	2.07%	1.82%	0.96%	2.0%	0.6%	0.9%	1.5%	2.5%	3.9%
18–24	M	4.52%	3.52%	2.85%	3.33%	5.02%	5.53%	3.25%	6.4%	2.1%	3.3%	4.8%	8.2%	11.1%
	F	3.97%	4.13%	2.50%	2.84%	5.02%	4.83%	2.31%	4.5%	1.7%	2.7%	3.9%	5.2%	6.4%
	M&F	4.15%	3.94%	2.60%	3.15%	5.02%	5.06%	2.61%	5.1%	1.8%	2.9%	4.2%	6.3%	7.8%
25–34	M	8.82%	6.46%	7.79%	5.06%	9.27%	11.45%	7.84%	10.1%	3.6%	6.7%	8.8%	12.2%	17.7%
	F	6.55%	6.34%	4.72%	4.86%	7.87%	9.64%	4.14%	6.2%	2.6%	4.5%	5.7%	8.0%	10.2%
	M&F	7.05%	6.37%	5.14%	4.97%	8.21%	10.03%	4.70%	7.2%	3.2%	5.1%	6.2%	8.6%	12.0%
35–64	M	11.58%	7.46%	10.24%	4.67%	10.40%	13.63%	11.43%	11.1%	4.9%	7.0%	9.5%	12.9%	20.5%
	F	8.91%	5.11%	5.98%	1.84%	6.79%	12.21%	5.50%	7.0%	4.0%	4.9%	5.9%	8.3%	11.4%
	M&F	9.86%	5.87%	7.09%	3.09%	8.23%	12.68%	7.48%	8.5%	4.5%	5.6%	7.1%	9.8%	14.6%
≥65	M	1.27%	0.91%	0.82%	0.00%	2.30%	5.35%	3.05%	4.6%	0.0%	0.0%	0.0%	1.7%	5.0%
	F	1.61%	0.86%	0.36%	0.00%	1.03%	3.33%	1.44%	6.9%	0.0%	0.0%	0.0%	0.7%	1.9%
	M&F	1.48%	0.88%	0.50%	0.00%	1.45%	4.01%	1.93%	8.5%	0.0%	0.0%	0.2%	1.7%	3.0%

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures													
Measure by Age / as Stated	**Sex**	**Amerigroup**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2011 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**	**2.56%**	**2.14%**	**1.75%**	**2.25%**	**3.23%**	**3.17%**	**2.30%**	**3.7%**	**0.6%**	**1.5%**	**2.3%**	**4.2%**	**6.6%**
	F	**3.13%**	**2.80%**	**2.27%**	**2.35%**	**3.37%**	**4.48%**	**2.04%**	**3.1%**	**1.0%**	**1.6%**	**2.5%**	**3.6%**	**5.0%**
	M&F	**2.88%**	**2.52%**	**2.06%**	**2.29%**	**3.31%**	**3.92%**	**2.15%**	**3.3%**	**0.9%**	**1.5%**	**2.5%**	**3.9%**	**5.4%**
Mental Health Utilization: Total (MPT)														
Any Services														
0–12	M	6.00%	7.83%	4.97%	22.50%	8.55%	7.66%	5.21%	7.3%	2.6%	4.2%	7.3%	9.2%	11.4%
	F	3.93%	5.03%	3.09%	19.08%	5.54%	4.79%	2.83%	4.7%	1.7%	2.5%	4.5%	6.0%	7.5%
	M&F	4.98%	6.46%	4.04%	21.16%	7.07%	6.25%	4.03%	6.1%	2.2%	3.4%	5.9%	7.7%	10.6%
13–17	M	10.79%	13.82%	8.39%	39.09%	15.09%	14.16%	8.94%	12.4%	4.5%	6.6%	12.3%	16.4%	20.2%
	F	10.77%	13.39%	8.13%	43.47%	14.52%	13.42%	7.28%	12.8%	5.0%	7.0%	12.8%	17.0%	20.9%
	M&F	10.78%	13.61%	8.25%	40.68%	14.80%	13.80%	8.10%	12.6%	4.5%	6.7%	12.4%	16.4%	20.1%
18–64	M	11.09%	10.15%	10.03%	17.13%	16.40%	14.55%	13.98%	12.1%	3.9%	8.5%	11.8%	16.2%	20.9%
	F	13.23%	13.76%	10.26%	18.85%	19.78%	18.15%	10.81%	15.0%	5.8%	9.8%	15.9%	18.9%	25.6%
	M&F	12.58%	12.70%	10.21%	17.79%	18.60%	17.09%	11.69%	14.1%	5.7%	9.5%	14.4%	17.9%	24.5%
≥65	M	10.16%	30.91%	19.57%	0.00%	7.64%	8.29%	4.22%	8.6%	0.0%	0.0%	0.8%	6.1%	12.4%
	F	13.70%	34.13%	23.40%	7.14%	11.01%	9.83%	5.35%	10.1%	0.0%	0.0%	1.7%	7.6%	13.5%
	M&F	12.33%	33.09%	22.23%	4.90%	9.90%	9.31%	5.01%	12.6%	0.0%	0.0%	1.5%	6.6%	14.0%
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**	**8.06%**	**9.48%**	**6.70%**	**26.47%**	**12.05%**	**10.41%**	**8.15%**	**9.4%**	**3.5%**	**5.9%**	**9.1%**	**11.7%**	**15.5%**
	F	**8.99%**	**10.43%**	**7.20%**	**25.77%**	**13.46%**	**11.98%**	**7.24%**	**10.2%**	**4.0%**	**6.2%**	**10.4%**	**12.6%**	**19.1%**
	M&F	**8.59%**	**10.03%**	**7.00%**	**26.21%**	**12.84%**	**11.31%**	**7.61%**	**9.9%**	**3.7%**	**6.1%**	**10.1%**	**12.2%**	**17.7%**
Inpatient														
0–12	M	0.10%	0.08%	0.07%	1.10%	0.09%	0.10%	0.07%	0.2%	0.0%	0.1%	0.1%	0.3%	0.4%
	F	0.05%	0.05%	0.05%	0.60%	0.05%	0.07%	0.04%	0.1%	0.0%	0.0%	0.1%	0.2%	0.2%
	M&F	0.08%	0.07%	0.06%	0.90%	0.07%	0.08%	0.05%	0.2%	0.0%	0.1%	0.1%	0.2%	0.4%
13–17	M	0.78%	0.92%	0.84%	3.69%	1.02%	1.20%	1.10%	1.0%	0.0%	0.4%	1.0%	1.4%	1.9%
	F	1.07%	0.78%	0.75%	4.62%	0.98%	1.25%	0.80%	1.3%	0.0%	0.9%	1.3%	1.7%	2.4%
	M&F	0.93%	0.85%	0.80%	4.03%	1.00%	1.23%	0.95%	1.2%	0.0%	0.8%	1.1%	1.6%	2.0%

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures													
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2011 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
18–64	M	2.21%	1.74%	2.28%	2.91%	2.12%	2.08%	2.95%	1.7%	0.1%	0.6%	1.2%	2.7%	3.5%
	F	1.52%	1.58%	1.22%	3.13%	1.79%	1.53%	1.45%	1.3%	0.1%	0.7%	1.3%	1.8%	2.5%
	M&F	1.73%	1.63%	1.46%	2.99%	1.91%	1.69%	1.87%	1.4%	0.1%	0.7%	1.4%	2.0%	2.8%
≥65	M	5.08%	29.09%	17.93%	0.00%	2.09%	1.90%	1.64%	1.0%	0.0%	0.0%	0.0%	0.5%	2.0%
	F	8.87%	31.97%	19.80%	7.14%	2.26%	2.90%	1.75%	1.4%	0.0%	0.0%	0.0%	0.9%	4.8%
	M&F	7.40%	31.04%	19.23%	4.90%	2.21%	2.56%	1.72%	1.2%	0.0%	0.0%	0.0%	0.8%	2.2%
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**	**0.77%**	**0.76%**	**0.73%**	**2.21%**	**0.92%**	**0.79%**	**1.02%**	**0.7%**	**0.1%**	**0.4%**	**0.7%**	**1.0%**	**1.4%**
	F	**0.86%**	**1.02%**	**0.75%**	**2.19%**	**1.03%**	**0.90%**	**0.83%**	**0.8%**	**0.1%**	**0.4%**	**0.8%**	**1.0%**	**1.3%**
	M&F	**0.82%**	**0.92%**	**0.74%**	**2.20%**	**0.98%**	**0.85%**	**0.91%**	**0.8%**	**0.1%**	**0.4%**	**0.7%**	**1.0%**	**1.3%**
Intensive Outpatient / Partial Hospitalization														
0–12	M	0.00%	0.04%	0.04%	0.17%	0.10%	0.07%	0.09%	0.4%	0.0%	0.0%	0.0%	0.3%	1.0%
	F	0.00%	0.03%	0.04%	0.15%	0.04%	0.04%	0.04%	0.2%	0.0%	0.0%	0.0%	0.1%	0.7%
	M&F	0.00%	0.04%	0.04%	0.16%	0.07%	0.05%	0.06%	0.3%	0.0%	0.0%	0.0%	0.2%	0.8%
13–17	M	0.07%	0.34%	0.21%	0.80%	0.43%	0.20%	0.27%	0.8%	0.0%	0.0%	0.2%	0.7%	2.1%
	F	0.00%	0.22%	0.21%	1.20%	0.48%	0.19%	0.30%	0.8%	0.0%	0.0%	0.1%	0.7%	2.3%
	M&F	0.03%	0.28%	0.21%	0.95%	0.46%	0.19%	0.29%	0.8%	0.0%	0.0%	0.2%	0.7%	2.1%
18–64	M	0.04%	0.07%	0.05%	0.12%	0.15%	0.22%	0.25%	0.7%	0.0%	0.0%	0.1%	0.7%	2.3%
	F	0.05%	0.15%	0.13%	0.22%	0.24%	0.37%	0.22%	0.7%	0.0%	0.0%	0.2%	0.6%	2.7%
	M&F	0.05%	0.12%	0.11%	0.16%	0.21%	0.33%	0.23%	0.7%	0.0%	0.0%	0.2%	0.6%	2.7%
≥65	M	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.6%	0.0%	0.0%	0.0%	0.0%	0.0%
	F	0.00%	0.00%	0.00%	0.00%	0.10%	0.00%	0.00%	1.1%	0.0%	0.0%	0.0%	0.0%	0.2%
	M&F	0.00%	0.00%	0.00%	0.00%	0.07%	0.00%	0.00%	1.3%	0.0%	0.0%	0.0%	0.0%	0.1%
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**0.02%**	**0.10%**	**0.07%**	**0.35%**	**0.16%**	**0.13%**	**0.16%**	**0.6%**	**0.0%**	**0.0%**	**0.1%**	**0.4%**	**1.6%**
	F	**0.02%**	**0.11%**	**0.10%**	**0.45%**	**0.18%**	**0.21%**	**0.16%**	**0.5%**	**0.0%**	**0.0%**	**0.1%**	**0.4%**	**1.6%**
	M&F	**0.02%**	**0.10%**	**0.09%**	**0.39%**	**0.17%**	**0.17%**	**0.16%**	**0.5%**	**0.0%**	**0.0%**	**0.1%**	**0.4%**	**1.6%**
Outpatient / ED														
0–12	M	5.98%	7.80%	4.96%	22.24%	8.54%	7.65%	5.20%	7.2%	2.5%	4.2%	7.3%	8.9%	12.2%
	F	3.92%	5.02%	3.07%	18.93%	5.53%	4.78%	2.83%	4.5%	1.7%	2.5%	4.5%	5.9%	7.5%
	M&F	4.97%	6.44%	4.02%	20.95%	7.06%	6.24%	4.02%	5.9%	2.1%	3.4%	5.9%	7.4%	10.4%

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2011 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
13–17	M	10.60%	13.56%	8.05%	38.05%	14.87%	13.92%	8.56%	11.8%	3.7%	6.1%	11.7%	15.4%	19.2%
	F	10.55%	13.20%	7.82%	41.94%	14.38%	13.31%	7.06%	12.1%	4.1%	6.4%	11.6%	16.0%	20.8%
	M&F	10.58%	13.38%	7.93%	39.46%	14.62%	13.62%	7.80%	12.0%	4.2%	6.5%	11.9%	15.7%	19.4%
18–64	M	10.15%	9.12%	8.86%	16.08%	15.71%	14.05%	13.40%	11.2%	3.2%	6.8%	10.9%	14.9%	20.2%
	F	12.72%	12.91%	9.66%	17.80%	19.34%	17.79%	10.53%	14.3%	4.8%	8.7%	14.9%	17.9%	24.7%
	M&F	11.94%	11.80%	9.47%	16.75%	18.08%	16.70%	11.33%	13.3%	4.1%	8.0%	13.8%	17.4%	23.6%
≥65	M	5.08%	2.73%	1.63%	0.00%	5.86%	6.39%	3.05%	7.5%	0.0%	0.0%	0.6%	3.8%	10.2%
	F	5.24%	2.16%	3.60%	0.00%	9.42%	7.20%	4.01%	8.6%	0.0%	0.0%	0.6%	5.1%	8.4%
	M&F	5.18%	2.34%	3.00%	0.00%	8.24%	6.92%	3.72%	11.3%	0.0%	0.0%	1.0%	4.8%	8.9%
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**	**7.77%**	**9.05%**	**6.34%**	**25.84%**	**11.77%**	**10.22%**	**7.92%**	**9.0%**	**3.0%**	**5.4%**	**8.9%**	**11.2%**	**15.4%**
	F	**8.71%**	**9.86%**	**6.81%**	**25.06%**	**13.20%**	**11.77%**	**7.06%**	**9.8%**	**3.2%**	**5.9%**	**9.5%**	**12.2%**	**18.8%**
	M&F	**8.30%**	**9.52%**	**6.62%**	**25.54%**	**12.57%**	**11.11%**	**7.42%**	**9.4%**	**2.8%**	**5.6%**	**9.7%**	**11.5%**	**17.2%**
Antibiotic Utilization: Total (ABX)														
Antibiotic Utilization														
Average Scripts PMPY for Antibiotics:														
0–9	M	1.38	1.70	1.32	1.82	1.51	1.42	1.10						
	F	1.41	1.78	1.33	2.06	1.55	1.49	1.10						
	M&F	1.39	1.74	1.32	1.92	1.53	1.46	1.10						
10–17	M	0.82	1.08	0.71	1.02	0.95	0.85	0.59						
	F	1.09	1.45	1.05	1.56	1.26	1.18	0.85						
	M&F	0.96	1.26	0.88	1.21	1.11	1.01	0.72						
18–34	M	0.88	1.04	0.89	0.98	0.92	0.94	0.78						
	F	1.96	2.12	2.12	1.84	1.94	2.05	1.81						
	M&F	1.67	1.83	1.85	1.30	1.63	1.75	1.56						
35–49	M	1.12	1.23	1.20	0.77	1.10	1.28	1.12						
	F	1.77	1.95	1.96	0.81	1.78	1.93	1.70						
	M&F	1.57	1.73	1.80	0.79	1.54	1.73	1.55						
50–64	M	1.20	1.24	1.27	0.71	1.15	1.45	1.14						
	F	1.72	1.88	1.84	0.58	1.77	2.00	1.57						
	M&F	1.49	1.64	1.63	0.64	1.48	1.78	1.37						

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2011 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
65–74	M	0.99	0.72	0.80	0.00	1.87	1.75	1.17						
	F	1.48	1.40	0.99	0.91	2.34	2.40	1.59						
	M&F	1.26	1.14	0.93	0.67	2.17	2.15	1.44						
75–84	M	1.17	0.37	0.71	0.00	1.39	1.63	1.61						
	F	1.55	0.71	0.68	0.00	2.19	2.02	1.45						
	M&F	1.41	0.59	0.69	0.00	1.97	1.89	1.49						
≥85	M	1.23	0.35	0.35	NA	1.57	2.08	0.46						
	F	1.10	0.44	0.09	0.00	2.06	1.85	0.92						
	M&F	1.14	0.42	0.17	0.00	1.96	1.89	0.86						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**1.14**	**1.37**	**1.08**	**1.30**	**1.22**	**1.20**	**0.92**	**0.9**	**0.7**	**0.8**	**0.9**	**1.0**	**1.2**
	F	**1.57**	**1.85**	**1.63**	**1.79**	**1.66**	**1.69**	**1.38**	**1.3**	**1.0**	**1.1**	**1.3**	**1.4**	**1.6**
	M&F	**1.38**	**1.65**	**1.41**	**1.49**	**1.47**	**1.48**	**1.19**	**1.1**	**0.9**	**1.0**	**1.1**	**1.3**	**1.4**
Average Days Supplied per Antibiotic Script														
0–9	M	9.09	9.06	9.27	10.32	8.99	9.16	9.27						
	F	9.26	9.35	9.39	11.01	9.19	9.32	9.38						
	M&F	9.17	9.20	9.33	10.62	9.09	9.24	9.32						
10–17	M	9.35	9.96	9.72	11.17	10.04	9.41	9.46						
	F	8.85	9.26	9.06	10.12	9.37	9.04	8.95						
	M&F	9.07	9.56	9.32	10.69	9.65	9.20	9.16						
18–34	M	9.40	9.44	9.64	11.36	9.53	9.28	9.42						
	F	8.19	8.37	7.98	9.39	8.39	8.28	7.93						
	M&F	8.37	8.53	8.16	10.33	8.59	8.42	8.11						
35–49	M	10.28	9.74	10.62	11.83	9.82	10.11	10.39						
	F	8.82	8.80	8.87	11.68	8.88	8.81	8.86						
	M&F	9.14	9.00	9.11	11.74	9.12	9.10	9.15						
50–64	M	10.59	9.86	10.89	10.57	10.04	10.06	10.28						
	F	9.09	9.09	9.21	12.34	9.16	9.24	9.01						
	M&F	9.64	9.30	9.68	11.46	9.48	9.51	9.49						

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age / as Stated	**Sex**	**Amerigroup**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2011 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
65–74	M	11.93	9.04	10.32	NA	9.34	9.01	9.21						
	F	9.81	9.93	10.79	7.00	9.46	9.33	8.89						
	M&F	10.56	9.71	10.66	7.00	9.42	9.23	8.98						
75–84	M	10.04	7.45	8.81	NA	8.52	10.03	9.99						
	F	9.90	9.66	6.74	NA	10.74	10.67	9.29						
	M&F	9.94	9.18	7.42	NA	10.30	10.49	9.48						
≥85	M	9.32	6.25	12.42	NA	9.20	8.83	5.44						
	F	10.55	6.41	8.29	NA	9.11	9.55	8.08						
	M&F	10.20	6.38	10.89	NA	9.12	9.41	7.91						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**9.33**	**9.38**	**9.54**	**10.76**	**9.40**	**9.34**	**9.48**	**9.8**	**9.3**	**9.4**	**9.7**	**10.0**	**10.3**
	F	**8.74**	**8.90**	**8.67**	**10.42**	**8.93**	**8.84**	**8.62**	**9.0**	**8.6**	**8.8**	**9.0**	**9.2**	**9.5**
	M&F	**8.95**	**9.06**	**8.94**	**10.61**	**9.10**	**9.01**	**8.90**	**9.3**	**8.8**	**9.1**	**9.2**	**9.5**	**9.8**
Average Scripts PMPY for Antibiotics of Concern:														
0–9	M	0.71	0.90	0.66	0.93	0.81	0.72	0.52						
	F	0.67	0.88	0.63	0.98	0.77	0.72	0.48						
	M&F	0.69	0.89	0.64	0.95	0.79	0.72	0.50						
10–17	M	0.41	0.54	0.35	0.46	0.47	0.44	0.28						
	F	0.50	0.68	0.47	0.67	0.58	0.54	0.36						
	M&F	0.46	0.61	0.41	0.53	0.52	0.49	0.32						
18–34	M	0.38	0.44	0.39	0.40	0.38	0.42	0.33						
	F	0.77	0.85	0.82	0.72	0.79	0.82	0.67						
	M&F	0.67	0.74	0.73	0.52	0.67	0.71	0.59						
35–49	M	0.52	0.57	0.54	0.30	0.52	0.62	0.53						
	F	0.83	0.95	0.92	0.32	0.85	0.94	0.75						
	M&F	0.73	0.84	0.84	0.31	0.74	0.84	0.69						
50–64	M	0.60	0.64	0.62	0.32	0.59	0.71	0.56						
	F	0.88	1.00	0.95	0.25	0.95	1.05	0.79						
	M&F	0.76	0.87	0.83	0.28	0.78	0.92	0.69						
65–74	M	0.37	0.41	0.46	0.00	1.02	0.97	0.62						
	F	0.82	0.66	0.54	0.74	1.30	1.34	0.83						
	M&F	0.62	0.56	0.51	0.55	1.20	1.20	0.76						

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures													
Measure by Age / as Stated	**Sex**	**Amerigroup**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2011 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
75–84	M	0.62	0.24	0.34	0.00	0.83	0.87	0.88						
	F	0.73	0.26	0.27	0.00	1.12	0.98	0.77						
	M&F	0.69	0.25	0.29	0.00	1.04	0.95	0.80						
≥85	M	0.49	0.20	0.21	NA	0.88	1.20	0.26						
	F	0.53	0.22	0.05	0.00	1.18	1.00	0.61						
	M&F	0.52	0.22	0.10	0.00	1.11	1.03	0.56						
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**	**0.57**	**0.69**	**0.53**	**0.62**	**0.62**	**0.60**	**0.43**	**0.4**	**0.2**	**0.3**	**0.4**	**0.5**	**0.6**
	F	**0.70**	**0.85**	**0.71**	**0.80**	**0.77**	**0.77**	**0.57**	**0.5**	**0.3**	**0.4**	**0.5**	**0.6**	**0.7**
	M&F	**0.64**	**0.78**	**0.64**	**0.69**	**0.71**	**0.70**	**0.51**	**0.5**	**0.3**	**0.4**	**0.5**	**0.5**	**0.6**
Percentage of Antibiotics of Concern of All Antibiotic Scripts														
0–9	M	51.50%	52.98%	49.76%	51.05%	53.71%	50.68%	47.20%						
	F	47.94%	49.33%	46.98%	47.87%	50.04%	47.94%	43.30%						
	M&F	49.73%	51.15%	48.37%	49.67%	51.89%	49.30%	45.27%						
10–17	M	49.89%	50.20%	49.16%	45.02%	49.03%	51.17%	46.87%						
	F	45.81%	47.14%	45.18%	43.02%	46.00%	45.91%	41.84%						
	M&F	47.56%	48.46%	46.77%	44.10%	47.30%	48.16%	43.87%						
18–34	M	43.19%	42.16%	43.66%	40.80%	40.92%	44.48%	42.11%						
	F	39.36%	40.06%	38.83%	38.98%	40.95%	40.23%	37.24%						
	M&F	39.91%	40.38%	39.34%	39.85%	40.95%	40.84%	37.83%						
35–49	M	46.44%	46.49%	45.39%	39.53%	47.63%	48.59%	46.82%						
	F	46.70%	48.82%	46.81%	39.20%	47.83%	48.75%	43.95%						
	M&F	46.64%	48.32%	46.62%	39.34%	47.78%	48.72%	44.50%						
50–64	M	49.80%	51.31%	48.78%	44.68%	51.22%	48.84%	49.63%						
	F	51.37%	53.12%	51.64%	42.11%	53.95%	52.70%	50.68%						
	M&F	50.80%	52.61%	50.84%	43.39%	52.95%	51.45%	50.28%						
65–74	M	37.36%	56.63%	57.45%	NA	54.34%	55.49%	53.26%						
	F	55.42%	47.08%	54.07%	81.82%	55.68%	55.72%	52.16%						
	M&F	49.03%	49.41%	54.95%	81.82%	55.25%	55.65%	52.48%						
75–84	M	52.83%	63.64%	47.62%	NA	59.28%	53.31%	54.33%						
	F	47.11%	36.71%	39.53%	NA	51.29%	48.71%	53.17%						
	M&F	48.85%	42.57%	42.19%	NA	52.87%	49.94%	53.47%						

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2011 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
≥85	M	40.00%	56.25%	58.33%	NA	55.86%	57.75%	55.56%						
	F	48.44%	50.00%	57.14%	NA	57.03%	53.92%	66.15%						
	M&F	46.07%	51.11%	57.89%	NA	56.83%	54.64%	65.47%						
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**	**49.79%**	**50.59%**	**48.69%**	**47.52%**	**50.63%**	**49.84%**	**46.73%**	**42.9%**	**34.6%**	**40.0%**	**43.9%**	**46.9%**	**50.3%**
	F	**44.45%**	**45.95%**	**43.56%**	**44.56%**	**46.60%**	**45.37%**	**41.24%**	**40.4%**	**32.9%**	**38.4%**	**40.9%**	**43.6%**	**47.5%**
	M&F	**46.34%**	**47.57%**	**45.13%**	**46.16%**	**48.06%**	**46.91%**	**42.98%**	**41.0%**	**33.8%**	**38.7%**	**42.0%**	**44.4%**	**47.3%**
Antibiotics of Concern Utilization														
Average Scripts PMPY for Quinolones:														
0–9	M	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
10–17	M	0.01	0.01	0.01	0.02	0.01	0.01	0.01						
	F	0.02	0.03	0.02	0.05	0.03	0.03	0.02						
	M&F	0.02	0.02	0.01	0.03	0.02	0.02	0.01						
18–34	M	0.06	0.07	0.07	0.06	0.07	0.07	0.05						
	F	0.17	0.18	0.19	0.17	0.18	0.18	0.16						
	M&F	0.14	0.15	0.17	0.10	0.14	0.15	0.13						
35–49	M	0.13	0.14	0.14	0.10	0.13	0.16	0.13						
	F	0.21	0.25	0.26	0.12	0.22	0.25	0.21						
	M&F	0.19	0.21	0.23	0.11	0.19	0.22	0.19						
50–64	M	0.22	0.19	0.24	0.16	0.19	0.25	0.20						
	F	0.31	0.30	0.32	0.10	0.28	0.34	0.27						
	M&F	0.27	0.26	0.29	0.13	0.24	0.30	0.24						
65–74	M	0.18	0.08	0.20	0.00	0.38	0.35	0.31						
	F	0.38	0.25	0.24	0.58	0.48	0.58	0.33						
	M&F	0.29	0.18	0.23	0.43	0.44	0.49	0.32						
75–84	M	0.18	0.12	0.20	0.00	0.35	0.24	0.36						
	F	0.29	0.11	0.14	0.00	0.47	0.46	0.33						
	M&F	0.25	0.11	0.16	0.00	0.43	0.39	0.34						
≥85	M	0.30	0.07	0.09	NA	0.31	0.64	0.00						
	F	0.24	0.07	0.04	0.00	0.51	0.45	0.35						
	M&F	0.26	0.07	0.05	0.00	0.47	0.48	0.31						

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2011 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**	**0.03**	**0.04**	**0.03**	**0.02**	**0.05**	**0.04**	**0.03**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	F	**0.09**	**0.11**	**0.11**	**0.06**	**0.11**	**0.11**	**0.10**	**0.1**	**0.0**	**0.1**	**0.1**	**0.1**	**0.1**
	M&F	**0.07**	**0.08**	**0.08**	**0.04**	**0.08**	**0.08**	**0.07**	**0.1**	**0.0**	**0.0**	**0.1**	**0.1**	**0.1**
Average Scripts PMPY for Cephalosporins 2nd-4th Generation:														
0–9	M	0.26	0.29	0.22	0.32	0.25	0.26	0.15						
	F	0.25	0.30	0.21	0.34	0.25	0.28	0.15						
	M&F	0.25	0.30	0.22	0.33	0.25	0.27	0.15						
10–17	M	0.08	0.10	0.07	0.08	0.08	0.09	0.04						
	F	0.10	0.13	0.08	0.12	0.11	0.11	0.05						
	M&F	0.09	0.12	0.08	0.10	0.10	0.10	0.05						
18–34	M	0.03	0.03	0.03	0.04	0.03	0.03	0.02						
	F	0.06	0.06	0.05	0.07	0.06	0.07	0.04						
	M&F	0.05	0.05	0.04	0.05	0.05	0.06	0.03						
35–49	M	0.03	0.04	0.04	0.01	0.04	0.05	0.03						
	F	0.07	0.07	0.06	0.01	0.06	0.07	0.04						
	M&F	0.06	0.06	0.05	0.01	0.05	0.07	0.04						
50–64	M	0.04	0.05	0.04	0.01	0.05	0.05	0.03						
	F	0.08	0.09	0.06	0.02	0.09	0.09	0.04						
	M&F	0.06	0.07	0.05	0.01	0.07	0.07	0.04						
65–74	M	0.04	0.05	0.03	0.00	0.12	0.10	0.03						
	F	0.06	0.13	0.02	0.00	0.12	0.12	0.05						
	M&F	0.05	0.10	0.03	0.00	0.12	0.11	0.04						
75–84	M	0.09	0.05	0.07	0.00	0.10	0.17	0.13						
	F	0.09	0.09	0.02	0.00	0.15	0.10	0.11						
	M&F	0.09	0.08	0.03	0.00	0.14	0.12	0.11						
≥85	M	0.00	0.07	0.00	NA	0.18	0.06	0.05						
	F	0.14	0.08	0.00	0.00	0.24	0.19	0.06						
	M&F	0.10	0.08	0.00	0.00	0.22	0.17	0.06						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures													
Measure by Age / as Stated	Sex	Ameri group	BlueCare		TennCare *Select*	UnitedHealthcare			National Medicaid HEDIS 2011 Means and Percentiles				
			-East	-West		-East	-Middle	-West	Mean	P10	P25	P50	P75	P90
Total	**M**	**0.15**	**0.17**	**0.13**	**0.16**	**0.14**	**0.16**	**0.09**	**0.1**	**0.0**	**0.0**	**0.1**	**0.1**	**0.1**
	F	**0.13**	**0.15**	**0.11**	**0.20**	**0.13**	**0.15**	**0.08**	**0.1**	**0.0**	**0.0**	**0.1**	**0.1**	**0.1**
	M&F	**0.14**	**0.16**	**0.12**	**0.17**	**0.14**	**0.15**	**0.08**	**0.1**	**0.0**	**0.0**	**0.1**	**0.1**	**0.1**
Average Scripts PMPY for Azithromycins and Clarithromycins:														
0–9	M	0.27	0.38	0.23	0.32	0.36	0.27	0.19						
	F	0.25	0.36	0.21	0.35	0.33	0.26	0.17						
	M&F	0.26	0.37	0.22	0.33	0.34	0.26	0.18						
10–17	M	0.21	0.28	0.17	0.21	0.25	0.23	0.13						
	F	0.26	0.35	0.23	0.31	0.30	0.28	0.17						
	M&F	0.24	0.32	0.20	0.24	0.28	0.25	0.15						
18–34	M	0.17	0.18	0.17	0.17	0.16	0.19	0.15						
	F	0.35	0.37	0.38	0.30	0.35	0.37	0.31						
	M&F	0.30	0.32	0.33	0.22	0.29	0.32	0.27						
35–49	M	0.21	0.21	0.20	0.13	0.18	0.25	0.20						
	F	0.35	0.38	0.36	0.09	0.34	0.39	0.31						
	M&F	0.30	0.33	0.33	0.11	0.28	0.35	0.28						
50–64	M	0.19	0.21	0.19	0.08	0.19	0.22	0.18						
	F	0.31	0.39	0.33	0.07	0.36	0.40	0.28						
	M&F	0.26	0.33	0.28	0.07	0.28	0.33	0.24						
65–74	M	0.07	0.12	0.12	0.00	0.34	0.33	0.16						
	F	0.27	0.19	0.15	0.08	0.47	0.44	0.30						
	M&F	0.18	0.16	0.14	0.06	0.42	0.40	0.25						
75–84	M	0.27	0.07	0.00	0.00	0.24	0.24	0.22						
	F	0.20	0.03	0.02	0.00	0.32	0.27	0.18						
	M&F	0.23	0.04	0.01	0.00	0.30	0.26	0.19						
≥85	M	0.10	0.07	0.03	NA	0.28	0.26	0.15						
	F	0.09	0.04	0.01	0.00	0.31	0.21	0.12						
	M&F	0.09	0.05	0.02	0.00	0.30	0.22	0.12						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**0.23**	**0.30**	**0.20**	**0.24**	**0.27**	**0.24**	**0.17**	**0.2**	**0.1**	**0.1**	**0.2**	**0.2**	**0.2**
	F	**0.30**	**0.37**	**0.29**	**0.32**	**0.33**	**0.32**	**0.24**	**0.2**	**0.2**	**0.2**	**0.2**	**0.3**	**0.3**
	M&F	**0.27**	**0.34**	**0.26**	**0.27**	**0.31**	**0.29**	**0.21**	**0.2**	**0.1**	**0.2**	**0.2**	**0.2**	**0.3**

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures													
Measure by Age / as Stated	Sex	Ameri group	BlueCare		TennCare *Select*	UnitedHealthcare			National Medicaid HEDIS 2011 Means and Percentiles					
			-East	-West		-East	-Middle	-West	Mean	P10	P25	P50	P75	P90
Average Scripts PMPY for Amoxicillin / Clavulanates:														
0–9	M	0.16	0.22	0.17	0.24	0.19	0.17	0.15						
	F	0.15	0.20	0.16	0.24	0.17	0.16	0.13						
	M&F	0.16	0.21	0.16	0.24	0.18	0.16	0.14						
10–17	M	0.09	0.12	0.08	0.10	0.10	0.09	0.06						
	F	0.09	0.13	0.09	0.13	0.11	0.10	0.07						
	M&F	0.09	0.12	0.08	0.11	0.10	0.09	0.07						
18–34	M	0.07	0.09	0.07	0.08	0.07	0.08	0.06						
	F	0.12	0.14	0.12	0.09	0.12	0.12	0.10						
	M&F	0.10	0.12	0.11	0.08	0.11	0.11	0.09						
35–49	M	0.09	0.12	0.10	0.05	0.10	0.10	0.10						
	F	0.13	0.16	0.16	0.06	0.14	0.15	0.11						
	M&F	0.12	0.15	0.14	0.06	0.12	0.13	0.11						
50–64	M	0.09	0.12	0.09	0.05	0.10	0.12	0.10						
	F	0.12	0.15	0.15	0.05	0.14	0.15	0.13						
	M&F	0.11	0.14	0.13	0.05	0.12	0.14	0.11						
65–74	M	0.07	0.13	0.02	0.00	0.11	0.14	0.10						
	F	0.11	0.08	0.07	0.08	0.16	0.13	0.08						
	M&F	0.09	0.10	0.06	0.06	0.14	0.13	0.09						
75–84	M	0.09	0.00	0.03	0.00	0.10	0.15	0.18						
	F	0.12	0.02	0.06	0.00	0.14	0.10	0.08						
	M&F	0.11	0.01	0.05	0.00	0.13	0.12	0.10						
≥85	M	0.10	0.00	0.06	NA	0.09	0.18	0.05						
	F	0.05	0.02	0.00	0.00	0.08	0.10	0.04						
	M&F	0.06	0.01	0.02	0.00	0.08	0.12	0.04						
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**	**0.12**	**0.16**	**0.12**	**0.15**	**0.13**	**0.13**	**0.11**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.2**
	F	**0.12**	**0.16**	**0.13**	**0.16**	**0.14**	**0.14**	**0.11**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**
	M&F	**0.12**	**0.16**	**0.13**	**0.15**	**0.14**	**0.13**	**0.11**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures													
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2011 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
Average Scripts PMPY for Ketolides:														
0–9	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
10–17	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
18–34	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
35–49	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
50–64	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
65–74	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
75–84	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
≥85	M	0.00	0.00	0.00	NA	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**

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures													
Measure by Age / as Stated	Sex	Ameri group	BlueCare		TennCare *Select*	UnitedHealthcare			National Medicaid HEDIS 2011 Means and Percentiles					
			-East	-West		-East	-Middle	-West	Mean	P10	P25	P50	P75	P90
Average Scripts PMPY for Clindamycins:														
0–9	M	0.02	0.02	0.04	0.04	0.01	0.02	0.03						
	F	0.02	0.01	0.04	0.04	0.01	0.02	0.03						
	M&F	0.02	0.02	0.04	0.04	0.01	0.02	0.03						
10–17	M	0.03	0.03	0.04	0.04	0.02	0.03	0.03						
	F	0.03	0.04	0.05	0.07	0.03	0.03	0.04						
	M&F	0.03	0.03	0.04	0.05	0.03	0.03	0.04						
18–34	M	0.05	0.06	0.05	0.04	0.06	0.05	0.04						
	F	0.08	0.10	0.08	0.08	0.09	0.08	0.07						
	M&F	0.07	0.09	0.08	0.05	0.08	0.08	0.07						
35–49	M	0.05	0.06	0.06	0.02	0.07	0.06	0.06						
	F	0.07	0.09	0.08	0.03	0.09	0.08	0.07						
	M&F	0.06	0.08	0.07	0.03	0.08	0.07	0.07						
50–64	M	0.05	0.05	0.05	0.02	0.05	0.05	0.04						
	F	0.05	0.07	0.07	0.01	0.07	0.06	0.06						
	M&F	0.05	0.06	0.06	0.01	0.06	0.06	0.06						
65–74	M	0.01	0.03	0.08	0.00	0.04	0.04	0.03						
	F	0.01	0.02	0.04	0.00	0.05	0.05	0.05						
	M&F	0.01	0.02	0.05	0.00	0.05	0.05	0.04						
75–84	M	0.00	0.00	0.00	0.00	0.02	0.05	0.00						
	F	0.03	0.01	0.03	0.00	0.04	0.02	0.05						
	M&F	0.02	0.01	0.02	0.00	0.03	0.03	0.04						
≥85	M	0.00	0.00	0.03	NA	0.00	0.06	0.00						
	F	0.00	0.01	0.00	0.00	0.03	0.05	0.04						
	M&F	0.00	0.01	0.01	0.00	0.02	0.05	0.03						
Unknown	M	NA	NA	NA	NA	NA	NA	NA						
	F	NA	NA	NA	NA	NA	NA	NA						
	M&F	NA	NA	NA	NA	NA	NA	NA						
Total	**M**	**0.03**	**0.03**	**0.04**	**0.04**	**0.03**	**0.03**	**0.03**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	F	**0.05**	**0.06**	**0.06**	**0.06**	**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**

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2011 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
Average Scripts PMPY for Misc. Antibiotics of Concern:														
0–9	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
10–17	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
18–34	M	0.00	0.00	0.00	0.01	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	0.01	0.00	0.00	0.00						
35–49	M	0.00	0.00	0.00	0.00	0.00	0.01	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						
50–64	M	0.01	0.00	0.01	0.00	0.01	0.01	0.01						
	F	0.02	0.01	0.01	0.00	0.01	0.01	0.01						
	M&F	0.01	0.01	0.01	0.00	0.01	0.01	0.01						
65–74	M	0.00	0.00	0.00	0.00	0.02	0.01	0.00						
	F	0.00	0.00	0.01	0.00	0.01	0.01	0.02						
	M&F	0.00	0.00	0.01	0.00	0.02	0.01	0.01						
75–84	M	0.00	0.00	0.03	0.00	0.01	0.01	0.00						
	F	0.00	0.01	0.00	0.00	0.01	0.02	0.02						
	M&F	0.00	0.01	0.01	0.00	0.01	0.02	0.02						
≥85	M	0.00	0.00	0.00	NA	0.01	0.00	0.00						
	F	0.02	0.00	0.00	0.00	0.01	0.01	0.00						
	M&F	0.01	0.00	0.00	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**	**0.00**	**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**

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age / as Stated	Sex	Ameri group	BlueCare		TennCare *Select*	UnitedHealthcare			National Medicaid HEDIS 2011 Means and Percentiles					
			-East	-West		-East	-Middle	-West	Mean	P10	P25	P50	P75	P90
All Other Antibiotics Utilization														
Average Scripts PMPY for Absorbable Sulfonamides:														
0–9	M	0.07	0.09	0.08	0.16	0.07	0.08	0.06						
	F	0.12	0.16	0.12	0.24	0.13	0.13	0.10						
	M&F	0.09	0.12	0.10	0.19	0.10	0.10	0.08						
10–17	M	0.06	0.08	0.05	0.10	0.07	0.06	0.04						
	F	0.12	0.15	0.11	0.19	0.13	0.13	0.09						
	M&F	0.09	0.11	0.08	0.13	0.10	0.09	0.07						
18–34	M	0.11	0.13	0.10	0.11	0.12	0.11	0.09						
	F	0.22	0.22	0.21	0.21	0.20	0.23	0.18						
	M&F	0.19	0.20	0.18	0.15	0.18	0.20	0.16						
35–49	M	0.15	0.15	0.14	0.10	0.15	0.19	0.15						
	F	0.20	0.21	0.20	0.08	0.19	0.22	0.18						
	M&F	0.19	0.19	0.19	0.09	0.18	0.21	0.17						
50–64	M	0.17	0.15	0.18	0.10	0.14	0.21	0.13						
	F	0.20	0.18	0.18	0.06	0.17	0.24	0.16						
	M&F	0.19	0.17	0.18	0.07	0.16	0.23	0.15						
65–74	M	0.11	0.08	0.05	0.00	0.19	0.20	0.13						
	F	0.12	0.15	0.10	0.08	0.22	0.28	0.14						
	M&F	0.11	0.12	0.09	0.06	0.21	0.25	0.14						
75–84	M	0.20	0.08	0.03	0.00	0.12	0.18	0.11						
	F	0.22	0.06	0.14	0.00	0.17	0.20	0.14						
	M&F	0.21	0.07	0.11	0.00	0.16	0.20	0.14						
≥85	M	0.10	0.04	0.00	NA	0.18	0.09	0.00						
	F	0.07	0.03	0.01	0.00	0.15	0.21	0.09						
	M&F	0.08	0.03	0.01	0.00	0.16	0.19	0.08						
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**	**0.10**	**0.08**	**0.12**	**0.09**	**0.10**	**0.07**	**0.1**	**0.0**	**0.0**	**0.1**	**0.1**	**0.1**
	F	**0.16**	**0.18**	**0.16**	**0.21**	**0.16**	**0.18**	**0.14**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.2**
	M&F	**0.13**	**0.15**	**0.13**	**0.16**	**0.13**	**0.14**	**0.11**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2011 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
Average Scripts PMPY for Aminoglycosides:														
0–9	M	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.02	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
10–17	M	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
18–34	M	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
35–49	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
50–64	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.01	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.01	0.00	0.00	0.00	0.00	0.00	0.00						
65–74	M	0.09	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.01	0.00						
	M&F	0.04	0.00	0.00	0.00	0.00	0.00	0.00						
75–84	M	0.02	0.02	0.00	0.00	0.00	0.02	0.00						
	F	0.00	0.02	0.03	0.00	0.00	0.05	0.00						
	M&F	0.01	0.02	0.02	0.00	0.00	0.04	0.00						
≥85	M	0.00	0.00	0.00	NA	0.01	0.00	0.00						
	F	0.00	0.02	0.00	0.00	0.00	0.01	0.00						
	M&F	0.00	0.02	0.00	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**	**0.00**	**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 A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2011 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
Average Scripts PMPY for 1st Generation Cephalosporins:														
0–9	M	0.07	0.07	0.07	0.08	0.06	0.07	0.04						
	F	0.08	0.07	0.07	0.08	0.07	0.07	0.05						
	M&F	0.07	0.07	0.07	0.08	0.07	0.07	0.05						
10–17	M	0.07	0.08	0.06	0.07	0.08	0.07	0.05						
	F	0.08	0.10	0.08	0.10	0.09	0.09	0.06						
	M&F	0.08	0.09	0.07	0.08	0.08	0.08	0.05						
18–34	M	0.09	0.10	0.08	0.07	0.09	0.09	0.07						
	F	0.15	0.16	0.13	0.12	0.14	0.16	0.11						
	M&F	0.13	0.14	0.12	0.09	0.13	0.14	0.10						
35–49	M	0.11	0.13	0.12	0.04	0.10	0.13	0.10						
	F	0.14	0.15	0.13	0.07	0.14	0.15	0.12						
	M&F	0.13	0.15	0.13	0.06	0.12	0.14	0.11						
50–64	M	0.11	0.12	0.11	0.07	0.10	0.15	0.11						
	F	0.14	0.16	0.16	0.03	0.13	0.17	0.12						
	M&F	0.13	0.14	0.14	0.05	0.12	0.16	0.12						
65–74	M	0.04	0.10	0.07	0.00	0.18	0.13	0.12						
	F	0.06	0.11	0.08	0.00	0.18	0.17	0.15						
	M&F	0.05	0.10	0.08	0.00	0.18	0.16	0.14						
75–84	M	0.00	0.02	0.13	0.00	0.09	0.14	0.20						
	F	0.18	0.05	0.08	0.00	0.18	0.19	0.16						
	M&F	0.11	0.04	0.10	0.00	0.15	0.17	0.17						
≥85	M	0.15	0.02	0.00	NA	0.10	0.32	0.10						
	F	0.16	0.02	0.01	0.00	0.15	0.16	0.08						
	M&F	0.15	0.02	0.01	0.00	0.14	0.19	0.08						
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**	**0.08**	**0.07**	**0.07**	**0.08**	**0.08**	**0.06**	**0.1**	**0.0**	**0.0**	**0.1**	**0.1**	**0.1**
	F	**0.11**	**0.12**	**0.10**	**0.09**	**0.11**	**0.11**	**0.08**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**
	M&F	**0.09**	**0.11**	**0.09**	**0.08**	**0.10**	**0.10**	**0.07**	**0.1**	**0.0**	**0.1**	**0.1**	**0.1**	**0.1**

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures													
Measure by Age / as Stated	Sex	Ameri group	BlueCare		TennCare *Select*	UnitedHealthcare			National Medicaid HEDIS 2011 Means and Percentiles					
			-East	-West		-East	-Middle	-West	Mean	P10	P25	P50	P75	P90
Average Scripts PMPY for Lincosamides:														
0–9	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
10–17	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
18–34	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
35–49	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
50–64	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
65–74	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
75–84	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
≥85	M	0.00	0.00	0.00	NA	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**

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age / as Stated	**Sex**	**Ameri group**	**BlueCare**		**TennCare *Select***	**UnitedHealthcare**			**National Medicaid HEDIS 2011 Means and Percentiles**					
			-East	**-West**		**-East**	**-Middle**	**-West**	**Mean**	**P10**	**P25**	**P50**	**P75**	**P90**
Average Scripts PMPY for Macrolides (not azith. or clarith.):														
0–9	M	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.01	0.00	0.00	0.00						
10–17	M	0.00	0.01	0.01	0.01	0.00	0.00	0.00						
	F	0.01	0.01	0.01	0.01	0.01	0.01	0.00						
	M&F	0.00	0.01	0.01	0.01	0.01	0.00	0.00						
18–34	M	0.01	0.01	0.01	0.02	0.01	0.01	0.00						
	F	0.01	0.02	0.01	0.01	0.02	0.01	0.01						
	M&F	0.01	0.02	0.01	0.01	0.01	0.01	0.01						
35–49	M	0.01	0.01	0.01	0.00	0.01	0.01	0.01						
	F	0.02	0.02	0.01	0.00	0.02	0.01	0.01						
	M&F	0.01	0.02	0.01	0.00	0.02	0.01	0.01						
50–64	M	0.01	0.01	0.00	0.00	0.01	0.01	0.00						
	F	0.01	0.02	0.01	0.00	0.02	0.02	0.01						
	M&F	0.01	0.01	0.01	0.00	0.01	0.02	0.01						
65–74	M	0.00	0.02	0.02	0.00	0.00	0.00	0.00						
	F	0.02	0.00	0.00	0.00	0.01	0.03	0.00						
	M&F	0.01	0.01	0.01	0.00	0.01	0.02	0.00						
75–84	M	0.00	0.00	0.00	0.00	0.01	0.01	0.03						
	F	0.00	0.01	0.00	0.00	0.00	0.02	0.00						
	M&F	0.00	0.01	0.00	0.00	0.00	0.01	0.01						
≥85	M	0.00	0.00	0.00	NA	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.01	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	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**	**0.00**	**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**	**0.01**	**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**	**0.00**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures													
Measure by Age / as Stated	Sex	Ameri group	BlueCare		TennCare *Select*	UnitedHealthcare			National Medicaid HEDIS 2011 Means and Percentiles					
			-East	-West		-East	-Middle	-West	Mean	P10	P25	P50	P75	P90
Average Scripts PMPY for Penicillins:														
0–9	M	0.52	0.62	0.50	0.61	0.55	0.55	0.47						
	F	0.53	0.64	0.50	0.66	0.55	0.57	0.47						
	M&F	0.52	0.63	0.50	0.63	0.55	0.56	0.47						
10–17	M	0.22	0.28	0.19	0.27	0.24	0.21	0.17						
	F	0.28	0.36	0.25	0.37	0.32	0.29	0.23						
	M&F	0.25	0.32	0.22	0.31	0.28	0.25	0.20						
18–34	M	0.18	0.25	0.18	0.21	0.22	0.19	0.16						
	F	0.32	0.38	0.34	0.33	0.33	0.33	0.29						
	M&F	0.28	0.34	0.31	0.26	0.30	0.29	0.26						
35–49	M	0.17	0.21	0.17	0.10	0.18	0.18	0.17						
	F	0.25	0.29	0.27	0.10	0.25	0.25	0.25						
	M&F	0.22	0.26	0.25	0.10	0.23	0.23	0.23						
50–64	M	0.15	0.15	0.15	0.07	0.13	0.18	0.16						
	F	0.18	0.20	0.21	0.08	0.17	0.19	0.20						
	M&F	0.17	0.18	0.19	0.07	0.15	0.19	0.18						
65–74	M	0.09	0.00	0.05	0.00	0.18	0.20	0.13						
	F	0.15	0.08	0.09	0.00	0.19	0.20	0.20						
	M&F	0.12	0.05	0.08	0.00	0.19	0.20	0.17						
75–84	M	0.13	0.00	0.03	0.00	0.16	0.18	0.11						
	F	0.08	0.04	0.02	0.00	0.18	0.13	0.18						
	M&F	0.10	0.03	0.02	0.00	0.17	0.15	0.17						
≥85	M	0.10	0.04	0.00	NA	0.07	0.09	0.10						
	F	0.02	0.02	0.00	0.00	0.15	0.10	0.04						
	M&F	0.04	0.02	0.00	0.00	0.13	0.10	0.04						
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**	**0.35**	**0.42**	**0.34**	**0.38**	**0.35**	**0.37**	**0.31**	**0.3**	**0.2**	**0.3**	**0.3**	**0.4**	**0.5**
	F	**0.37**	**0.43**	**0.36**	**0.47**	**0.37**	**0.39**	**0.32**	**0.4**	**0.3**	**0.3**	**0.4**	**0.4**	**0.5**
	M&F	**0.36**	**0.43**	**0.35**	**0.42**	**0.36**	**0.38**	**0.32**	**0.4**	**0.3**	**0.3**	**0.3**	**0.4**	**0.4**

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures													
Measure by Age / as Stated	Sex	Ameri group	BlueCare		TennCare *Select*	UnitedHealthcare			National Medicaid HEDIS 2011 Means and Percentiles					
			-East	-West		-East	-Middle	-West	Mean	P10	P25	P50	P75	P90
Average Scripts PMPY for Tetracyclines:														
0–9	M	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
	M&F	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
10–17	M	0.05	0.08	0.05	0.09	0.08	0.06	0.04						
	F	0.05	0.08	0.07	0.08	0.08	0.06	0.06						
	M&F	0.05	0.08	0.06	0.09	0.08	0.06	0.05						
18–34	M	0.09	0.10	0.12	0.14	0.09	0.09	0.11						
	F	0.13	0.14	0.18	0.16	0.13	0.14	0.16						
	M&F	0.12	0.13	0.17	0.14	0.12	0.12	0.15						
35–49	M	0.11	0.10	0.15	0.20	0.10	0.11	0.12						
	F	0.13	0.14	0.18	0.12	0.15	0.14	0.16						
	M&F	0.12	0.13	0.17	0.16	0.13	0.13	0.15						
50–64	M	0.10	0.12	0.13	0.09	0.13	0.13	0.12						
	F	0.13	0.16	0.16	0.07	0.17	0.15	0.13						
	M&F	0.12	0.14	0.15	0.08	0.15	0.14	0.13						
65–74	M	0.23	0.10	0.08	0.00	0.20	0.17	0.10						
	F	0.17	0.21	0.10	0.00	0.18	0.15	0.14						
	M&F	0.20	0.16	0.10	0.00	0.19	0.16	0.12						
75–84	M	0.07	0.02	0.00	0.00	0.13	0.15	0.19						
	F	0.05	0.07	0.05	0.00	0.22	0.11	0.07						
	M&F	0.06	0.05	0.03	0.00	0.20	0.13	0.10						
≥85	M	0.39	0.00	0.03	NA	0.17	0.15	0.00						
	F	0.07	0.04	0.00	0.00	0.14	0.04	0.05						
	M&F	0.15	0.03	0.01	0.00	0.14	0.06	0.04						
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**	**0.06**	**0.04**	**0.04**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	F	**0.07**	**0.09**	**0.10**	**0.06**	**0.09**	**0.08**	**0.09**	**0.1**	**0.0**	**0.0**	**0.1**	**0.1**	**0.1**
	M&F	**0.06**	**0.07**	**0.08**	**0.07**	**0.07**	**0.06**	**0.07**	**0.0**	**0.0**	**0.0**	**0.0**	**0.1**	**0.1**

Table A. HEDIS 2012 Plan-Specific Rates with National Benchmarks: Utilization Measures														
Measure by Age / as Stated	Sex	Ameri group	BlueCare		TennCare *Select*	UnitedHealthcare			National Medicaid HEDIS 2011 Means and Percentiles					
			-East	-West		-East	-Middle	-West	Mean	P10	P25	P50	P75	P90
Average Scripts PMPY for Misc. Antibiotics:														
0–9	M	0.00	0.01	0.00	0.02	0.01	0.00	0.00						
	F	0.01	0.03	0.01	0.06	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	0.01	0.01	0.01	0.00	0.00						
	F	0.06	0.07	0.06	0.13	0.06	0.06	0.06						
	M&F	0.03	0.04	0.03	0.06	0.03	0.03	0.03						
18–34	M	0.03	0.02	0.03	0.03	0.02	0.02	0.02						
	F	0.36	0.35	0.42	0.28	0.32	0.36	0.38						
	M&F	0.27	0.26	0.33	0.12	0.23	0.27	0.29						
35–49	M	0.05	0.04	0.07	0.02	0.04	0.04	0.04						
	F	0.21	0.19	0.25	0.12	0.18	0.21	0.23						
	M&F	0.16	0.14	0.21	0.08	0.13	0.16	0.18						
50–64	M	0.06	0.06	0.07	0.07	0.05	0.05	0.04						
	F	0.16	0.17	0.16	0.10	0.15	0.17	0.14						
	M&F	0.12	0.13	0.13	0.08	0.10	0.12	0.10						
65–74	M	0.07	0.03	0.07	0.00	0.08	0.08	0.06						
	F	0.14	0.19	0.08	0.08	0.25	0.22	0.13						
	M&F	0.11	0.13	0.08	0.06	0.19	0.17	0.11						
75–84	M	0.13	0.00	0.17	0.00	0.06	0.07	0.09						
	F	0.29	0.19	0.10	0.00	0.31	0.33	0.11						
	M&F	0.23	0.12	0.12	0.00	0.24	0.25	0.11						
≥85	M	0.00	0.04	0.12	NA	0.16	0.23	0.00						
	F	0.26	0.08	0.01	0.00	0.30	0.34	0.06						
	M&F	0.19	0.07	0.04	0.00	0.27	0.32	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**	**0.01**	**0.02**	**0.01**	**0.02**	**0.02**	**0.01**	**0.01**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	F	**0.15**	**0.16**	**0.19**	**0.12**	**0.14**	**0.16**	**0.17**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.2**
	M&F	**0.09**	**0.10**	**0.12**	**0.06**	**0.09**	**0.10**	**0.10**	**0.1**	**0.0**	**0.1**	**0.1**	**0.1**	**0.1**

* *Data were reported separately for male and female categories for HEDIS 2012, whereas they were combined into one category for HEDIS 2011.*

APPENDIX B | *HEDIS 2011 National Medicaid Means and Percentiles*

Table B. HEDIS 2011 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)	42.2%	3.2%	29.2%	47.6%	61.7%	70.5%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC):						
BMI Percentile: 3–11 years	37.5%	0.6%	17.2%	37.5%	61.1%	73.0%
12–17 years	36.8%	0.8%	18.9%	36.3%	54.3%	67.2%
Total	**37.3%**	**0.7%**	**19.7%**	**37.5%**	**58.8%**	**69.8%**
Counseling for Nutrition: 3–11 years	47.4%	0.6%	39.9%	53.3%	64.4%	73.2%
12–17 years	41.3%	0.8%	31.3%	46.7%	56.8%	66.4%
Total	**45.6%**	**0.7%**	**39.0%**	**51.1%**	**61.6%**	**72.0%**
Counseling for Physical Activity: 3–11 years	35.6%	0.0%	26.6%	39.4%	49.4%	59.9%
12–17 years	38.5%	0.0%	29.7%	42.8%	53.7%	63.2%
Total	**36.7%**	**0.0%**	**28.5%**	**40.6%**	**51.0%**	**60.6%**
Childhood Immunization Status (CIS):						
DTaP/DT	80.2%	70.8%	77.3%	81.7%	85.6%	88.5%
IPV	90.8%	85.6%	88.3%	92.3%	94.6%	95.9%
MMR	90.6%	86.1%	89.3%	91.9%	93.6%	95.4%
HiB	90.3%	84.3%	87.6%	91.0%	94.3%	96.1%
HepB	90.1%	82.9%	87.3%	91.8%	94.6%	95.9%
VZV	90.0%	85.4%	89.0%	91.3%	93.6%	95.1%
PCV	79.4%	68.8%	74.2%	81.3%	85.0%	88.8%
HepA	36.5%	24.3%	29.0%	36.4%	42.8%	48.7%
RV	57.6%	43.6%	49.9%	59.4%	65.2%	72.2%
Influenza	43.6%	22.0%	34.5%	44.0%	53.3%	60.3%
Combination 2	74.1%	62.3%	69.0%	75.1%	80.7%	85.8%
Combination 3	69.9%	56.8%	64.4%	71.0%	76.7%	82.6%
Combination 4	31.6%	20.0%	25.8%	31.4%	37.0%	41.9%
Combination 5	47.2%	34.4%	39.4%	47.4%	55.0%	62.5%
Combination 6	36.4%	16.8%	28.0%	37.0%	44.8%	51.5%
Combination 7	23.8%	13.6%	17.5%	23.1%	28.0%	35.9%
Combination 8	19.0%	8.8%	13.0%	18.0%	22.1%	27.4%
Combination 9	27.8%	12.2%	20.4%	26.8%	34.3%	39.9%
Combination 10	15.2%	6.3%	9.9%	14.4%	18.6%	23.6%
Immunizations for Adolescents (IMA):						
Meningococcal	56.3%	38.0%	45.9%	54.8%	67.9%	79.7%
Tdap/Td	67.8%	45.3%	54.7%	68.5%	83.2%	87.8%
Combination 1	52.2%	33.8%	40.0%	49.8%	63.7%	75.5%

Table B. HEDIS 2011 National Medicaid Means and Percentiles						
Measure	Medicaid Mean	Percentile				
		10th	25th	50th	75th	90th
Human Papillomavirus Vaccine for Female Adolescents (HPV)*						
Lead Screening in Children (LSC)	66.2%	34.6%	55.5%	72.2%	80.5%	87.6%
Breast Cancer Screening (BCS)	51.3%	38.7%	45.3%	52.4%	57.4%	62.9%
Cervical Cancer Screening (CCS)	67.2%	53.0%	64.0%	69.7%	74.2%	78.7%
Chlamydia Screening in Women (CHL):						
16–20 years	54.6%	42.9%	48.7%	53.6%	60.6%	66.7%
21–24 years	62.3%	50.5%	57.6%	62.5%	68.7%	72.2%
Total	**57.5%**	**46.0%**	**51.5%**	**57.2%**	**63.4%**	**69.1%**
Respiratory Conditions						
Appropriate Testing for Children With Pharyngitis (CWP)	64.9%	45.1%	55.1%	68.1%	75.7%	83.0%
Appropriate Treatment for Children With Upper Respiratory Infection (URI)	87.2%	79.2%	83.4%	87.5%	91.9%	94.8%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)	23.5%	15.1%	18.8%	22.0%	26.2%	31.6%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	31.3%	19.1%	24.6%	30.5%	35.5%	47.2%
Pharmacotherapy Management of COPD Exacerbation (PCE):						
Systemic corticosteroid	65.3%	46.5%	59.4%	67.6%	73.5%	76.8%
Bronchodilator	82.1%	71.1%	77.5%	84.3%	87.1%	89.3%
Use of Appropriate Medications for People With Asthma (ASM):						
5–11 years	91.8%	87.5%	90.1%	92.3%	94.3%	96.0%
12–18 years**						
19–50 years**						
51–64 years**						
Total						
Medication Management for People With Asthma (MMA)*						
Medication Complication 50%: 5–11 years						
12–18 years						
19–50 years						
51–64 years						
Total						
Medication Complication 75%: 5–11 years						
12–18 years						
19–50 years						
51–64 years						
Total						
Cardiovascular Conditions						
Cholesterol Management for Patients With Cardiovascular Conditions (CMC):						
LDL-C Screening	82.0%	74.4%	78.3%	82.5%	85.9%	89.1%
LDL-C Controlled (<100 mg/dL)	42.8%	28.9%	35.1%	44.0%	50.0%	57.1%

Table B. HEDIS 2011 National Medicaid Means and Percentiles						
Measure	**Medicaid Mean**	**Percentile**				
		10th	**25th**	**50th**	**75th**	**90th**
Controlling High Blood Pressure (CBP)	55.6%	42.1%	47.9%	56.4%	63.7%	67.6%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	76.3%	61.0%	70.3%	79.3%	84.5%	88.6%
Diabetes						
Comprehensive Diabetes Care (CDC):						
HbA1c Testing	82.0%	73.6%	77.6%	82.2%	87.1%	90.9%
HbA1c Control (<7.0%)	34.7%	23.6%	28.8%	35.2%	41.3%	44.4%
HbA1c Control (<8.0%)	46.9%	33.8%	39.9%	47.4%	54.8%	59.1%
Retinal Eye Exam Performed	53.1%	34.0%	43.8%	52.8%	63.7%	70.6%
LDL-C Screening	74.7%	63.7%	70.4%	75.4%	80.3%	84.2%
LDL-C Controlled (<100 mg/dL)	34.6%	21.5%	27.3%	35.2%	41.4%	45.9%
Medical Attention for Nephropathy	77.7%	68.1%	73.9%	78.5%	82.5%	86.9%
Blood Pressure Control (<130/80 mm Hg)	38.7%	25.0%	32.0%	38.5%	44.2%	54.8%
Blood Pressure Control (<140/90 mm Hg)	60.4%	43.8%	54.3%	61.2%	68.3%	76.0%
Musculoskeletal Conditions						
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	70.1%	53.3%	63.7%	73.0%	78.3%	83.2%
Use of Imaging Studies for Low Back Pain (LBP)	75.5%	67.0%	72.3%	75.6%	79.7%	82.3%
Behavioral Health						
Antidepressant Medication Management (AMM):						
Effective Acute Phase Treatment	50.7%	43.0%	46.4%	50.1%	53.6%	59.9%
Effective Continuation Phase Treatment	34.4%	25.7%	29.2%	32.7%	37.5%	44.2%
Follow-Up Care for Children Prescribed ADHD Medication (ADD):						
Initiation Phase	38.1%	24.9%	31.8%	38.3%	43.6%	50.7%
Continuation and Maintenance Phase	43.9%	23.0%	34.7%	45.2%	52.6%	62.5%
Follow-Up After Hospitalization for Mental Illness (FUH):						
7-day follow-up	44.6%	23.0%	33.1%	45.1%	53.9%	68.3%
30-day follow-up	63.8%	36.0%	57.1%	66.6%	74.6%	82.6%
Medication Management						
Annual Monitoring for Patients on Persistent Medications (MPM):						
ACE Inhibitors or ARBs	86.0%	79.9%	83.6%	86.5%	88.6%	90.6%
Digoxin	89.7%	80.4%	87.5%	90.3%	93.3%	95.5%
Diuretics	85.5%	79.3%	82.8%	85.8%	88.6%	90.7%
Anticonvulsants	67.7%	57.6%	63.2%	68.6%	72.5%	76.6%
Total	**83.9%**	**78.3%**	**81.8%**	**84.2%**	**86.7%**	**88.1%**
Measures Collected Through CAHPS Health Plan Survey						
Medical Assistance With Smoking Cessation (MSC)*:**						
Advising Smokers and Tobacco Users to Quit	73.63%	64.68%	69.93%	74.82%	78.01%	80.81%
Discussing Cessation Medications	42.69%	30.23%	36.44%	42.71%	48.82%	54.97%
Discussing Cessation Strategies	38.53%	30.04%	33.75%	38.14%	42.96%	48.45%
HEDIS Effectiveness of Care Measures Where Lower Rates Indicated Better Performance						
Comprehensive Diabetes Care (CDC):						
HbA1c Poor Control (>9.0%)	44.0%	29.1%	34.9%	42.6%	52.1%	60.4%

Table B. HEDIS 2011 National Medicaid Means and Percentiles						
Measure	Medicaid Mean	Percentile				
		10th	25th	50th	75th	90th
HEDIS Access/Availability of Care Measures						
Adults' Access to Preventive/Ambulatory Health Services (AAP):						
20–44 years	81.2%	69.3%	78.5%	83.2%	86.4%	88.4%
45–64 years	86.0%	78.7%	84.5%	87.4%	89.8%	91.0%
Children and Adolescents' Access to Primary Care Practitioners (CAP):						
12–24 months	96.1%	92.6%	95.1%	97.0%	97.8%	98.6%
25 months–6 years	88.3%	82.0%	86.8%	89.6%	91.2%	92.7%
7-11 years	90.2%	85.2%	87.9%	91.3%	93.3%	94.7%
12–19 years	88.1%	81.1%	86.5%	89.7%	91.9%	93.4%
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET):						
Initiation of AOD Treatment: 13–17 years	44.7%	24.6%	33.1%	44.9%	54.7%	65.1%
≥18 years	42.7%	31.0%	34.6%	40.4%	48.4%	59.4%
Total	**42.9%**	**30.0%**	**35.7%**	**40.8%**	**48.8%**	**60.7%**
Engagement of AOD Treatment: 13–17 years	19.9%	4.4%	7.6%	19.4%	27.4%	38.1%
≥18 years	13.6%	2.1%	5.4%	13.3%	19.9%	25.0%
Total	**14.2%**	**2.0%**	**5.7%**	**14.5%**	**20.5%**	**25.9%**
Prenatal and Postpartum Care (PPC):						
Timeliness of Prenatal Care	83.7%	71.4%	80.3%	86.0%	90.0%	93.2%
Postpartum Care	64.4%	53.7%	59.6%	64.6%	70.6%	75.2%
Call Answer Timeliness (CAT)	82.7%	70.7%	79.7%	84.6%	89.3%	94.7%
HEDIS Access/Availability of Care Measures Where Lower Rates Indicated Better Performance						
Call Abandonment (CAB)	2.9%	0.9%	1.5%	2.1%	3.6%	6.2%
HEDIS Utilization and Relative ResourceUse Measures						
Utilization						
Frequency of Ongoing Prenatal Care (FPC):						
<21%	10.4%	1.8%	4.0%	7.7%	11.5%	19.1%
21–40%	6.9%	1.9%	2.9%	4.9%	8.8%	13.8%
41–60%	8.1%	4.0%	5.5%	7.0%	9.8%	14.2%
61–80%	13.6%	7.1%	10.6%	13.4%	16.8%	19.7%
≥81%	61.1%	34.7%	50.8%	64.4%	74.9%	81.8%
Well-Child Visits in the First 15 Months of Life (W15):						
0 Visits	2.2%	0.5%	0.8%	1.6%	2.7%	4.4%
1 Visits	2.2%	0.7%	1.2%	1.9%	2.7%	4.1%
2 Visits	3.3%	1.1%	2.1%	2.9%	4.5%	6.1%
3 Visits	5.7%	2.7%	3.8%	5.4%	7.3%	9.3%
4 Visits	10.1%	5.3%	7.4%	9.5%	12.2%	15.6%
5 Visits	16.1%	8.3%	11.9%	16.5%	19.8%	21.9%
6 or More Visits	60.2%	41.9%	52.2%	61.3%	68.9%	77.1%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	71.9%	60.9%	66.1%	72.3%	77.6%	82.9%
Adolescent Well-Care Visits (AWC)	48.1%	35.0%	39.6%	46.1%	57.2%	64.1%

**First year measure*
***For ASM age stratification changed for 2012 HEDIS; hence, there are no National data*
****The three MSC rates were included in Quality Compass in 2011; all other Medicaid national rates taken from NCQA's HEDIS Audit Means, Percentiles and Rations: 2011.*

APPENDIX C | *MCO Population Reported in Member Months*

Table C. HEDIS 2012 MCO Population Reported in Member Months by Age and Sex																					
Age Group	Amerigroup			BlueCare-East			BlueCare-West			TennCareSelect			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	52985	51691	104,676	53187	50265	103,452	46287	42377	88,664	6419	5792	12,211	42068	40114	82,182	54823	52975	107,798	40743	38762	79,505
1–4	199106	188339	387,445	192977	185510	378,487	168430	164764	333,194	40322	32538	72,860	159201	153388	312,589	197801	190635	388,436	158250	155487	313,737
5–9	194451	191200	385,651	199821	192685	392,506	173961	174650	348,611	70661	41615	112,276	174398	168559	342,957	197611	191975	389,586	158628	156629	315,257
10–14	160224	156101	316,325	167681	162979	330,660	147541	148457	295,998	81921	45441	127,362	146861	146637	293,498	157087	152520	309,607	133737	134825	268,562
15–17	78040	81433	159,473	90841	90147	180,988	75469	78589	154,058	63804	35937	99,741	74219	76367	150,586	76819	73733	150,552	70940	75066	146,006
18–19	44099	60649	104,748	47286	61109	108,395	43128	55316	98,444	39886	22060	61,946	44442	55000	99,442	42803	51764	94,567	42755	58550	101,305
0–19 Subtotal	**728,905**	**729,413**	**1,458,318**	**751,793**	**742,695**	**1,494,488**	**654,816**	**664,153**	**1,318,969**	**303,013**	**183,383**	**486,396**	**641,189**	**640,065**	**1,281,254**	**726,944**	**713,602**	**1,440,546**	**605,053**	**619,319**	**1,224,372**
0–19 Subtotal %	**77.81%**	**58.73%**	**66.94%**	**75.79%**	**54.08%**	**63.19%**	**82.96%**	**55.70%**	**66.56%**	**93.80%**	**92.13%**	**93.16%**	**70.79%**	**55.01%**	**61.92%**	**77.46%**	**56.15%**	**65.20%**	**78.03%**	**55.65%**	**64.84%**
20–24	43076	119570	162,646	39232	131342	170,574	31358	119736	151,094	14455	9210	23,665	44962	101574	146,536	38947	119359	158,306	39592	117914	157,506
25–29	25828	102153	127,981	33649	121526	155,175	17520	112550	130,070	1013	860	1,873	24624	84089	108,713	27141	112533	139,674	14523	92107	106,630
30–34	27361	89738	117,099	34737	103072	137,809	15761	96549	112,310	883	867	1,750	29105	83214	112,319	29777	95783	125,560	16840	83464	100,304
35–39	23998	67146	91,144	29723	80352	110,075	13853	65704	79,557	598	874	1,472	29191	66177	95,368	24911	70552	95,463	16331	61793	78,124
40–44	20797	44813	65,610	25613	56753	82,366	11269	43364	54,633	785	811	1,596	27864	48176	76,040	21914	48043	69,957	15105	42332	57,437
20–44 Subtotal	**141,060**	**423,420**	**564,480**	**162,954**	**493,045**	**655,999**	**89,761**	**437,903**	**527,664**	**17,734**	**12,622**	**30,356**	**155,746**	**383,230**	**538,976**	**142,690**	**446,270**	**588,960**	**102,391**	**397,610**	**500,001**
20–44 Subtotal %	**15.06%**	**34.10%**	**25.91%**	**16.43%**	**35.90%**	**27.74%**	**11.37%**	**36.73%**	**26.63%**	**5.49%**	**6.34%**	**5.81%**	**17.19%**	**32.94%**	**26.05%**	**15.20%**	**35.11%**	**26.66%**	**13.21%**	**35.73%**	**26.48%**
45–49	19671	31322	50,993	23641	45244	68,885	11436	30901	42,337	632	924	1,556	27047	37679	64,726	20432	34549	54,981	16207	29193	45,400
50–54	18547	24025	42,572	20873	34883	55,756	12343	23919	36,262	711	820	1,531	28989	32190	61,179	16674	27050	43,724	18141	24438	42,579
55–59	16205	18103	34,308	17389	28642	46,031	11782	18557	30,339	583	687	1,270	25829	26926	52,755	14914	19997	34,911	17734	18162	35,896
60–64	10517	12614	23,131	12665	23155	35,820	7724	13519	21,243	288	442	730	15554	20139	35,693	9915	15751	25,666	10732	12502	23,234
45–64 Subtotal	**64,940**	**86,064**	**151,004**	**74,568**	**131,924**	**206,492**	**43,285**	**86,896**	**130,181**	**2,214**	**2,873**	**5,087**	**97,419**	**116,934**	**214,353**	**61,935**	**97,347**	**159,282**	**62,814**	**84,295**	**147,109**
45–64 Subtotal %	**6.93%**	**6.93%**	**6.93%**	**7.52%**	**9.61%**	**8.73%**	**5.48%**	**7.29%**	**6.57%**	**0.69%**	**1.44%**	**0.97%**	**10.75%**	**10.05%**	**10.36%**	**6.60%**	**7.66%**	**7.21%**	**8.10%**	**7.57%**	**7.79%**
65–69	787	921	1,708	1050	1786	2,836	528	1280	1,808	35	122	157	5057	7773	12,830	3118	4775	7,893	2528	4088	6,616
70–74	316	422	738	335	412	747	180	352	532	16	23	39	2925	5681	8,606	1634	3000	4,634	1411	2879	4,290
75–79	263	445	708	361	572	933	182	354	536	14	19	33	1617	4117	5,734	1155	2196	3,351	629	1749	2,378
80–84	280	494	774	349	770	1,119	175	403	578	12	1	13	1025	2692	3,717	632	1715	2,347	316	1245	1,561
85–89	138	390	528	317	907	1,224	270	535	805	0	1	1	580	1880	2,460	291	1220	1,511	164	852	1,016
≥90	106	306	412	228	1109	1,337	137	409	546	0	2	2	266	1177	1,443	119	769	888	71	849	920
≥65 Subtotal	**1,890**	**2,978**	**4,868**	**2,640**	**5,556**	**8,196**	**1,472**	**3,333**	**4,805**	**77**	**168**	**245**	**11,470**	**23,320**	**34,790**	**6,949**	**13,675**	**20,624**	**5,119**	**11,662**	**16,781**
≥65 Subtotal: %	**0.20%**	**0.24%**	**0.22%**	**0.27%**	**0.40%**	**0.35%**	**0.19%**	**0.28%**	**0.24%**	**0.02%**	**0.08%**	**0.05%**	**1.27%**	**2.00%**	**1.68%**	**0.74%**	**1.08%**	**0.93%**	**0.66%**	**1.05%**	**0.89%**
Total	**936,795**	**1,241,875**	**2,178,670**	**991,955**	**1,373,220**	**2,365,175**	**789,334**	**1,192,285**	**1,981,619**	**323,038**	**199,046**	**522,084**	**905,824**	**1,163,549**	**2,069,373**	**938,518**	**1,270,894**	**2,209,412**	**775,377**	**1,112,886**	**1,888,263**

ATTACHMENT F

QUALITY IMPROVEMENT STRATEGY

STATE OF TENNESSEE

BUREAU OF TENNCARE

2012

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY

And

Quality Strategy: Annual Update Report

Contents

Acronyms and Initialisms

ADHD	Attention Deficit Hyperactivity Disorder
ANA	Annual Network Adequacy and Benefit Delivery Review
AQS	Annual Quality Survey
ASH	Abortion, Sterilization, Hysterectomy
BCBST	BlueCross BlueShield of Tennessee
BHO	Behavioral Health Organization
CAD	Coronary Artery Disease
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CFR	Code of Federal Regulations
CHCS	Center for Health Care Strategies
CHF	Congestive Heart Failure
CLIA	Clinical Laboratory Improvement Amendments
CM	Case Management
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
COTS	Commercial Off-the-Shelf
CQM	Clinical Quality Measure
CRA	Contractor Risk Agreement
DBM	Dental Benefits Manager
DHS	Department of Human Services
DM	Disease Management
DUR	Drug Utilization Review
ED	Emergency Department
EDS	Electronic Data Systems
EH	Eligible Hospital
EHR	Electronic Health Record
EP	Eligible Professional
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
F/EA	Fiscal/Employer Agent
HCBS	Home and Community-Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HSAG	Health Services Advisory Group
ICD	International Classification of Diseases
ICF-MR	Intermediate Care Facility for the Mentally Retarded
LDL-C	Low-Density Lipoprotein Cholesterol
LEIE	List of Excluded Individuals and Entities
LEP	Limited English Proficiency
LOC	Level of Care
LTC	Long Term Care
LTSS	Long Term Services and Supports

MAC	Maximum Allowable Cost
MAR	Management and Administrative Reporting
MCC	Managed Care Contractor
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
MMR	Measles, Mumps and Rubella
MRR	Medical Record Review
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NF	Nursing Facility
NPI	National Provider Identifier
NQF	National Quality Forum
OIG	Office of Inspector General
PA	Performance Activity or Prior Authorization
PAC	Pharmacy Advisory Committee
PAE	Pre-Admission Evaluation
PBM	Pharmacy Benefits Manager
PCP	Primary Care Provider
PCS	Procedural Coding System
PDL	Preferred Drug List
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PMV	Performance Measure Validation
POS	Point of Sale
ProDUR	Prospective Drug Utilization Review
QI	Quality Improvement
QM/QI	Quality Management/Quality Improvement
QP	Quality Process
RFP	Request for Proposal
RTF	Residential Treatment Facility
SED	Serious Emotional Disturbance
SPMI	Serious and Persistent Mental Illness
SSI	Supplemental Security Income
TBI	Tennessee Bureau of Investigation
TCMIS	TennCare Management Information System
TDCI	Tennessee Department of Commerce and Insurance
TDOH	Tennessee Department of Health
UM	Utilization Management
VOB	Verification of Benefits
VSHP	Volunteer State Health Plan

I. Introduction

I.A Overview

Driver for Implementation of Managed Care

The purpose of Tennessee's managed care program, TennCare, is demonstrating 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 the Managed Care Program

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

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

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

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

When TennCare II began, several MCOs were either leaving the program or at risk of leaving the program, due to their inability to maintain financial viability. A Stabilization Plan was introduced under TennCare II whereby the MCOs were temporarily removed from risk. Pharmacy benefits and dental benefits were carved out of the MCO scope of services, and new single benefit managers were selected for those services. Enrollment of demonstration eligibles was sharply curtailed, with new enrollment

being open only to uninsurable persons with incomes below poverty and "Medicaid rollovers," persons losing Medicaid eligibility who met the criteria for the demonstration population.

In 2004, in the face of projections that TennCare 's growth would soon make it impossible for the state to meet its obligations in other critical areas, Governor Phil Bredesen proposed a TennCare Reform package to accomplish goals such as "rightsizing" program enrollment and reducing the dramatic growth in pharmacy spending. With approval from the Centers for Medicare & Medicaid Services (CMS), the state began implementing these modifications in 2005.

On October 5, 2007, the waiver for the TennCare II extension was approved for three additional years. The TennCare II extension made additional revisions in the program, one of which was to require that children in the demonstration population who have incomes below 200 percent of poverty be classified as Title XXI children. The extension also mandated a new cap on supplemental payments to hospitals.

The integration of behavioral health into the managed care model evolved from the TennCare 1 waiver. In 1996, Behavioral Health services were carved out and the Partner's program was established whereby Behavioral Health Organizations (BHOs) contracted directly with the Bureau of TennCare to manage behavioral health services. A primary focus of the carve-out was to provide services for the priority population; a group that included adults with serious and persistent mental illness (SPMI) and children with serious emotional disturbance (SED). The Bureau began integrating behavioral and medical health care delivery for Middle Tennessee members in 2007 with the implementation of two expanded MCOs. TennCare continued the process with the implementation of new MCO contracts in West Tennessee in November 2008 and East Tennessee in January 2009. The transferring of behavioral health services to Volunteer State Health Plan of Tennessee for TennCare*Select* members completed the Bureau's phased-in implementation of a fully integrated service delivery system that works with health care providers, including doctors, and hospitals, to ensure that TennCare members receive all of their medical and behavioral services in a coordinated and cost –effective manner.

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

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

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

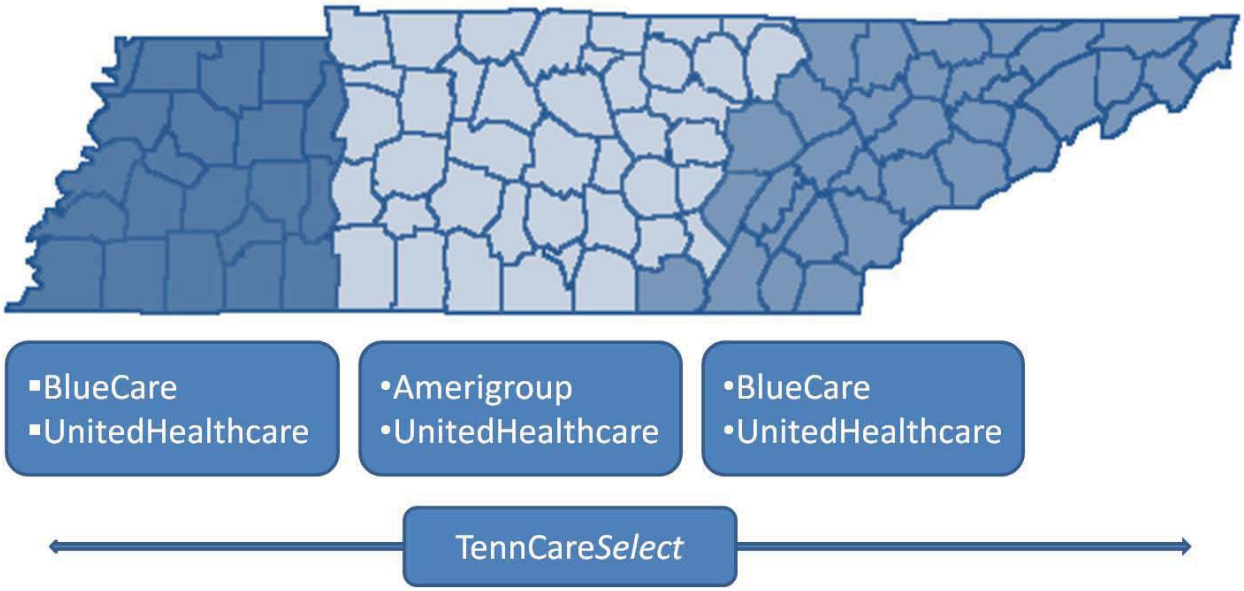
MCO Contracting and Turnover Experience

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

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

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

TennCare MCOs by Grand Region



Dental Benefits Manager

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 DBM. Delta Dental of Tennessee, operating as "TennDent", 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 TennDent's 2012 proposed Early and Periodic Screening, Diagnosis, and Treatment (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
- Training of Non-Traditional Providers
- Dental Screening Program
- Member Mailings (annual reminder notices, annual Member Handbook, quarterly Member Newsletter) and Education
- Rural County Targeted Outreach
- Preconception/ Prenatal Oral Health Care and Coordination
- Teens
- "See Your Dentist" Reminder Pad
- Dental Health Month

Pharmacy Benefits Manager

Since October 1, 2008, TennCare's pharmacy benefits have been managed by SXC Health Solutions. The 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 Health Solutions 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 Health Solutions 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 (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 Revised Federal Consent Decree 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 Health Solutions 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 eligibles are enrolled in TennCare, including those who are dually eligible for TennCare and Medicare. There are approximately 1.2 million persons currently enrolled in TennCare. There are several mechanisms for TennCare eligibility.

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

- Children under age twenty-one (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 the child 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 receive a Social Security check
- People who live in a nursing home and have income below $2,022 per month (300% of SSI benefit), or receive other long-term care services that TennCare pays for

TennCare Standard is only available for children under age nineteen (19) who are already enrolled in TennCare Medicaid and:

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

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

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

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

TennCare Standard Spend Down is limited to adults who are currently enrolled in Standard Spend Down and meet the following criteria:

- Aged (aged sixty –five (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 thirty (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, with CHOICES Group 3 beginning this calendar year:

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

- CHOICES Group 2 is for individuals who meet the NF Level of Care (LOC) and are receiving Home and Community-Based Services (HCBS) as an alternative to NF care. Those in CHOICES 2 may be enrolled in either TennCare Medicaid, if they are SSI-eligible, or 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 implemented CHOICES Group 3 on July 1, 2012.
    - 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 (CHCS) for its statewide implementation of the new TennCare CHOICES Long Term Services and Supports program. In its report *Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services*, CHCS identified Tennessee as one of five innovative states with demonstrated expertise in managed care approaches to long-term care. Tennessee, along with Arizona, Hawaii, Texas and Wisconsin, 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.

Process to Obtain Public Input on Strategy

The Quality Strategy is available on TennCare's Web site. When the Quality Strategy is updated, TennCare will notify MCCs, providers, and advocacy groups that an updated Quality Strategy has been 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 are encouraged.

I.B Strategy Goals and Objectives

Four (4) primary goals for TennCare enrollees shape the Quality Strategy. Assuring appropriate access to care, providing quality care, and assuring satisfaction with services are processes that ultimately contribute to the fourth goal: improving health care.

Goal 1*: Assure appropriate access to care.*

Goal 2: *Provide quality care.*

Goal 3: *Assure satisfaction with services.*

Goal 4: *Improve health care.*

These four (4) goals and their associated objectives align with two (2) of the three (3) aims of the National Quality Strategy:

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

Better care that is accessible and reliable is captured by TennCare's goal of access to care, while the goal of quality of care relates to not only the safety of care, but its patient-centeredness. TennCare's goal of satisfaction with care also focuses on care that is patient-centered. The healthy people and communities aim is supported not only by TennCare's goal of improving health care, but the structure of its approach—integrated physical and behavioral health care.

Progress toward these four (4) goals is gauged by physical and behavioral health performance measures implemented in 2007. These objectives are drawn from nationally recognized and respected measure sets. Many of the strategy objectives are statewide weighted Healthcare Effectiveness Data and Information Set (HEDIS) rates or statewide average Consumer Assessment of Healthcare Providers and Systems (CAHPS) rates. The MCOs annually complete and submit all applicable HEDIS measures designated by NCQA as relevant to Medicaid. The MCOs are required to contract with an NCQA-certified HEDIS auditor to validate the processes of the health plan in accordance with NCQA requirements. In addition, MCOs annually conduct CAHPS surveys (adult survey, child survey and children with chronic conditions survey) using an NCQA-certified CAHPS survey vendor.

Since the CHOICES population is integrated into TennCare's managed care structure, progress towards the four (4) primary goals set forth in the Quality Strategy is also assessed using the Long Term Services and Supports sub-assurances and associated performance measures. 2011 served as the baseline year for these performance measures. TennCare continues to assess processes and performance and will report data to CMS as it becomes available.

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

Physical 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	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*

Goal	Objective	Additional Information
	HEDIS rate for breast cancer screening will increase to 48%.	*Analysis of Audited Results from TennCare Managed Care Organizations (MCOs)*.
	2.4 By 2013, the statewide weighted HEDIS rate for cervical cancer screening will increase to 65%.	Data source: *A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs)*.
	2.5 By 2013, providers of EPSDT screening services will document the delivery of 95% of the required seven components of an EPSDT screen.	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.	Data source: *The Impact of TennCare: A Survey of Recipients*.
	3.2 By 2013, the statewide average for adult CAHPS getting needed care-always or usually will increase to 82%.	Data source: *A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs)*.
	3.3 By 2013, the statewide average for child CAHPS getting care quickly-always or usually will increase to 81%.	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.	Data source: *A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs)*.
	4.2 By 2013, the statewide weighted HEDIS rate for controlling high blood pressure will increase to 55%.	Data source: *A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs)*.
	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.	Data source: *A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs)*.
	4.4 By the end of each	Data source: *CMS-416.*

Goal	Objective	Additional Information
	demonstration year, the state will achieve a total statewide EPSDT screening rate of at least 80%. 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 Services and Supports

The table below discusses the CHOICES 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 Pre-Admission Evaluation (PAE) (i.e., nursing facility level of care eligibility determination) prior to enrollment in CHOICES and receipt of Medicaid-reimbursed HCBS.	Data Source: Medicaid Management Information Systems (MMIS) report Sampling Approach: 100% of all CHOICES Group 2 members enrolled Frequency: Quarterly Remediation: TennCare is responsible for quarterly reports and review/ analysis of data, as well as remediation of

Assurance	Sub-Assurance	Performance Measure	Additional Information
			individual findings.
Service Plan	2. CHOICES members are offered a 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 April and October Remediation: TennCare is responsible for semi-annual member record review and review/ analysis of data. MCOs will be responsible for remediation of individual findings with review/

Assurance	Sub-Assurance	Performance Measure	Additional Information
			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 October Remediation: TennCare is responsible for annual member record review and review/ analysis of data. MCOs will be responsible for remediation of individual findings with review/ validation by TennCare.

Assurance	Sub-Assurance	Performance Measure	Additional Information
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 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 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 percent (95%) confidence interval. Any records used previously in a semi-annual audit will be excluded. Frequency: Annually in October Remediation: TennCare is responsible for annual member record review and review/analysis of data. MCOs will be responsible for remediation of individual findings with review/validation by TennCare.

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
Participant Rights	7. CHOICES members are informed of and afforded the right to request a Fair Hearing when services are denied, reduced, suspended or terminated.	7. 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 April and October Remediation: TennCare is responsible for semi-annual record review and review/ analysis of data. MCOs will be responsible for remediation of individual findings with review/ validation by TennCare.

Data Sources

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

Using individual MCO results, the External Quality Review Organization (EQRO) calculates the statewide weighted HEDIS rates and the statewide CAHPS averages in the annual *HEDIS/CAHPS Report: A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs)*.

The Impact of TennCare: A Survey of Recipients

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

EPSDT Medical Record Review

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

CMS-416 Report

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

MMIS Report

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

CHOICES Record Review

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

II. Assessment

II.A Quality and Appropriateness of Care

Use of Demographic Data

TennCare identifies the race, ethnicity, and primary language spoken of its enrollees upon application. Eligibility for TennCare and other Medicaid programs is determined by the Department of Human Services (DHS). All ninety-five (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 CRA § 2.23.5. The requirements state that the MCOs must receive, process and update enrollment files sent daily by TennCare and the MCOs must update eligibility/enrollment databases within twenty-four (24) hours of receipt of enrollment files.

TennCare uses information about language and need for an interpreter to identify those Limited English Proficiency (LEP) groups constituting five percent (5%) of the TennCare population or one-thousand (1,000) enrollees, whichever is less. In CRA § 2.17.2.5, the contract with the MCOs requires that all vital documents be translated and available to the LEP groups identified by TennCare within 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 CRA § 2.18.2.

The contracts require that member materials such as the member handbook and the quarterly member newsletter contain statements on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free in CRA § 2.17.4.5.23 and 2.17.5.3.2.

Use of the EQRO Technical Report

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 DBM. The three federally mandated activities – performed by the EQRO for TennCare – are: validation of performance measures (PMVs); validation of performance improvement projects (PIPs); and monitoring compliance with federal and state standards. Qsource, TennCare's current 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 included CHOICES standards and file reviews.

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.

As mandated by Title 42 Code of Federal Regulations (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.

Performance Standards

Two of the Quality Strategy goals and objectives are associated with sanctions for MCOs that do not meet a threshold level of performance.

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 eighty percent (80%)	Attachment VII-Performance Standards CMS-416 TENNderCare screening ratio (calculated quarterly by TennCare)	Equal to or greater than eighty percent (80%)	$5,000 for each full percentage point the ratio is below eighty percent (80%) 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 eighty percent (80%).

Strategy Objective	Performance Measure	Benchmark	Sanction
2.5 By 2013, providers of EPSDT screening services will document the delivery of ninety-five percent (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	Corrective Action Plan 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 Corrective Action Plan (CAP) to TennCare.

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 non-performance.

Federal Requirements: 42 CFR § 438.206 Availability of Services		
State Standards	**State Monitoring**	**MCO Sanctions**
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. CRA Attachment III addresses general access standards and Attachment IV addresses specialty network standards. Attachment V addresses access and availability for behavioral health services.	2.30.8 requires the MCOs to submit provider network reports including, but not limited to: monthly Provider Enrollment File, annual Provider Compliance with Access Requirements, quarterly Primary Care Provider (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. 2.30.13 requires the MCOs to submit customer service reports including, but not limited to: quarterly Member Services and Provider Services Phone Line Report; quarterly 24/7 Nurse Triage Line Report; quarterly ED Assistance Tracking Report; Provider Satisfaction Survey Report and CHOICES Provider Satisfaction Survey Report; and quarterly Translation/	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.8 - 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 maintain provider agreements in accordance with Section 2.12 and Attachment XI of the contract.

	Interpretation Services Report.	
	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, specialist provider network, CHOICES HCBS provider network, provider participation accuracy, provider information 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.
	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 TennCare during readiness review and/or during operations: 57. Member services phone line policies and procedures that ensure compliance with Section 2.18.1. 58. Policies and procedures regarding interpreter and translation services that ensure compliance with Section 2.18.2. 60. Description of 24/7 Emergency Department (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 CAP for any element not meeting one hundred percent (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	4.20.2.2.7 B.4 – Liquidated damages can be assessed

	Accreditation Survey. For specific Information, see Attachment A: State Requirements Deemed Met by NCQA Accreditation Survey- Availability of Services.	for failure to submit NCQA Accreditation Report within 10 days of receipt.

Federal Requirements: 42 CFR § 438.208 Coordination and Continuity of Care		
State Standards	**State Monitoring**	**MCO Sanctions**
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, 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.	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 CHOICES HCBS Late and Missed Visits Report, quarterly Consumer Direction of HCBS Report, and quarterly CHOICES Care Coordination 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 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 care services that ensure compliance with Section 2.9.9. 20. Policies and procedures for coordination among behavioral health providers that ensure compliance with Section 2.9.10. 21. Policies and procedures for coordination of pharmacy services that ensure compliance with Section 2.9.11. 22. Policies and procedures for coordination of dental services that ensure compliance with Section 2.9.12. 25. Policies and procedures for inter-agency coordination that ensure compliance with Section 2.9.15.	
	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 CAP for any element not meeting 100% compliance.
	Some of these requirements	4.20.2.2.7 B.4 – Liquidated

	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.	damages can be assessed for failure to submit the NCQA Accreditation Report within 10 days of receipt.

Federal Requirements: 42 CFR § 438.210 Coverage and Authorization of Services		
State Standards	**State Monitoring**	**MCO Sanctions**
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	2.30.4 requires the MCOs to submit specialized service reports including, but not limited to: quarterly Psychiatric Hospital/Residential Treatment Facility (RTF) Readmission Report, , quarterly Post-Discharge Services Report, quarterly Behavioral Health Crisis Response 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. 2.30.11 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; quarterly Cost and Utilization Summaries; monthly CHOICES	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.

utilization management (UM) in 2.14. This 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.	Utilization 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. 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	4.20.2.2.7 B.4 – Liquidated damages can be assessed for failure to submit the NCQA Accreditation Report within 10 days of receipt.

	Services.	

Structure and Operations

Federal Requirements: 42 CFR § 438.214 Provider Selection		
State Standards	**State Monitoring**	**MCO Sanctions**
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 that ensure compliance with Section 2.11.8.
	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.	

Federal Requirements: 42 CFR § 438.218 Enrollee Information		
State Standards	**State Monitoring**	**MCO Sanctions**
The contracts with the MCOs contain requirements for member materials in section 2.17. This section addresses: prior approval process for all member materials; written material guidelines; distribution of member materials; member handbooks; quarterly member	2.17.1.1 requires the MCOs to submit to TennCare for review and prior written approval all materials that will be distributed to members. This includes but is not limited to member handbooks, provider	4.20.2.2.7 B.7 - Liquidated damages can be assessed for failure to obtain approval of member materials as required by Section 2.17. B. 8 – Liquidated damages

newsletter; identification card; CHOICES member materials; provider directories; additional information available upon request.	directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, member education and outreach activities.	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 CAP for any element not meeting one hundred percent (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-Enrollee Information.	4.20.2.2.7 B.4 – Liquidated damages can be assessed for failure to submit the NCQA Accreditation Report within 10 days of receipt.

Federal Requirements: 42 CFR § 438.224 Confidentiality		
State Standards	**State Monitoring**	**MCO Sanctions**

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.	2.30.21 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, 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: 92. HIPAA policies and procedures that ensure compliance with Section 2.27.	
	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-Confidentiality.	4.20.2.2.7 B.4 Liquidated damages can be assessed for failure to submit the NCQA Accreditation Report within 10 days of receipt.

Federal Requirements: 42 CFR § 438.226 Enrollment and Disenrollment		
State Standards	**State Monitoring**	**MCO Sanctions**

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 an MCO; unacceptable reasons for disenrollment from an MCO; informing TennCare of potential ineligibility; and effective date of disenrollment from an 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: 42 CFR § 438.228 Grievance Systems - Complaints		
State Standards	**State Monitoring**	**MCO Sanctions**
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.	2.30.14 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: 69. 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 CAP for any element not meeting one hundred percent (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.

Federal Requirements: 42 CFR § 438.228 Grievance Systems - Appeals		
State Standards	**State Monitoring**	**MCO Sanctions**
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: 69. 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 CAP for any element not meeting one hundred percent (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.

Federal Requirements: 42 CFR § 438.230 Subcontractural Relationships and Delegation		
State Standards	**State Monitoring**	**MCO Sanctions**
The contracts with the MCOs contain subcontract requirements in section 2.26 and address 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 (F/EA), standards, quality of care, interpretation/translation services and LEP provisions, children in state custody, assignability, claims 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 the 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 to provide quality care to enrollees, assure enrollees' satisfaction with services and 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 non-performance.

<table>
<tr><th colspan="3">Federal Requirements: 42 CFR § 438.236 Practice Guidelines</th></tr>
<tr><th>State Standards</th><th>State Monitoring</th><th>MCO Sanctions</th></tr>
<tr><td rowspan="3">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 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 2.8.7.3 , 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.</td><td>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.</td><td>4.20.2.1.1 – Liquidated damages can be assessed for each day that a report or deliverable is late, incorrect, or deficient.</td></tr>
<tr><td>Some of these requirements are evaluated as part of the Annual Quality Survey (AQS)[iii], an EQRO mandatory activity.</td><td>TennCare requires that each MCC submit a CAP for any element not meeting one hundred percent (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.</td></tr>
<tr><td>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-Practice Guidelines.</td><td>4.20.2.2.7 B.4 – Liquidated damages can be assessed for failure to submit NCQA Accreditation Report within 10 days of receipt.</td></tr>
</table>

Federal Requirements: 42 CFR § 438.240 Quality Assessment and Performance Improvement Program - 42 CFR 438.240(a)		
State Standards	**State Monitoring**	**MCO Sanctions**
The contracts with the MCOs address	2.30.12 .1 requires the MCOs	4.20.2.1.1 – Liquidated

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 Health Plans. 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.	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.	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 CAP for any element not meeting one hundred percent (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-Program.	4.20.2.2.7 B.4 – Liquidated damages can be assessed for failure to submit the NCQA Accreditation Report within 10 days of receipt.

Federal Requirements: 42 CFR § 438.240(c) Performance Measurement		
State Standards	**State Monitoring**	**MCO Sanctions**
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	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

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.		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 conditions survey. The MCO is required to enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys.	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 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.	

Federal Requirements: 42 CFR § 438.240(d) Performance Improvement Projects		
State Standards	**State Monitoring**	**MCO Sanctions**
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 nonclinical PIPs must be in the area of long-term care.	2.30.12 .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.	

Federal Requirements: 42 CFR § 438.242 Health Information Systems		
State Standards	**State Monitoring**	**MCO Sanctions**

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 (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.	2.30.18 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.

[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 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 MCOs and the 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 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 AQS of each MCO and the DBM. The purpose of the AQS is to determine the extent to which each TennCare MCC is in compliance with the TennCare 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 § 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 Systems

The TennCare Management Information System (TCMIS) supports the operation of TennCare and supports evaluation of progress toward targets for quality strategy objectives. Since 2009, TennCare has contracted with HP Enterprise Services for operation and enhancement of TCMIS.

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 eighty percent (80%).

The current contract with HP Enterprise Services requires specific assessments of the TCMIS. The required assessments include Management and Administrative Reporting (MAR) review and International Classification of Diseases (ICD) version10 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**– 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** - 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.

Health Information Technology

Tennessee continues to advance the adoption and use of electronic health records (EHRs) to drive improvements in patient healthcare outcomes. Advancements in health information technology (HIT) 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 is necessary to build Tennessee's health care delivery foundation to improve both individual and population health. The Office of eHealth Initiatives, in the Tennessee Department of Health Care Finance and Administration, is the coordinating authority for HIT in Tennessee and provides leadership, guidance, and operational support for eHealth efforts throughout the state. TennCare promotes the use of HIT at the provider level, and the Tennessee Department of Health (TDOH) coordinates public health reporting.

TennCare continues to achieve significant progress in implementing the Medicaid side of the federal Electronic Health Record (EHR) Incentive Program and facilitating provider participation in this quality improvement initiative. The EHR Incentive Program encourages the adoption and meaningful use of certified EHR technology by eligible professionals (EPs) and eligible hospitals (EHs). EHRs have the potential to systematically improve healthcare access, delivery, and quality, and the meaningful use measures are designed to both encourage and reflect these improvements. Providers earn financial incentives across one to five (Medicare) or six (Medicaid) years for adopting an EHR and demonstrating meaningful use of certified EHR technology. As of May 2012, 1710 Medicaid EPs and EHs and 1079 Medicare EPs and EHs had earned payments for successfully following the program guidelines.

As TennCare promotes successful participation in the EHR program, quality improvements across multiple sectors are anticipated. Meaningful Use guides use of certified EHR technology in a way that is informed, relevant, and responsible. TennCare is committed to promoting this program as it focuses providers on individual quality improvement, establishes processes for quality improvement, identifies quality improvement mechanisms through functions such as clinical decision support, and ultimately offers ways to measure quality improvement through the clinical quality measures (CQMs) as well as other functionality. The National Quality Forum (NQF)-endorsed CQMs will allow individual providers to calculate and review their activities in alignment with best practices, with that data available to the state to measure and facilitate improvements in population and public health. One of the core CQMs that every participant must report is NQF 0013, the percentage of patients with a diagnosis of hypertension who have blood pressure recorded. This measure will reflect well on Objective 4.2, increasing the statewide weighted HEDIS rate for controlling high blood pressure to 55%, while the alternate core CQM on Childhood Immunization Status aligns with Objectives 2.5 and 4.4 regarding EPSDT components and screening rates.

Measurable improvements in quality, safety, efficiency, and reducing health disparities will result from meaningful use criteria that integrate patient information into the EHR. Mandatory drug-formulary checks will enable better prescribing practices while the incorporation of clinical lab test results as structured data will improve patient safety and reduce redundant lab work. Participating hospitals are

required to record advance directives for patients sixty-five (65) and older. In Stage 1, providers can select the menu measure to send reminders to patients for preventive and follow-up care.

Furthermore, the foundation of meaningful use supports appropriate integration of health information technology into a practice's workflow, including engaging patients and families in their healthcare and maintaining privacy and security. For example, providers must give more than fifty percent (50%) of their patients seen during the EHR reporting period clinical summaries for each office visit. Certified EHR technology can be configured to identify patient-specific education resources based on patient characteristics. Providers may also opt to provide patients with electronic access to their health information, while all this information is stored in a system for which a security risk analysis has been performed and updates implemented.

Additionally, care coordination will be systematically improved. Participating EPs are establishing methods for the exchange of key clinical information and choosing to perform medication reconciliation and provide summaries of care for patients received and referred, respectively. The data on patients captured in Stage 1 Meaningful Use will populate the continuity of care documents to be a touchstone of future care coordination efforts. .

As with TennCare's Quality Strategy, these processes will ultimately improve population and public health, and additional meaningful use measures have been established to ensure EHR use contributes to public health reporting. Submitting data to immunization registries is a key feature of meaningful use, and TennCare collaborates with TDOH on this measure. TDOH works with EPs and EHs to successfully submit data, and they also receive reportable lab results from EHs.

III. Improvement/Interventions

Implementation of Interventions by the State Specific to the Strategy Objectives

TennCare has implemented a number of interventions to support the four goals of the TennCare Quality Strategy: assure appropriate access to care, provide quality care, assure enrollee satisfaction with services, and improve health care. TennCare monitors health plan activities through contractual requirements and associated deliverables, NCQA accreditation, EQRO assessments, audits and desk reviews, collaborative workgroups, site visits and other activities.

NCQA Health Plan Accreditation

TennCare MCOs are contractually required to achieve and maintain NCQA accreditation. Per CFR § 438.360, TennCare uses information obtained from the NCQA accreditation review for the oversight of the managed care plans. NCQA utilizes leading experts, advisory committees, and input from federal and state agencies to guide the review of the current NCQA accreditation requirements. Every accreditation cycle, TennCare partners with NCQA to develop a state-specific scoring guide for the MCOs based on additional state requirements, the CRA, and federal consent decrees.

The table below displays the NCQA Health Plan Report Card as of May 31, 2012, for TennCare MCOs. Health plans can receive a maximum of four (4) stars in each category: Access and Service, Qualified Providers, Staying Healthy, Getting Better, and Living with Illness. TennCare MCOs undergo accreditation as organizations, rather than as Grand Region entities, but are required to collect and report HEDIS and CAHPS measures by Grand Region.

MCO	Access and Service	Qualified Providers	Staying Healthy	Getting Better	Living with Illness	Overall Accreditation Status
Amerigroup	★★★★	★★★★	★★	★★	★★★	Excellent
UnitedHealthcare	★★★★	★★★★	★	★★	★★	Commendable
Volunteer State Health Plan	★★★★	★★★★	★★	★★	★★★	Excellent

- *Access and Service:* NCQA evaluates how well the health plan provides its members with access to needed care and with good customer service. To evaluate these activities, NCQA reviews appeals and denial records, interviews MCO staff, and appraises CAHPS results.

- *Qualified Providers:* NCQA evaluates health plan activities that ensure each provider is licensed and trained to practice medicine and that the health plan's members are happy with their providers. NCQA uses credentialing reviews and CAHPS results to evaluate these activities.

- *Staying Healthy:* NCQA evaluates the MCOs' ability to help members maintain good health and avoid illness. To evaluate these activities, NCQA reviews health plan records, grades relevant HEDIS data and reviews materials sent to members.

- *Getting Better:* NCQA evaluates the MCOs' efforts to help members recover from illness. To evaluate these activities, NCQA reviews health plan records and interviews health plan staff.

- *Living with Illness:* NCQA evaluates health plan activities that help members manage chronic illness by grading relevant HEDIS data and interviewing health plan staff.

- *Overall Accreditation Status:* Overall Accreditation Status refers to the level of NCQA accreditation a health plan has received.

In each accreditation cycle, TennCare reviews NCQA accreditation scores and requires Corrective Action Plans for any standard in which an MCO scored less than one hundred percent (100%).

Integrated Operations

Since 2009, TennCare has operated with fully integrated physical and behavioral health care. For optimal integrated physical and behavioral health care, coordination occurs within TennCare, among MCO staff from various departments, between providers, and at a member level. Examples of this approach include the Integrated Care Workgroup between TennCare and MCO staff, MCO outreach to providers, and MCO outreach to members with co-morbid conditions.

In 2010, TennCare integrated Long Term Services and Supports into the managed care structure through the CHOICES program. Integration of this population allows TennCare to provide MCO Care Coordination for members and offers members more consumer-driven options, such as home and community-based services. *TENNderCARE*

TennCare's 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 ninety-five (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 Tennessee Department of Health participate in an MCC Collaborative. Meetings are held on a quarterly basis to identify innovative methods of providing

TENNderCare outreach to youth under the age of twenty-one (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 fifteen (15) and twenty (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 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 concluded in April 2011 with two sites completing the project: VSHP Partnership in the East region (urban site) and the Haywood County Clinic in the West region (rural site). The objective of each site was to treat patients whose medical needs did not meet the intensity of receiving emergency department services and to facilitate the relationship with PCPs. Since December 2008 through March 31, 2011, the VSHP Partnership treated a total of 16, 960 patients, of which sixty-four percent (64%) were Medicaid enrollees. Similarly, the Haywood County Clinic treated 2,329 patients, of which fifty-two percent (52%) were Medicaid enrollees. Although the grant concluded, MCOs continue to work on improving non-emergency rates.

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. For 2011, TennCare selected HEDIS measures as the basis for the quality incentives.

For East, Middle, and West MCOs, the following physical health HEDIS measures were selected:

- Adolescent Well-Care Visits.
- Breast Cancer Screening
- Controlling High Blood Pressure
- Hemoglobin A1c (HbA1c) Control
- HbA1c Testing
- Low-Density Lipoprotein Cholesterol (LDL-C) Screening

For East, Middle, and West MCOs, the following behavioral health HEDIS measures were selected:

- Antidepressant Medication Management
- Follow-Up Care for Children Prescribed ADHD Medication
- Follow-Up After Hospitalization for Mental Illness

For TennCare*Select*, the following physical health HEDIS measures were selected:

- Adolescent Well-Care Visits
- Appropriate Treatment for Children with Upper Respiratory Infection
- Childhood Immunization Status: Measles, Mumps and Rubella (MMR) Vaccination
- Children and Adolescents' Access to a PCP (ages 7-11)
- Children and Adolescents' Access to a PCP (ages 12-19)
- Well Child Visits in the 3rd, 4th, 5th and 6th Years

For TennCare*Select*, the following behavioral health HEDIS measures were selected:

- Follow-Up Care for Children Prescribed ADHD Medication
- Follow-Up After Hospitalization for Mental Illness

Amerigroup met the criteria for five (5) quality incentive payments with the following measures: Breast Cancer Screening, HbA1C Control HbA1C Testing, LDL-C Screening, and Follow-up Care for Children Prescribed ADHD Medication. UnitedHealthcare East met the criteria for one (1) quality incentive payment, Adolescent Well-Care Visits. UnitedHealthcare West met the criteria for two (2) quality incentive payments for the following measures: Adolescent Well-Care Visits and Follow-Up After Hospitalization for Mental Illness. BlueCare West met the payment criteria for one (1) quality incentive measure, Controlling High Blood Pressure. TennCare*Select* met the payment criteria for five (5) measures: Adolescent Well-Care Visits, Children and Adolescents' Access to PCP (7-11 years), Children and Adolescents' Access to PCP (12-19 years), Well Child Visits in the 3rd, 4th, 5th and 6th Years, and Follow-Up After Hospitalization for Mental Illness.

TennCare plans to continue the pay-for-performance quality incentive payment program in 2012 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 where members are considered participants, enrolled in the program upon identification of eligibility, and remain until a member actively notifies the health plan of his/her desire to opt-out. DM 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's DM program has been evolving over the past several years. TennCare is planning a restructuring of the program from a disease specific model to a Population Health model in order to better meet the population's needs, more accurately capture the interventions provided to members, and align the program with national trends.

The proposed Population Health model stratifies all TennCare members into three (3) levels of risk: No Risk, Low or Moderate Risk, and High Risk. The hierarchy encompasses seven (7) programs: Wellness, Maternity, "Opt Out" Health Risk Management, Care Coordination, and three (3) "Opt In" programs, Chronic Care Management, High Risk Pregnancy and Complex Case Management. The Population Health approach promotes interventions designed to maintain and improve members' health across the entire care continuum from low-risk, healthy individuals to high-risk individuals with one (1) or more chronic conditions. It includes elements in common with TennCare's traditional DM program, such as wellness, preventive services and health promotion, but differs in the scope of services and definitions for target populations. The proposed program addresses multiple risks and co-morbidities in a "whole-person" approach and directs interventions based on risk and lifestyle rather than disease. The approach targets the upstream causes of ill health, such as poor nutrition, physical inactivity and substance abuse, by providing proactive rather than reactive interventions. Currently TennCare is working with the MCOs to determine the data needs, barriers and time frames for implementing Population Health.

TennCare Health Plan Meetings and MCC Awards

Qsource conducts three meetings a year that are attended by TennCare and its MCCs. Each meeting is organized around a specific quality improvement 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. Annually, the Division of Quality Oversight at TennCare presents awards to MCCs and MCC staff based on performance, best practices, and outstanding initiatives. The awards are used as a benchmarking tool for MCCs recognizing program design and effectiveness.

Tennessee Department of Commerce and Insurance

The Tennessee Department of Commerce and Insurance (TDCI) operates under an inter-agency agreement with the Bureau of TennCare to review all MCOs' provider agreements to ensure the provider agreements meet the uniform requirements set forth in the CRA. When TDCI receives a provider agreement that contains clinical information or other information outside their area of expertise, a copy is sent to the Bureau of TennCare for review and comments. As a means of quality assurance, the Tennessee Comptroller's office is responsible for auditing the activities of TDCI.

Performance Improvement Projects

The MCOs are contractually required to conduct five (5) PIPs annually. The MCOs currently conduct one (1) clinical PIP, one (1) non-clinical PIP, one (1) PIP related to behavioral health, and two (2) PIPs related

to CHOICES. In addition to the requirement that one (1) PIP be validated by the EQRO, TennCare reviews and evaluates all five (5) PIPs for relevancy, completeness, and accuracy according to the CMS protocol, *Conducting Performance Improvement Projects, version 1.0.* In 2011, TennCare conducted training sessions with MCO staff to ensure that the CMS protocols were understood and followed when conducting PIPs. Corrective Action Plans were required of MCOs with deficiencies in any PIP.

Initial Core Set of Children's Health Care Quality Measures

The Children's Health Insurance Program Reauthorization Act ("CHIPRA") of 2009 required the Secretary of Health and Human Services to identify a core set of pediatric quality measures for voluntary use by State Medicaid and CHIP programs. In February of 2011, CMS released the technical specifications for this core set of twenty-four (24) measures which were selected by CMS over a two (2) year period in collaboration with the Agency for Healthcare Research and Quality (AHRQ). Fifteen (15) of the twenty-four (24) measures are NCQA HEDIS/CAHPS measures and two (2) other measures are dental utilization measures which TennCare already collects and reports annually on the CMS-416. The TennCare Healthcare Informatics Division calculated four (4) of the CHIPRA measures using available administrative data.

In March 2012, TennCare reported twenty-one (21) of the twenty-four (24) measures to CMS, excluding Developmental Screening in the First Three Years of Life, Otitis Media with Effusion—Avoidance of Inappropriate Use of Systemic Antimicrobials in Children, and Pediatric Central Line—Associated Blood Stream Infections.

In its reporting of these measures, TennCare acknowledged efforts already underway to improve the care and services associated with many of the CHIPRA measures. In particular, a maternity workgroup between TennCare and the MCOs serves as an example of an intervention related to four (4) of the measures.

IV. Strategy Effectiveness

Planned evaluations

The table below summarizes TennCare's 2012 evaluation of the strategy objectives using 2011 data. 2011 HEDIS/CAHPS results are compared to the 2011 Medicaid National Average. Change has been determined from the baseline rates according to the percentage point increase or decrease.

Evaluation of Quality Strategy Objectives				
Goals	**Objectives**	**2011 Statewide Rate**	**2011 National Average**	**Percentage Point Change from Baseline Statewide Rate to 2011 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- 80.28% b. 45-64 years old- 85.69%	a. 81.19% b. 86.04%	**a. Increase – 10.28%** **b. Increase – 11.69%**
	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 7-11 year olds; 82% for 12-19 year olds**	a. 7-11 years old- 92.80% b. 12-19 years old- 88.63%	a. 90.22% b. 88.14%	**a. Increase – 5.80% (objective met)** **b. Increase – 6.63% (objective met)**

Evaluation of Quality Strategy Objectives				
Goals	**Objectives**	**2011 Statewide Rate**	**2011 National Average**	**Percentage Point Change from Baseline Statewide Rate to 2011 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: Heads of Household- 94%; Children- 97%**	a. Heads of household- 91% b. Children- 91%	NA-Not a HEDIS/CAHPS Rate	a. 3% decrease b. 6% decrease
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%**	46.19%	48.07%	**Increase – 11.19% (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%**	83.12%	83.67%	**Increase – 5.12% (objective met)**
	2.3 By 2013, the statewide weighted HEDIS rate for breast cancer screening will increase to 50%. **Baseline 2007: 44%**	43.79%	51.35%	Decrease – 0.21%

Evaluation of Quality Strategy Objectives				
Goals	**Objectives**	**2011 Statewide Rate**	**2011 National Average**	**Percentage Point Change from Baseline Statewide Rate to 2011 Statewide Rate**
	2.4 By 2013, the statewide weighted HEDIS rate for cervical cancer screening will increase to 68%. **Baseline 2007: 63%**	67.29%	67.19%	**Increase - 4.29%**
	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%**	92.2%	NA-Not a HEDIS/CAHPS measure	**Increase – 3.2%**
3. Assure enrollees' satisfaction with services.	3.1 By 2013, 95% of TennCare enrollees will be satisfied with TennCare. **Baseline 2007: 90%**	95%	NA-Not a HEDIS/CAHPS rate	**Increase – 5% (objective met)**
	3.2 By 2013, the statewide average for adult CAHPS getting needed care-always or usually will increase to 82%. **Baseline 2007: 78%**	77.76%	75.95%	Decrease – 0.24%
	3.3 By 2013, the statewide average for child CAHPS getting care quickly-always or usually will increase to 81%. **Baseline 2007: 79%**	85.89%	79.89%	**Increase - 6.89% (objective met)**

Evaluation of Quality Strategy Objectives				
Goals	**Objectives**	**2011 Statewide Rate**	**2011 National Average**	**Percentage Point Change from Baseline Statewide Rate to 2011 Statewide Rate**
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%**	78.87%	82.03%	**Increase – 10.87% (objective met)**
	4.2 By 2013, the statewide weighted HEDIS rate for controlling high blood pressure will increase to 55%. **Baseline 2007: 50%**	52.96%	55.60%	**Increase – 2.96%**
	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- 41.52% b. 30 day- 64.79%	a. 44.56% b. 63.83%	Due to changes in MCOs, 2010 will become the baseline for this measure **a. Increase 3.59%** **b. Increase 3.55%**
	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%**	100%	Not a HEDIS/CAHPS measure	**Increase – 33% (objective met)**

Evaluation of Quality Strategy Objectives				
Goals	**Objectives**	**2011 Statewide Rate**	**2011 National Average**	**Percentage Point Change from Baseline Statewide Rate to 2011 Statewide Rate**
	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: acute phase- 50.11%; continuation phase- 32.03%**	a. Acute- 47.13% b. Continuation- 28.23%	a. 50.74% b. 34.44%	Due to changes in MCOs, 2010 will become the baseline for this measure a. Decrease 2.98% b. Decrease 3.80%
	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: initiation- 34.29%; continuation- 44.15%**	a. Initiation- 39.11% b. Continuation- 47.00%	a. 38.10% b. 43.91%	**Due to changes in MCOs, 2010 will become the baseline for this measure** **a. Increase 4.82%** **b. Increase 2.85%**

Long Term Services and Supports

The table below summarizes TennCare's 2011 baseline evaluation of the CHOICES assurances and sub-assurances. Semi-annual results were calculated in May and November 2011; however, moving forward some semi-annual performance measures will be calculated in April and October.

Evaluation of CHOICES Assurances			
Assurance	Sub-Assurance	Performance Measure	2011 Results

Evaluation of CHOICES Assurances			
Assurance	Sub-Assurance	Performance Measure	2011 Results
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 Pre-Admission Evaluation (PAE) (i.e., nursing facility level of care eligibility determination) prior to enrollment in CHOICES and receipt of Medicaid-reimbursed HCBS.	**a. Quarter 1: 100.0%** **b. Quarter 2: 100.0%** **c. Quarter 3: 100.0%** **d. Quarter 4: 100.0%**
Service Plan	2. CHOICES members are offered a 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.	**a. May 2011- 96.52%** **b. November 2011- 94.2%**
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.	**98.7%**
Qualified Providers	4. CHOICES HCBS providers meet minimum provider qualifications established by the State prior to enrollment in CHOICES and delivery of	4. Number and percent of CHOICES HCBS providers reviewed for whom the MCO provides documentation that the provider meets minimum qualifications	**100.0%**

Evaluation of CHOICES Assurances			
Assurance	Sub-Assurance	Performance Measure	2011 Results
	HCBS.	established by the State and was credentialed by the MCO in accordance with NCQA guidelines prior to enrollment in CHOICES and delivery of HCBS.	
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.	**37.2%**
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.	**a. May 2011- 47.3%** **b. November 2011- 72.0%**

Evaluation of CHOICES Assurances			
Assurance	Sub-Assurance	Performance Measure	2011 Results
Participant Rights	7. CHOICES members are informed of and afforded the right to request a Fair Hearing when services are denied, reduced, suspended or terminated.	7. 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.	**a. May 2011- 67.5%** **b. November 2011- 54.8%**

Strategy Evaluation and Revision

Annually, by April, TennCare plans to review the Quality Strategy and provide a report to CMS in July of each year that will include information on the implementation and effectiveness of the strategy. A revised strategy will also be provided whenever significant changes occur in the TennCare Program. These changes may include additional programs, new Managed Care Contractors, etc. The objectives will be reviewed and revised as needed in 2013 according to successes and priorities of TennCare. National quality initiatives and measure sets, such as the Initial Core Set of Children's Health Care Quality Measures, the Initial Core Set of Adult Health Care Quality Measures, the *National Strategy for Quality Improvement in Health Care*, the *National Healthcare Quality Report* and the *National Healthcare Disparities Report,* will inform TennCare's long term strategy.

V. Conclusions

Best Practices

Performance Measure Validation

The following MCO promising practices have been identified for 2011 by the EQRO:

- An increasingly sophisticated knowledge and a strong commitment to the HEDIS reporting process.
- The use of NCQA-certified HEDIS reporting software, ensuring compliance with measure algorithms and the accurate production of HEDIS results.
- Innovative improvements to reporting and data mining processes to ensure more accurate enrollment data.
- Implementation of new programs and processes for claims auditing, which created results for the measurement year that exceeded established CMS accuracy standards.

Performance Improvement Projects

The following elements were demonstrated in the 2011 PIPs by the EQRO:

- Well-founded study topics relevant to the member population and based on high-volume and/or high-risk conditions.
- Data analysis and interpretation based upon NCQA benchmark rates and HEDIS national measures.
- Clear and concise documentation representative of data collection processes.
- Continuous quality improvement for monitoring and modifying interventions.
- A strong commitment to improving member knowledge of medication adherence through targeted provider education.
- 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

Practices identified by the EQRO during the ANA review are:

- Adherence to the network access and availability requirements established by TennCare.
- An efficient credentialing and recredentialing process with well-organized files and easily accessible information.
- Communication of existing benefits and pertinent information via member handbooks, provider manuals, newsletters, health plan websites, and other written materials.

Annual Quality Survey

The following were identified by the EQRO during the AQS:

- *Substantial* or *Total Compliance* ratings across virtually all quality process standards and performance activities.
- Strong outreach and targeted activities, 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.
- Innovation in creation of systems designed to improve outreach to members in need of EPSDT services and/or preventive services for the adult population.

Disease and Case Management

Several MCO achievements or innovative initiatives have been identified by TennCare addressing either DM or Case Management (CM) services for enrollees:

- Amerigroup identified in 2011 almost one thousand pregnant enrollees as tobacco users. Outreach and referral to the Tobacco Quit Line was offered to these enrollees.
- Amerigroup recently implemented a change to their CM program that is more rigorous than contractual standards. All members enrolled in CM now receive a "face to face" from the designated case manager within forty-five (45) days of enrollment, if deemed appropriate.
- UnitedHealthcare has been commended for their community-based weight management interventions. The MCO has partnered with YMCA, Weight Watchers, the Hope and Healing Center in Memphis, TN, and the Coordinated School Health Program.
- Volunteer State Health Plan implemented a pilot project beginning in 2010 to embed case managers full-time in the emergency departments at LeBonheur Children's Hospital in Memphis, TN. The key objectives are of the project are to improve the quality of care that members receive, decrease emergency department utilization, decrease in-patient hospitalizations, and to increase member compliance.

Behavioral Health

Many best practices have emerged since the integration of physical and behavioral health in the TennCare structure. One of the most outstanding examples is an initiative implemented by Volunteer State Health Plan titled *Assessing and Improving Coordination of Care between Primary Care Physicians and Behavioral Health Providers.* The MCO modified its PCP Treatment Record Audit Tool to include criteria related to behavioral health and audited behavioral health providers to determine coordination with PCPs.

Ongoing Challenges for the State

The transition to the ICD-10 will prove to be a challenging endeavor for providers and TennCare MCOs. During the initial transition, providers are anticipated to spend additional time documenting more accurate patient data, clinical processes, and health outcomes. MCOs are establishing the technical capacity in order to ensure that services will be coded and billed according to the ICD-10 structure.

MCOs will be training staff and providers to ensure that TennCare enrollees continue to receive timely and quality health care.

Additional initiatives are under development that will impact the operational structure at TennCare, including a proposal for a managed care program for dual-eligibles and a reorganization of the Disease Management program to a Population Health model.

TennCare has been collaborating with the MCOs to collect accurate demographic data and will use the data to drive projects focused on disparate populations. The *National Healthcare Disparities Report* identifies that although quality of health care is improving, health care disparities are not, and TennCare will be faced with the challenge of measuring and reducing health care disparities.

Recommendations by the State for Ongoing Quality Improvement

The EQRO annually identifies areas for improvement for the State in the *EQRO Technical Report*. The findings identify that TennCare should continue to monitor health plan performance and implement the necessary corrective action requirements to ensure improvements are made to achieve compliance across all activities. TennCare should also continue to monitor MCO performance related to timeliness and access in order to identify network deficiencies.

Recommendations by the EQRO for TennCare:

- Continue the pay-for-performance quality incentive program to encourage MCOs to demonstrate significant improvement from previous reporting years for specified HEDIS measures.
- Continue to link performance measure outcomes and improvements with the *Quality Assessment and Performance Improvement Strategy* and EQR oversight activities.
- Consider expanding the MCC statewide collaborative workgroups beyond adolescent outreach and diabetes and maternity wellness.
- Evaluate the current statewide collaborative workgroups to assess outcomes and opportunities for improvement.
- Continue encouraging MCOs to provide DM education to promote member self-awareness of DM techniques.
- Continue quality initiatives and activities that target specific populations, including disabled members.
- Continue the quality initiatives that promote the successful coordination of medical-behavioral services.
- Continue to support new federal legislative and regulatory provisions.

TennCare also evaluates its performance, as well as the MCOs' performance, annually and creates recommendations for ongoing quality improvement.

Recommendations for Improvement Recognized by TennCare:

- Restructure the DM program to a Population Health model.

- Improve analysis of data and information received from MCOs and other sources, specifically data related to demographic characteristics.
- Increase staffing at the State level to allow for additional oversight of the CHOICES Care Coordination program.
- Immediately Increase collaboration between the Division of Quality Oversight, Long-Term Supports and Services, and the MCOs in improving/correcting deficiencies identified through audits of the CHOICES program.

The Quality Strategy reflects TennCare's commitment to continuous quality improvement. The document reflects TennCare's quality model, guides efforts targeting priority areas, and recognizes opportunities for improvement across populations and services. TennCare will continue to identify domains where increased integration and coordination among stakeholders will enable our program to achieve the quality goals. At the time this report was written many of the recommendations identified had already begun and will be reported in the next Quality Strategy update. The Quality Strategy is intended to be a comprehensive, cohesive document leveraged to align current and future initiatives, as well as inform changes to MCC contracts.

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

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	**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 3. Providers maintain the confidentiality of

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records. 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…	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	**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
	available in the form of 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	*CRA § 2.7.1.2-.3 (E/W, Middle and TCS)*	**UM 12A Policies and Procedures and UM 12C Organization's Authorized**

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
Coverage and Authorization of Services		**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 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.	**UM 12A Policies and Procedures** The organization's emergency services policies and procedures require coverage of emergency services in the following situations. 1. To screen and stabilize the member without prior approval, where a prudent layperson, acting 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	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)

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	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.	
	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**
	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	The organization provides interventions to members based on assessment.

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	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.	
	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**

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
		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
	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	**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
	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.	
	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	The organization has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions 2. Specifying the type of personnel

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	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.	responsible for each level of UM decision-making
	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	**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
	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.	
	CRA § 2.14.1.6 (E/W, Middle and TCS)	**UM 4E 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,	The organization: 1. Has written UM decision-making criteria that are objective and based on medical

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
	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.	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
	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-

Federal Requirements	2010 State Standards	2010 NCQA Accreditation Standards
		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**
	…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:	**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.

Federal Requirements	2010 State Standards	2010 NCQA Standards
	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	
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 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;	The organization adopts written PHI policies and procedures that address: 1. Information included in notification of privacy practices 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

Federal Requirements	2010 State Standards	2010 NCQA Standards
	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.	
	CRA § 2.27.2 and 2.27.2.8 (E/W, Middle and TCS)	**RR 6C Authorization**
	In accordance with HIPAA regulations, the CONTRACTOR shall, at a minimum: Make available to TENNCARE enrollees the right to amend their PHI data in accordance with the federal HIPAA regulations. The CONTRACTOR shall also send information to enrollees educating them of their rights and necessary steps in this regard.	The organization has policies and procedures that address members' right to authorize or deny the release of PHI beyond uses for treatment, payment or health care operations.
	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

Federal Requirements	2010 State Standards	2010 NCQA Standards
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 delegated.	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.
	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,	For delegation arrangements in effect for 12 months or longer, the organization annually evaluated delegate performance against NCQA standards for delegated activities.

Federal Requirements	2010 State Standards	2010 NCQA Standards
	consistent with NCQA standards and state MCO laws and regulations.	
	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	The organization ensures that practitioners are using relevant clinical practice guidelines by: 3. Updating the guidelines at least every two years

Federal Requirements	2010 State Standards	2010 NCQA Standards
	(2) years or whenever the guidelines change.	
	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 providers' adherence to the guidelines in order to improve the members' conditions.	The organization ensures that practitioners are using relevant clinical practice guidelines by: 4. Distributing the guidelines to the appropriate practitioners.
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:	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

Federal Requirements	2010 State Standards	2010 NCQA Standards
	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 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…	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
	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	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

Federal Requirements	2010 State Standards	2010 NCQA Standards
	approve the QM/QI program description and associated work plan prior to submission to TENNCARE…	
	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 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 network-wide safe clinical practices

[vii] Based on the 2011 NCQA Standards and Guidelines for the Accreditation of Health Plans and the Contractor Risk Agreements dated January 1, 2012. The "CONTRACTOR" refers to the Managed Care Organization who has entered into agreement with the Bureau of TennCare.