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2020 Annual EQRO Technical Report

Tennessee. Division of TennCare.

Tennessee External Quality Review Organization (EQRO)

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2020 Annual

EQRO Technical Report

TN Division of TennCare

Qsource

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Acknowledgements, Acronyms, and Initialisms[1]

A ..... Administrative/All

AG ..... Amerigroup Tennessee, Amerigroup, a wholly owned subsidiary of Anthem, Inc.

AGE/AGM/AGW ..... Amerigroup referenced by operational region: East (E), Middle (M), and West (W)

AMM ..... Antidepressant Medication Management (HEDIS measure)

ANA ..... Annual Provider Network Adequacy and Benefit Delivery Review

Anthem ..... a registered trademark of Anthem Insurance Companies, Inc.

AOD ..... Alcohol or Other Drug Abuse or Dependence

AON ..... Area of Noncompliance

AQS ..... Annual Quality Survey

ASH ..... Abortion, Sterilization, and Hysterectomy

BC ..... BlueCare Tennessee℠ and BlueCare, independent Licensees of the BlueCross BlueShield Association

BCE/BCM/BCW ..... BlueCare Tennessee referenced by operational region: East (E), Middle (M), and West (W)

BH ..... Behavioral Health

BlueCross®, BlueShield® ..... registered marks of the BlueCross BlueShield Association

C ..... Clinical or Critical (PIPs)

CAHPS® ..... Consumer Assessment of Healthcare Providers and Systems, a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

CDC ..... Comprehensive Diabetes Care (HEDIS measure)

CFR ..... *Code of Federal Regulations*

CHIP ..... Children's Health Insurance Program

CHOICES ..... a program providing long-term care benefits to members meeting CHOICES program criteria

CIS ..... Childhood Immunization Status (HEDIS measure)

CMS ..... Centers for Medicare & Medicaid Services

CRA ..... Contractor Risk Agreement

CY ..... Calendar Year

d.b.a. ..... Doing Business As

D-SNPs ..... Dual-Eligible Special Needs Plans

DBM/DBMC ..... Dental Benefits Manager/DBM Contract

DQ ..... DentaQuest of Tennessee, LLC

ECF ..... Employment and Community First

ED ..... Emergency Department

EPSDT ..... Early and Periodic Screening, Diagnostic, and Treatment

EQR/EQRO ..... External Quality Review/EQR Organization

FUA ..... Follow-Up After Emergency Department Visit for AOD (HEDIS measure)

FUH ..... Follow-Up After Hospitalization for Mental Illness (HEDIS measure)

FY ..... Fiscal Year

GDP ..... General Dental Practitioner

HCBS ..... Home and Community-Based Services

HD ..... HEDIS Determination

HDO ..... Use of Opioids at High Dosages (HEDIS measure)

HEDIS® ..... Healthcare Effectiveness Data and Information Set, a registered trademark of NCQA

HIPAA ..... *Health Insurance Portability and Accountability Act*

HPA ..... Health Plan Administrator

[1] *Other company and product names may be trademarks of the respective companies with which they are associated. The mention of such companies and product names is with due recognition and without intent to misappropriate such names or marks.*

HSAG ..... Health Services Advisory Group, Inc.
I/DD .....Intellectual/Developmental Disabilities
ID..... Identification
IMA .....Immunizations for Adolescents (HEDIS measure)
IS ..... Information System(s)
LOC .....Level of Care
LTSS ..... Long-Term Services and Supports
MCC .....Managed Care Contractor
MCO .....Managed Care Organization
MD..... Doctor of Medicine
MRR ..... Medical Record Review
MY .....Measurement Year
NA .....Not Applicable/Not Assessed
NC .....Non-Clinical
NCQA .....National Committee for Quality Assurance
NCQA HEDIS Compliance Audit™ .....a trademark of NCQA
NICU..... Neonatal Intensive Care Unit
NR .....Not Reported
OB/GYN ..... Obstetrician/Gynecologist
ORM ..... Office Reference Manual
OUD .....Opioid Use Disorder
P ..... Partial
P&P .....Policy and Procedure
PA..... Performance Activity
PBM.....Pharmacy Benefits Manager
PCP ..... Primary Care Provider/Practitioner
PCR..... Plan All-Cause Readmissions (HEDIS measure)
PDV ..... Provider Data Validation
PIHP ..... Prepaid Inpatient Health Plan
PIP..... Performance Improvement Project
PMV.....Performance Measure Validation
POD.....Pharmacotherapy for OUD (HEDIS measure)
PSS .....Provider Satisfaction Survey
QAPI..... Quality Assurance and Performance Improvement
QI/QIP/QIPD..... Quality Improvement/QI Program/ QIP Description
QM/QMP ..... Quality Monitoring/QM Program
QP .....Quality Process
Qsource® .....a registered trademark
Quality Strategy.....Quality Assessment and Performance Improvement Strategy
R .....Reportable
R1/R1/R3.....Remeasurement Year 1, 2, 3
Roadmap..... Record of Administrative Data Management and Processes
SAA .....Adherence to Antipsychotic Medications for Individuals with Schizophrenia (HEDIS measure)
SCP ..... Specialty Care Provider
SDF .....Silver Diamine Fluoride
SF-12®.....12-Item Short Form Survey, a registered Trademark of Medical Outcomes Trust
SSD ..... Diabetes and Cardiovascular Disease Screening and Monitoring for People With Schizophrenia or Bipolar Disorder (HEDIS measure)
TCA ..... Tennessee Code Annotated
TCS ..... TennCare*Select*, administered by BlueCare Tennessee
TDCI .....Tennessee Department of Commerce and Insurance
TennCare .....TN Division of TennCare
TN..... Tennessee
TSA ..... TennCare*Select* Agreement
UHC.....UnitedHealthcare Community Plan
UHCE/UHCM/UHCW ..... UHC referenced by operational region: East (E), Middle (M), and West (W)
UnitedHealthcare®..... a registered mark of UnitedHealth Group, Inc.
UM .....Utilization Management

Executive Summary

Overview

Qsource produced this *2020 Annual EQRO Technical Report* to summarize the quality, timeliness, and accessibility of care furnished by the managed care contractors (MCCs) of the State of Tennessee Division of TennCare (TennCare) to the members of the state's Medicaid program. Results were determined by aggregating and analyzing data obtained through the three federally mandated external quality review (EQR) activities that Qsource conducted as the EQR organization (EQRO) for TennCare:

- Monitoring access, timeliness, and quality of care by monitoring compliance with federal and state standards through the Annual Provider Network Adequacy and Benefit Delivery (ANA) Review and the Annual Quality Survey (AQS)
- Monitoring quality of care by validating performance measures (PMV)
- Monitoring quality of care by validating performance improvement projects (PIPs)

These activities were conducted in accordance with the CMS EQR Protocols released in October 2019, which were current during the 2019 calendar year. Qsource's EQR assessment tools review compliance with the following standards of 42 CFR 438, Subpart D, as well as Quality Assurance and Performance Improvement (QAPI) standards:

1. 42 CFR 438.206: Availability of services
2. 42 CFR 438.207: Assurances of adequate capacity and services
3. 42 CFR 438.208: Coordination and continuity of care
4. 42 CFR 438.210: Coverage and authorization of services
5. 42 CFR 438.214: Provider selection
6. 42 CFR 438.224: Confidentiality
7. 42 CFR 438.228: Grievance and appeal systems
8. 42 CFR 438.230: Subcontractual relationships and delegation
9. 42 CFR 438.236: Practice guidelines
10. 42 CFR 438.242: Health information systems

During the period under review in this report (measurement year [MY] 2019), TennCare's MCCs included managed care organizations (MCOs) operating in Tennessee's East, Middle, and West Grand Regions; a statewide MCO available to certain TennCare members under age 21 years enrolled by the State; a statewide dental benefits manager (DBM); and a statewide pharmacy benefits manager (PBM). While TennCare also contracts with a health plan administrator (HPA) and DBM for the CoverKids Children's Health Insurance Program (CHIP), and with nine Dual-Eligible Special Needs Plans (D-SNPs) for Medicare cost-sharing, EQRO reporting for both populations is

separate from the TennCare-only population and, therefore, not included in this report.

TennCare annually identifies goals and objectives in a State *Quality Assessment and Performance Improvement Strategy* (Quality Strategy), to provide guidance for the Medicaid program. Qsource meets all the qualifications and standards of independence for EQROs set forth in Title 42 *Code of Federal Regulations* (CFR) §438.354, including demonstrated expertise with Medicaid program assessment and managed care policies, processes, and data systems. The Centers for Medicare & Medicaid Services (CMS) supplemented the EQRO reporting parameters of 42 CFR Results from Qsource's 2020 EQR activities show that TennCare's plans are committed to delivering timely, accessible, and high-quality care to members. Findings for each activity are summarized in this section.

In 2020, the plans were: Amerigroup (**AG**), referenced by operational region as **AGE** (East), **AGM** (Middle), and **AGW** (West); BlueCare (**BC**) referenced by region as **BCE**, **BCM**, and **BCW**, and as administrator of the statewide TennCare*Select* (**TCS**); UnitedHealthcare (**UHC**) referenced by region as **UHCE**, **UHCM**, and **UHCW**; DentaQuest (**DQ**), the statewide DBM; and **OptumRx**, the statewide PBM. *(Note: As 2020 was the first year of the PBM's contract with TennCare, it was not subject to EQR activities for MY2019.)*

§438.364 in providing guidelines for this report, which includes the following sections:

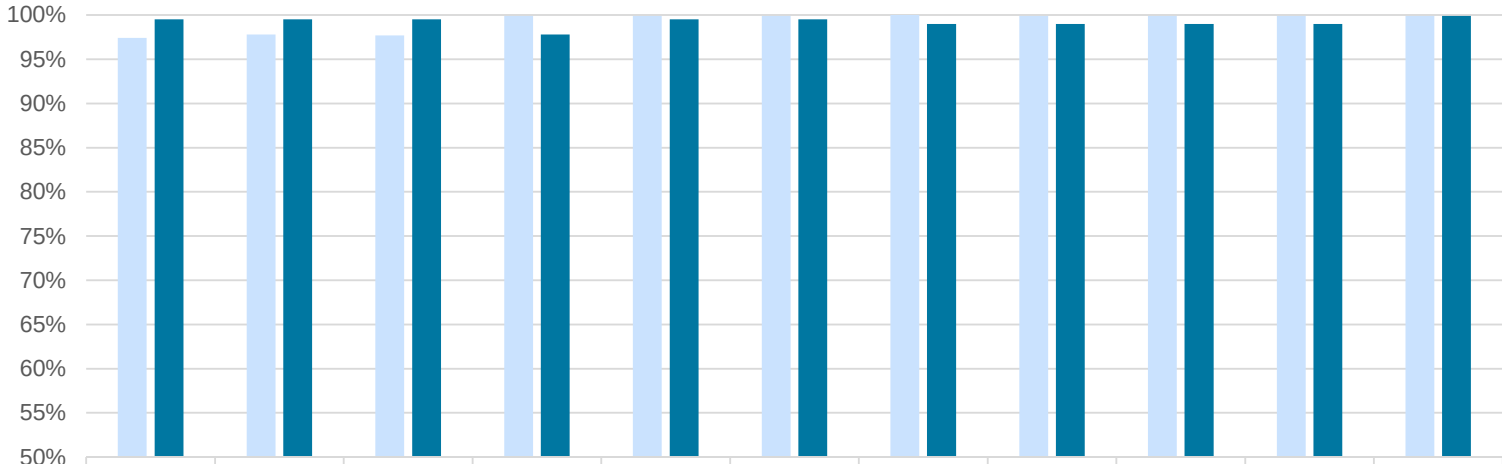
- Overview of EQRO Activities
- ANA Review, AQS, PMV, and PIP Validation (each including subsections on Assessment Background, Technical Method of Data Collection and Analysis, Description of Data Obtained, and Comparative Findings)
- Conclusions, including any identified performance strengths and recommendations for improvement

Assessments and Results

Access, Timeliness, and Quality: ANA Review

Figure 1 shows each MCO and the DBM's 2020 ANA evaluation scores. Network Adequacy includes an assessment of the number and type of providers in each MCC's provider network and the proximity of members to these providers. Benefit Delivery is an evaluation of each MCC's delivery of covered benefits (via handbooks, contracts, and policies) to its members and providers. Most overall Network Adequacy scores were 99.9% or better, with only three plans receiving slightly lower scores: **AGE** (97.4%), **AGM** (97.8%), and **AGW** (97.7%). For Benefit Delivery, all but one plan achieved scores of 99.0% or higher, with **BCE** the exception at 97.8%.

Figure 1. 2020 ANA Review Results: Overall Network Adequacy and Benefit Delivery Scores



	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW	DQ
Network Adequacy	97.4%	97.8%	97.7%	>99.9%	99.9%	99.9%	100%	99.9%	99.9%	>99.9%	>99.9%
Benefit Delivery	99.5%	99.5%	99.5%	97.8%	99.5%	99.5%	99.0%	99.0%	99.0%	99.0%	>99.9%

Individual plan results and available trending are presented in the ANA Review section of this report.

Access, Timeliness, and Quality: AQS

The AQS assessed plans for compliance with statewide quality process (QP) standards and operational performance activities (PAs) based on contractual, regulatory, legislative, and judicial requirements. According to CMS Protocol, in order to avoid duplication, elements that were met through a national accrediting entity were deemed. All plans' credentialing and recredentialing policies and procedures (P&Ps) were assessed during the 2019 ANA. Those results, as well as results for CHOICES credentialing and recredentialing file reviews, were included in detail in the *2020 AQS Technical Papers* and *2020 AQS Summary Report* and are included in the AQS section of this report.

As shown in Table 1, 2020 AQS compliance scores were high overall. QP standards are reported as a single statewide score for each MCO/DBM. **BC**, **TCS**, and **DQ** achieved compliance scores of 100% for all applicable QP standards, while **AG** fell short of 100% on two of eight standards and **UHC** on three of eight. For both the quantity and quality ratings for the CHOICES credentialing and recredentialing file reviews, all applicable MCOs achieved 100% compliance. PA file review scores are reported by region. During the 2020 AQS, all MCO operational regions achieved 100% compliance on all applicable PA file reviews except **UHCE**, which fell short of 100% for UM Denials and Appeals, and **UHCM**, which earned 95.0% for CHOICES Annual Level of Care (LOC) Assessment. **DQ** earned 100% for two of three PAs and 97.5% for the third, Appeals.

Table 1. 2020 AQS Summary Results

	AG	BC	TCS	UHC	DQ
QP Standards Range	94.0–100%	100%	100%	95.0–100%	100%
CHOICES Credentialing/ Recredentialing Range	100%	100%		100%	
PA File Reviews Range	AGE: 100% AGM: 100% AGW: 100%	BCE: 100% BCM: 100% BCW: 100%	100%	UHCE: 97.1–100% UHCM: 95.0–100% UHCW: 100%	97.5–100%

Note: Gray cells designate where a measure was not applicable (NA).

Individual MCC results and available trending are presented in the AQS section of this report.

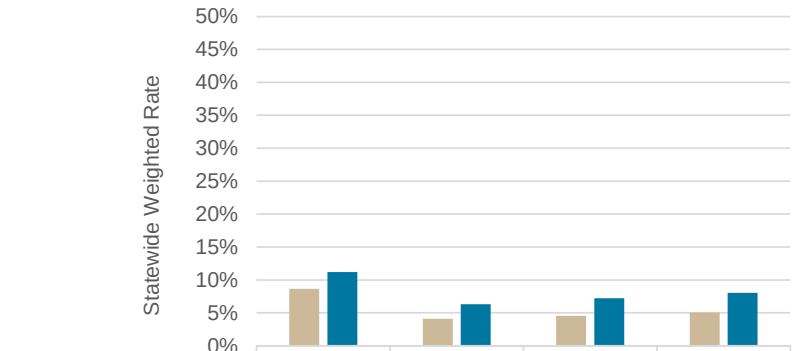
Quality Care: PMV

All TennCare MCOs report a full set of Healthcare Effectiveness Data and Information Set (HEDIS) measures as part of the required National Committee for Quality Assurance (NCQA) accreditation. To verify MCO reporting accuracy and compliance with reporting standards, TennCare annually selects two measures for the EQRO to validate. The DBM and PBM are not required to report performance measures, so are not included in this EQRO activity.

For the 2020 validations, each MCO passed the audit, was determined to be in full compliance with all standards, and received a Reportable (*R*) designation for the two audited measures: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA), and Pharmacotherapy for Opioid Use Disorder (POD). PMV scores are statewide and not reported by operational region. **TCS**, administered by **BC**, was evaluated as one rate with the statewide **BC** data. **Figure 2** shows trending for FUA: Total rates for both age cohorts, and Figure 3 shows the HEDIS 2020 rates for POD by MCO.

Individual MCO results and available trending are presented in the PMV section of this report.

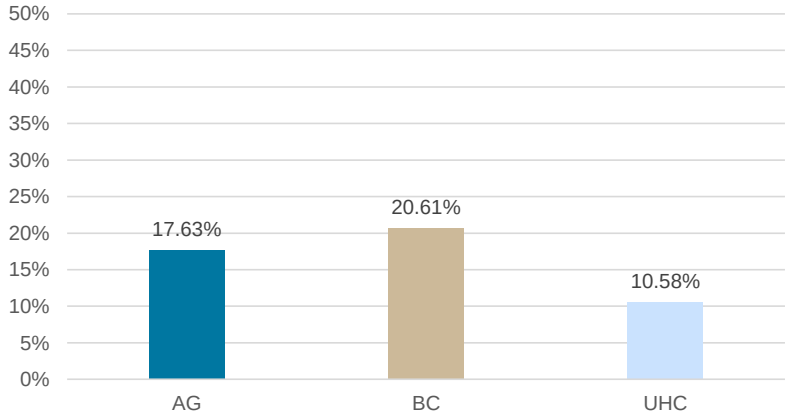
Figure 2. 2017–2020 Statewide Rates for FUA: Totals



	2017	2018	2019	2020
FUA: 7-Day Follow-Up	8.66%	4.11%	4.53%	5.04%
FUA: 30-Day Follow-Up	11.19%	6.29%	7.23%	8.04%

Note: The Total rates include both age cohorts, 13–17 years and 18+ years. NCQA urged trending with caution due to a change in measure specifications in 2018.

Figure 3. 2020 MCO Rates for POD: 16-64 years



Note: First-year measure; trending not possible.

Quality Care: PIP Validation

Devised by MCCs and approved by TennCare, PIP studies measure the effectiveness of quality improvement (QI) interventions in improving processes, healthcare provided, and QI sustainability. For the year under review, MCCs were contractually required to conduct and report methodologically sound PIPs in accordance with CMS protocol, and to choose topics that reflect Medicaid enrollment demographics and prevalence and potential consequences of disease.

TennCare Quality Strategy and MCC contracts specify that the DBM and PBM both annually submit one non-clinical and one clinical PIP, and that MCOs annually submit at least three non-clinical and two clinical PIPs, along with a PIP in an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) topic if the MCO has an overall rate below 80% on the State's CMS-416 report. One of the MCOs' non-clinical PIPs must be in long-term services and supports (LTSS), and the clinical PIPs must include one in behavioral health (relevant to population health programs for bipolar disorder, major depression, or schizophrenia) and one in child or perinatal health. Any PIPs conducted in more than one MCO region must be submitted with region-specific data and information, including improvement strategies, and statewide PIPs are considered valid for each region, if applicable. Since 2015, TennCare has elected to have Qsource validate all PIPs that were underway during the 12 months preceding review. All CRA specifications were met this year in the 54 studies conducted by TennCare's plans and submitted for 2020 PIP validation.

This year's PIPs covered 24 study topics (with several shared by more than one MCO), and were at different stages of progress during the review year, from Baseline (initial year) to Remeasurement Year 3. Of the 54 PIPs, 50 earned a validation status of Met (Table 2) and 47 of those also earned overall element validation scores of 100%. These results reflect Qsource's confidence in the MCCs' topic selections, study designs, and findings, and show that TennCare's MCCs share a commitment to improving the quality of and access to care that members receive.

Table 2. 2020 PIP Validation Statuses			
MCC	**PIPs Met/Submitted**	**MCC**	**PIPs Met/Submitted**
AGE	4/4	**TCS**	5/6
AGM	3/3	**UHCE**	4/5
AGW	5/5	**UHCM**	4/5
BCE	6/6	**UHCW**	5/6
BCM	6/6	**DQ**	2/2
BCW	6/6		

Note: Because 2020 was the baseline measurement year for the PBM's PIPs, those PIPs will be validated in 2021.

Individual MCC results are presented in the PIP Validation section of this report.

Overview

This section provides a brief history of TennCare, its Quality Strategy, the guidelines for this report, and descriptions and objectives of the EQR activities conducted in 2020.

Background

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

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

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

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

Since enacting reform measures in early 2005, the TennCare program has stabilized, allowing for a return to the full-risk model under which MCOs are paid a per-member, per-month capitation rate for delivering care. In August 2006, two nationally recognized MCOs with experience in Medicaid managed care were awarded bids under this model, which was also marked by a reintegration of physical and behavioral health services and an enhanced focus on disease management. These MCOs began serving members in the Middle Grand Region on April 1, 2007. West Grand Region MCOs returned to the full-risk, integrated model effective November 1, 2008. East Grand Region MCOs also returned to this model on January 1, 2009, marking integration by all MCOs and eliminating

the need for behavioral health organizations to continue serving TennCare members.

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

On January 1, 2015, new contracts took effect between the State and its existing MCOs—**AG**, **BC**, and **UHC**—with full statewide implementation completed by the end of CY2015. This expanded coverage for all three MCOs and helped ensure quality and accessibility across the state through three covering plans, a PBM, and a DBM.

Effective on July 5, 2019, the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) is the first update to Medicaid and CHIP managed care regulations in over a decade and includes the following goals:

- Support TennCare efforts to advance delivery system reform and through flexible value-based purchasing models and provider reimbursement requirements in the managed care contract.
- Modernize and improve the quality of care through network adequacy standards, resources with accessible and consistent content, a quality rating system, and expanded quality strategies.
- Strengthen the beneficiary experience of care through enrollments and supports, including managed long-term services and supports.
- Improve accountability and transparency through changes in screening processes, encounter data management, and treatment of overpayments, as well as implementation of procedures to prevent fraud, waste, and abuse.
- Align key Medicaid and CHIP managed care requirements with other health coverage programs to smooth beneficiary coverage transitions and ease administrative burdens tied to participation across publicly-funded programs and the commercial market. Requirements include the medical loss ratio and appeals and grievances management.

State Quality Strategy Goals

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

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

- **Vision Statement**: "A healthier Tennessee."
- **Mission Statement**: "Improving lives through high-quality cost-effective care."

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

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

Using its Vision and Mission Statements and Core Values, TennCare developed four primary goals. These goals work together and help shape TennCare's approach to improving the quality of healthcare for its members:

11. Assure appropriate access to care
12. Provide high-quality, cost-effective care
13. Assure satisfaction with services
14. Improve healthcare

Additional Quality Strategy objectives, assessed through LTSS measures, have been established based on the CHOICES program, which was implemented in 2010. As the name suggests, CHOICES is designed to provide adults who are elderly or have physical disabilities with viable alternatives to institutional care. Quality assurance for these services focuses on the following:

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

Measures from the HEDIS audit, PIPs, AQS, and ANA are the primary mechanisms for assessing TennCare's primary goals, specifically as applied to the integrated physical and behavioral health services delivered by TennCare's MCOs. For select performance measures, TennCare offers incentives to MCOs that demonstrate significant improvement from the previous reporting period as determined by established NCQA methodology.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program (analyzed by the EQRO with the HEDIS) and *The Impact of TennCare: A Survey of Recipients* (a member satisfaction survey administered by the University of Tennessee) are used to measure member satisfaction. TennCare receives Quarterly Point of Service Satisfaction Reports for the CHOICES HCBS and ECF CHOICES programs that provide member

satisfaction data entered directly and recorded in electronic visit verification systems.

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

EQR Activity Descriptions and Objectives

Based on the 2012 CMS EQR Protocols, which were in effect for the entirety of MY2019, EQR requires three mandated activities and can include five optional activities. Each state may also assign other responsibilities to its designated EQRO, such as the provision of ongoing technical assistance. This section summarizes the activities that Qsource performed for TennCare in 2020.

EQR Mandatory Activities

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

- Monitoring access, timeliness, and quality of care by assessing compliance with federal and state standards through ANA and AQS
- Monitoring quality of care via PMV
- Monitoring quality of care via PMV PIP validation

Qsource is responsible for the production of this *2020 Annual EQRO Technical Report*, which compiles the results of these EQR activities. Qsource's efforts are a primary means of assessing the quality, timeliness, and accessibility of services provided by TennCare's MCCs. Health Services Advisory Group, Inc. (HSAG), Qsource's subcontractor, assisted in the completion of the ANA.

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

- A brief description of the data collection, aggregation, and analyses for each of the EQR compliance activities
- A summary of findings from each review (ANA, AQS, PMV, and PIP validation)
- Comparative information and assessments of the degree to which benefit managers have addressed prior year EQRO recommendations for QI
- A summary of strengths and opportunities demonstrated by each MCC in providing healthcare services to TennCare members
- Recommendations for improving the quality of these services

The mandated EQR activity audit periods for TennCare MCCs are summarized in Table 3 for the review period of January–December

2019. Applicable trending results are presented in the individual activity sections of this report.

Table 3. 2020 Audit Periods for EQR Activities

Activity	Audit Period
ANA Review	February–March 2020
AQS	February–May 2020
PMV	March–April 2020
PIP Validation	July–September 2020

The following reports were generated for each of the reviews:

- *2020 ANA Reports* for individual plans
- *2020 AQS Technical Papers* for individual plans
- *2020 AQS Summary Report* for all plans
- *2020 Annual PMV Reports* for individual plans
- *2020 Annual PIP Validation Technical Papers* for individual PIP topics, by plan
- *2020 Annual PIP Validation Summary Report* for all plans

This *2020 Annual EQRO Technical Report* is based on detailed findings that can be examined in the individual and summary reports. Each EQR activity's brief descriptions and objectives are described in the following paragraphs of this section.

ANA

Per 42 CFR §438.206 and their respective contracts, TennCare plans must ensure the following:

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

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

AQS

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

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

- compare the quality of service and healthcare that MCCs provide to their members, including physical–behavioral integration, where applicable;

- identify, implement, and monitor system interventions to improve quality;
- evaluate performance processes; and
- plan/initiate activities to sustain and enhance current performance processes.

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

PMV

To evaluate performance levels, TennCare selected a process for an objective, comparative review of quality-of-care outcomes and performance measures. Its primary aims were to evaluate the accuracy of MCO-reported measures and to determine whether those measures were calculated according to required technical specifications. To satisfy CMS protocol for MCOs and to meet the requirements set forth in 42 CFR §438.358 (b)(1)(ii), TennCare identified for validation the following two HEDIS measures, defined by the NCQA and validated through an NCQA HEDIS Compliance Audit: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) and Pharmacotherapy for Opioid Use Disorder (POD). Trending and comparisons among MCOs are available in the PMV section of this report.

PIP Validation

The primary objective of the EQRO's PIP validation is to determine the compliance of each MCC with the requirements set forth in 42 CFR §438.330(d)(2). MCCs must conduct PIPs that are designed to achieve, through ongoing measurements and interventions, significant and sustained improvement in clinical and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. PIP study topics must reflect Medicaid enrollment in terms of demographic characteristics and, if applicable, in terms of the prevalence and potential consequences (risks) of disease. Each PIP must be completed in a reasonable timeframe to allow PIP success-related data in the aggregate to produce new information on quality of care every year.

The 2020 PIP validation process evaluated 54 PIPs spread across 9 regional MCOs, one statewide MCO, and one DBM. Validation was performed only for ongoing and baseline PIPs that were already underway during the 12 months preceding review; thus, the PBM's PIPs, which were in their baseline year in 2020, were not validated this year. The validation process included a review of each PIP's study design and approach, an evaluation of each PIP's compliance with the analysis plan, and an assessment of the effectiveness of plan interventions. The results of the validation process can be found in the PIP section.

Additional Contractual Activities

In addition to those EQR activities mentioned, Qsource provides TennCare and MCCs with technical assistance—an EQR-related activity also defined by 42 CFR §438.358. In this capacity, Qsource maintains ongoing, collaborative communication with TennCare and supports the MCCs and benefit managers in their EQR

activities. Further examples of Qsource technical assistance include the following areas of expertise: (a) Medicaid legislation, (b) MCC accreditation standards and guidelines as outlined by NCQA, and (c) continuous QI. Qsource also participates in MCC collaborative workgroups, conducts PIP training for MCC staff, and assists the TennCare Quality Oversight with its strategic planning sessions and Quality Strategy development.

Qsource performs additional activities as part of its EQRO contract with TennCare. These include the following 2020 deliverables:

- *Annual Abortion, Sterilization, and Hysterectomy (ASH) Audit Report*
- *Annual Child Focus Study*
- *Annual CHOICES Report: Group Enrollment Trend*
- *Annual EPSDT Summary Report*
- *Annual HEDIS/CAHPS Report: Comparative Analysis of Audited Results from TennCare Managed Care Organizations*
- *Annual HEDIS D-SNPs Report*
- *Annual Impact Analysis Report*
- *Medication-Assisted Treatment (MAT) Provider Network Survey*
- *Quarterly Provider Data Validation (PDV) Report*
- *Monthly Healthcare Policy Research Report*
- Additional ad hoc reports as requested by TennCare

Qsource also conducts meetings with TennCare and representatives of the plans three times a year. The three 2020 meetings featured presentations from experts on person-centered support in LTSS; treating opioid use disorder in pregnancy; opportunities for closing gaps in care for chronic kidney disease; preventing and treating childhood obesity; intensive case management for substance use disorder; eliminating gender- and race-based health disparities; improving healthcare for adults with autism and other developmental disabilities; providing culturally appropriate healthcare in Appalachia; improving access to dental care for improved health; adverse childhood events and their effect on brain development; and upcoming changes to the PIP validation process based on new CMS guidelines. Qsource posts highlights online within a month of each health plan meeting, which were held on February 11, June 23, and September 15 in 2020. (*Note: Due to the COVID-19 pandemic, the June and September meetings were held as live webinars in 2020.)*

Technical Report Guidelines

To assist both EQROs and state agencies, CMS supplemented the requirements of 42 CFR §438.364 and provided guidelines for this *2020 Annual EQRO Technical Report*, which—in addition to the Executive Summary and this Overview—includes the following sections:

- ANA Review
- AQS
- PMV
- PIP Validation
- Summary and Conclusions with recommendations for the State Quality Strategy

State Utilization of the EQRO Technical Report

The *Annual EQRO Technical Report* provides TennCare with unbiased data for the MCCs and benefit managers. As mandated by 42 CFR § 438.364, these data make it possible to benchmark performance statewide and nationally. The data also depict the healthcare landscape for the state's Medicaid population, which assists TennCare in its collaborations with other state agencies to address common health issues—particularly those that are prevalent, chronic, and preventable. TennCare can use these data to measure progress toward goals and objectives of TennCare's Quality Strategy, identify areas where targeted QI interventions could be beneficial, and determine if new or restated goals are needed. Multiyear trending, a critical component for State assessment, is offered where possible and will continue to be evaluated annually.

State Quality Initiatives

Each year TennCare assesses the effectiveness of its Quality Strategy and updates it to include any significant changes since the previous year's strategy regarding program structure, benefits and MCC changes. Updated evaluation data, interventions, and activities are also considered.

TennCare has implemented several initiatives to support both QI among its contractors and the goals of its Quality Strategy. These include the implementation of the Care Coordination Tool, which will perform a number of tasks, including producing risk scores, prioritizing patients and activities based on those scores, tracking gaps in care, and allowing members to view prescription fill information. The implementation of a Clinical Knowledge Module will standardize the clinical information loaded from the admission, discharge information, and transfer information feeds. As use of this module increases, it will allow for the development of a clinical database that will address gaps in care and help reduce hospital admissions.

Through its Quality Apps project, the State the state will have the ability to collect clinical quality data that cannot be acquired from processed medical billing claims. Ultimately, these Quality Apps will provide payers, beginning with the State's Medicaid participating MCOs, with the necessary information to reimburse providers for high quality health outcomes.

TennCare's 2019 Update to State Quality Strategy helped determine the parameters of state Medicaid initiatives, of which Population Health, Pay-for-Performance, and PIP Validation were chosen for inclusion in this report due to the programs' relevance to EQR activities. These represent only a small fraction of TennCare's total efforts.

Population Health

By July 1, 2013, TennCare required each MCC to replace the disease/health management model with operationalized population health programs. By 2014, all MCCs had transitioned from disease management to population health and all TennCare members had been stratified into three population health levels. TennCare's

Quality Strategy measures improvement via four population health outcome measures: emergency department (ED) visits, readmissions, neonatal intensive care unit (NICU) babies, and end-stage renal disease.

Unlike disease management, which addresses only those members with existing health conditions, population health is a more comprehensive approach that requires intensive care management for high-risk members and more personalized health management for those at lower risk levels. Population health programs are designed to help members self-manage their conditions and risk factors. TennCare emphasizes improving members' self-management of two specific conditions, pregnancy and diabetes. Statewide collaborative working groups have been established with each MCC. To support those efforts, TennCare requires MCCs to offer the following population health programs:

- Wellness
- Low- to Moderate-Risk Maternity
- "Opt Out" Health Risk Management
- Care Coordination
- "Opt In" Chronic Care Management
- "Opt In" High-Risk Maternity
- "Opt In" Complex Case Management

As part of the evaluation process, all MCOs were required to conduct rapid cycle improvement projects. Some of the successful projects included changing or improving member behavior regarding ED utilization and ensuring newly diagnosed diabetic members receive needed supplies in a timely manner.

Pay-for-Performance

The pay-for-performance initiative has been in place since 2006. The required reporting of HEDIS measures has allowed TennCare to establish performance incentives for those MCOs that meet defined benchmarks. Pay-for-performance quality incentive payments are offered to MCOs that demonstrate significant improvement from the previous reporting period for specified measures in which MCOs scored below the 25th percentile for the National Medicaid Average.

PIP Validation

In addition to the CMS requirements of two PIPs for each plan, TennCare requires MCOs to conduct at least two clinical and three non-clinical PIPs. The DBM and PBM must conduct at least one clinical and one non-clinical PIP. For the MCOs, the two clinical PIPs must include one in the area of behavioral health that is relevant to one of the population health programs for bipolar disorder, major depression, or schizophrenia. The other must be in the area of either child health or perinatal (prenatal/postpartum) health. Furthermore, one of the three non-clinical PIPs is required to be in the area of LTSS. Beginning in 2017, a PIP in the area of EPSDT was also required if the MCO's CMS-416 report rates were lower than 80%. All these specifications were met per CRA requirements in 2020.

Annual Network Adequacy and Benefit Delivery (ANA) Review

Assessment Background

For the ANA reviews, directed by the Tennessee Department of Commerce and Insurance (TDCI) and TennCare, Qsource evaluated each TennCare plan to determine if it had a provider network adequate to ensure the effective and efficient delivery of healthcare to members, pursuant to *TCA* §56-32-131. The ANA reviews were conducted from February 4 through March 5, 2020.

Technical Methods of Data Collection and Analysis

ANA reviews include a desk audit of documents, an onsite review, administrative data analyses, and measure scoring. Each evaluation area's metric contributes to performance scores via a rating system for an overall Network Adequacy and an overall Benefits Delivery score.

For Network Adequacy, quantitative analyses were conducted of provider files supplied by the plans and downloaded from TennCare. Once extracted from source files, provider and member data were cleaned and imported into SAS for preliminary review. Quest Analytics Suite software was used to further clean and geocode data, including standardizing addresses to United States Postal Service specifications to ensure consistent and accurate assessment of network access by members. Member complaints related to access and availability provided by the plans and TDCI were analyzed to determine a ratio per total members, and CHOICES HCBS and ECF CHOICES data were reviewed by county.

Benefits delivery evaluation was based on desk review of documentation including member handbooks and provider manuals. All credentialing/recredentialing findings and results were incorporated by Qsource into AQS technical papers at TennCare's request. Details on the ANA review process and results can be found in each MCC's *2020 Annual Network Adequacy Report*.

Description of Data Obtained

The 2020 ANA measurement period was January 1 to December 31, 2019, and focused on the following data sources:

- The distribution, availability, and assignment of providers to TennCare members
- Provider appointment availability and plan P&Ps
- Provider Manual and Member Handbook
- Sample of provider contracts
- Plan staff interviews, as needed, regarding availability and accessibility of providers to members
- Plan credentialing/recredentialing P&Ps and a sample of CHOICES credentialing/recredentialing files

Comparative Findings

Network Adequacy

All plans achieved high compliance scores for overall Network Adequacy in 2020, with no plan earning less than 97.4% compliance and the majority showing improvement over 2019 scores. **Tables 4** and **5** present high-level summaries of the Network Adequacy scores for MCOs and the DBM, respectively.

Table 4. 2020 ANA Network Adequacy Scores: MCO Access/Availability

Measure	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
Primary Care Provider (PCP) Average	>99.9%	99.8%	99.9%	100%	100%	100%	100%	>99.9%	>99.9%	99.9%
Specialty Care Provider (SCP) Average	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Behavioral Health (BH) Provider Average	100%	100%	100%	100%	100%	100%	100%	100%	100%	>99.9%
Opioid Use Disorder Treatment Providers	100%	100%	99.8%	100%	100%	100%	100%	>99.9%	>99.9%	99.9%
General Optometry and Hospitals Avg.	>99.9%	99.9%	99.9%	>99.9%	>99.9%	100%	100%	>99.9%	100%	>99.9%
Special Programs Average	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
CHOICES HCBS Providers Average	99.7%	>99.9%	99.2%	99.7%	99.1%	99.3%		99.3%	99.5%	99.7%
ECF CHOICES Providers Average	89.9%	91.3%	91.3%	100%	100%	100%		100%	100%	100%
Overall Network Adequacy Score	**97.4%**	**97.8%**	**97.7%**	**>99.9%**	**99.9%**	**99.9%**	**100%**	**99.9%**	**99.9%**	**>99.9%**

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

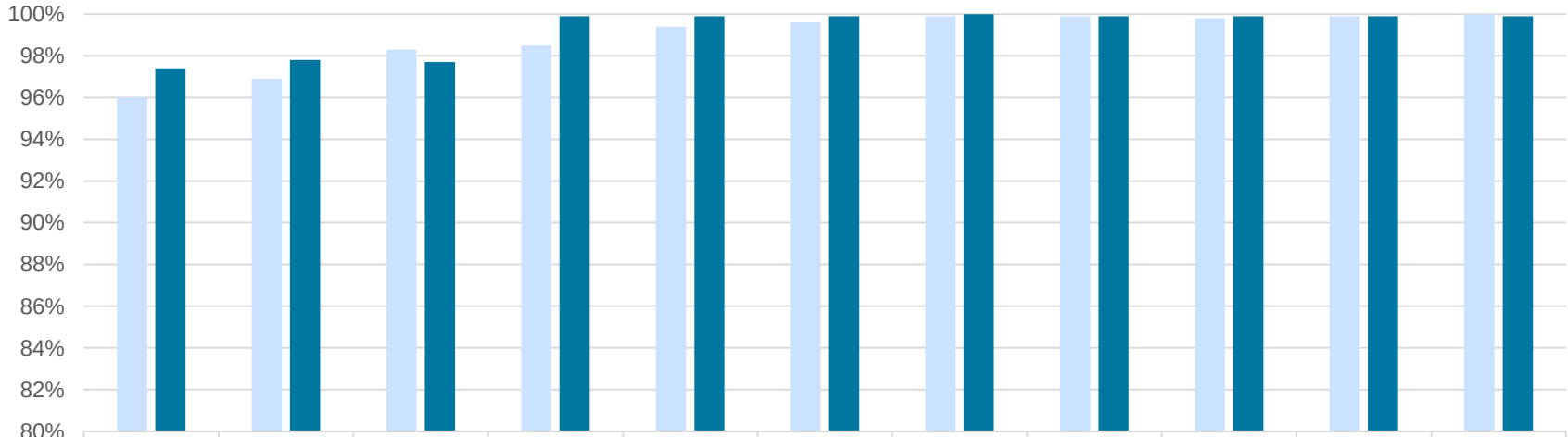
Table 5. 2020 ANA Network Adequacy Scores: DBM Access/Availability

Measure	Standard (max)	Members < 21 Years	ECF CHOICES
General Dental Provider (GDP) Ratio	2,500:1	100%	
GDP Distance	≤30 miles or ≤45 minutes	100%	
Oral Surgery Distance	≤60 miles or ≤60 minutes	100%	
Orthodontic Services Distance	≤60 miles or ≤60 minutes	100%	
Pediatric Dental Services Distance	≤70 miles or ≤70 minutes	100%	
Dental Provider Distance (ECF CHOICES)[1]	Two: ≤30 miles or ≤45 mins./ ≤60 or ≤60		>99.9%
Overall Network Adequacy Results: >99.9%[2]			

Note: Cells in gray are NA.
[1] The distance requirement is one provider within 30 miles travel distance or 45 minutes travel time for 75% of the members, and 60 miles travel distance or 60 minutes travel time for all ECF CHOICES members. The ECF CHOICES distance requirements were calculated using all ECF members selecting dental benefits.
[2] The overall score is based on the combination of scores for Standard 1 (75% of members within 30 miles travel distance or <45 minutes travel time) and Standard 2 (100% of members within 60 miles travel distance or 60 minutes travel time). However, because Standard 1 is based on 75% of the non-dual members, the Standard 1 score is adjusted, or weighted, to the total population. This adjusted score is then combined with the Standard 2 score to obtain the overall score.

Compared to the previous ANA review, most plans showed an improvement in overall Network Adequacy scores in 2020. The exceptions were **AGW** and **DQ**, which showed slight declines (of 0.6 percentage points and less than 0.1 percentage point, respectively), and **UHCE** and **UHCW**, which maintained the same overall rates from the previous year (**Figure 4**).

Figure 4. 2019–2020 Overall Network Adequacy Scores



	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW	DQ
2019	96.0%	96.9%	98.3%	98.5%	99.4%	99.6%	99.9%	99.9%	99.8%	99.9%	100%
2020	97.4%	97.8%	97.7%	>99.9%	99.9%	99.9%	100%	99.9%	99.9%	>99.9%	>99.9%

Benefit Delivery

The information in **Table 6** was obtained from reviews of the six areas used to determine the effectiveness of the plans' delivery of covered benefits. TennCare plans earned high compliance scores for overall Benefit Delivery in 2020, with **BCE** earning the lowest score at 97.8%.

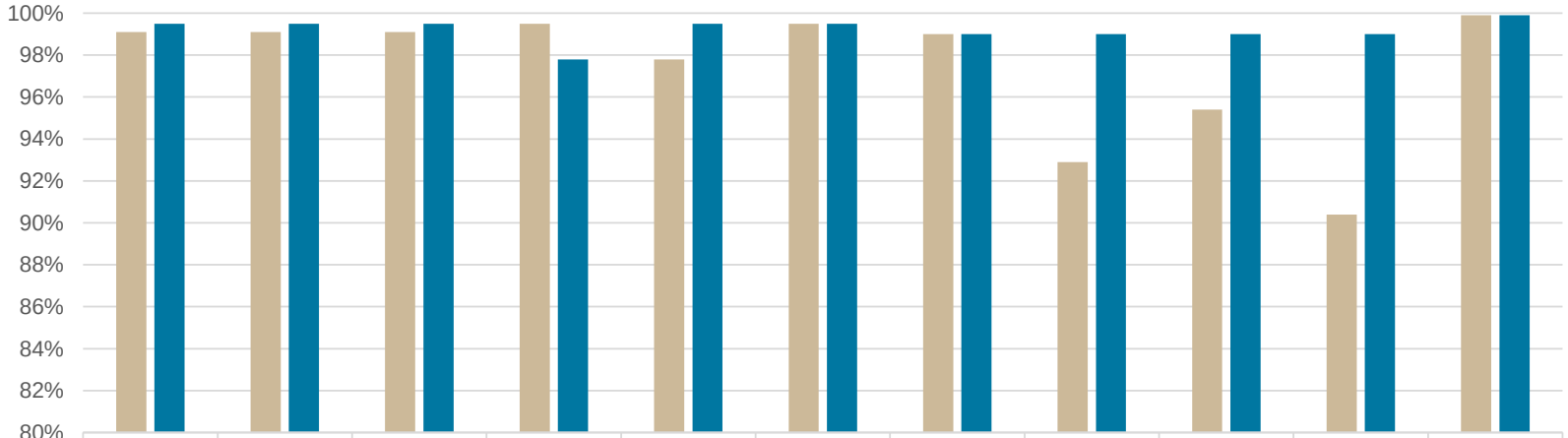
Table 6. 2020 ANA Benefit Delivery Scores: Plan Averages

AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW	DQ
Covered Benefits—Member Handbook										
97.0%	97.0%	97.0%	97.0%	97.0%	97.0%	94.3%	98.5%	98.5%	98.5%	100%
Covered Benefits—Provider Manual										
100%	100%	100%	100%	100%	100%	100%	95.5%	95.5%	95.5%	100%
Appointment Availability—Policies and Procedures										
100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Appointment Availability—Complaints										
99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	>99.9%	>99.9%	>99.9%	>99.9%
MCO Provider Contracts—Quantity										
100%	100%	100%	95.0%	100%	100%	100%	100.0%	100%	100%	100%
MCO Provider Contracts—Quality										
100%	100%	100%	95.0%	100%	100%	100%	100%	100%	100%	100%
Overall Benefit Delivery Results										
99.5%	**99.5%**	**99.5%**	**97.8%**	**99.5%**	**99.5%**	**99.0%**	**99.0%**	**99.0%**	**99.0%**	**>99.9%**

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

As shown in **Figure 5**, the majority of plans improved or maintained overall compliance percentages from 2019, with **DQ** again achieving the highest overall Benefit Delivery score (>99.9%). **UHC**'s three regions showed the most dramatic improvement, with each improving by several percentage points to achieve 99.0% compliance in 2020.

Figure 5. 2019–2020 Overall Benefit Delivery Scores



	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW	DQ
2019	99.1%	99.1%	99.1%	99.5%	97.8%	99.5%	99.0%	92.9%	95.4%	90.4%	99.9%
2020	99.5%	99.5%	99.5%	97.8%	99.5%	99.5%	99.0%	99.0%	99.0%	99.0%	>99.9%

Conclusions

Best practices are noted during the ANA review when a plan demonstrates particular proficiency in a given assessment element or plan activity, and are identified regardless of compliance score. Recommendations are given when a plan achieves less than 100% compliance with an assessment element. **Table 7** lists the best practices and recommendations for improvement identified for each of the TennCare Medicaid plans during the 2020 ANA review.

Table 7. 2020 ANA Review Best Practices and Recommendations by MCC

AG	
Best Practices	
In 2017, **AG** developed a Very Important Provider (VIP) Provider Engagement Model that offered regional pillar providers and health systems an additional level of service via an **AG** contact with whom they could engage to resolve issues. **AG** assigned to each group a Provider Relations Associate, who worked with an Operations Business Analyst to resolve issues identified by the VIPs. The number of VIPs assigned to any given business analyst was dependent on the size of the health system or provider group. For example, a large health system with several facilities and physician practices required a single analyst to manage all projects, whereas one analyst could manage several of the smaller health systems or practices. The direct **AG** contacts provided expedited resolution to issues above and beyond the normal resolution process. Due to the success of the program, the number of provider groups in the program with complex issues has decreased from 28 to 5. The key to the VIP Provider Engagement Model success was end-to-end issues resolution such as root cause analysis, timely completion of warranted claims reprocessing, and mitigation to prevent further claims payment issues.	
Recommendations	
Network Adequacy	**AGE** achieved a score of 100% in 84 of 91 Network Adequacy measures. For performance improvement, **AGE** should ♦ address the shortage of OB/GYN providers in Morgan County; ♦ address the shortage of optometry providers in Monroe County; ♦ address the shortage of hospitals contracted to provide services to members in Morgan County; and ♦ for substance abuse outpatient treatment services, address the shortage of providers who meet the distance/time standard (i.e., within 30 miles/30 minutes to 75% of the members) in Sequatchie County. For CHOICES HCBS and ECF CHOICES provider types, **AGE** should ♦ address the shortage of adult day care providers in Campbell, Claiborne, Cocke, Hamilton, Knox, and Sullivan counties; and ♦ address the shortage of specialized consultation and training providers in Bledsoe, Claiborne, Franklin, Grainger, Grundy, Hamblen, Hancock, Jefferson, Monroe, Sequatchie, and Sevier counties.
	AGM achieved a score of 100% in 85 of 91 Network Adequacy measures. For performance improvement, **AGM** should ♦ address the shortage of providers of OB/GYN providers in Hickman, Houston, Humphreys, Lewis, Perry, Pickett, Stewart, and Wayne counties; ♦ address the shortage of optometry providers in Lincoln County; ♦ address the shortage of hospitals contracted to provide services to members in Fentress and Pickett counties; and ♦ for providers of opioid use disorder treatment for children and adults, address the shortage of providers who meet the distance/time standard (i.e., within 45 miles/45 minutes for 75% of non-dual members) in Houston and Stewart counties.

Table 7. 2020 ANA Review Best Practices and Recommendations by MCC	
	For CHOICES HCBS and ECF CHOICES provider types, **AGM** should address the shortage of adult day care providers in Davidson, Rutherford, and Sumner counties.
	AGW achieved a score of 100% in 84 of 91 Network Adequacy measures. For performance improvement, **AGW** should ♦ address the shortage of OB/GYN providers in Benton, Decatur, and Henderson counties; ♦ address the shortage of optometry providers in Hardeman County; ♦ address the shortage of hospitals contracted to provide services to members in McNairy County; ♦ for providers of opioid use disorder treatment for children and adults, address the shortage of providers who meet the distance/time standard (i.e., within 60 miles/60 minutes for all members) in Dyer, Fayette, Hardeman, and Lauderdale counties; and ♦ for providers of opioid use disorder treatment for children and adults, address the shortage of providers who meet the distance/time standard (i.e., within 45 miles/45 minutes for 75% of non-dual members) in Dyer, Hardeman, Lake, and Lauderdale counties. For CHOICES HCBS and ECF CHOICES provider types, **AGW** should address the shortage of adult day care providers in Gibson, Haywood, Madison, Obion, and Tipton counties.
	No providers of CHOICES community transportation or community support development, organization, and navigation were identified in the datasets **AG** submitted for any Grand Region.
Benefit Delivery	**AG** must inform members in all regions about benefits related to reconstructive breast surgery, including surgical procedures on the non-diseased breast (to establish symmetry) if performed within five years of the date of the reconstructive surgery performed on a diseased breast. The three regions must also ensure that members receive consistent information regarding the age groups and frequency of mammography screenings.
BC	
Best Practices	
In 2019, **BC** developed an internal system for capturing and trending member complaints concerning providers. The provider complaints dashboard uses data from four reporting warehouses (i.e., Medicare Advantage, BlueCare Plus, Commercial, and BC Tennessee/TennCare*Select*/CoverKids) and groups these data into specific complaint categories including access, attitude and service, billing and financial issues, quality of practitioner office site, quality of care, and all other complaints. This dashboard enables credentialing department staff and contracting and provider network management staff members to access provider complaint information through a single, enterprise-wide complaints repository. The information contained within the provider complaints dashboard can be aggregated to develop ad hoc reports and can be viewed by specialty, line of business, complaint category, and month or quarter. Reports can be generated for the Provider Participation Status Committee to evaluate during the recredentialing process. End users can search the database using a provider's tax identification number, and network managers can easily access the information when speaking to or meeting with practitioners.	
Recommendations	
Network Adequacy	**BCE** achieved a score of 100% in 89 of 91 Network Adequacy measures. For performance improvement, **BCE** should address the shortage of hospitals in Morgan County. For CHOICES HCBS and ECF CHOICES provider types, **BCE** should address the shortage of adult day care providers in Blount, Campbell, Claiborne, Cocke, Loudon, McMinn, Rhea, Roane, Sevier, and Sullivan counties.
	BCM achieved a score of 100% in 89 of 91 Network Adequacy measures. For performance improvement, **BCM** should address the shortage of hospitals in Pickett and Fentress counties. For CHOICES HCBS and ECF CHOICES provider types, **BCM** should address the shortage of adult day care providers in Bedford, Cumberland, Davidson, Dickson, Maury, Robertson, Sumner, Warren, and Wilson counties.
	BCW achieved a score of 100% in 90 of 91 Network Adequacy measures. For CHOICES HCBS and ECF CHOICES provider types, **BCW** should address the shortage of adult day care providers in Chester, Dyer, Gibson, Haywood, Lake, Lauderdale, Obion, and Tipton counties.

Table 7. 2020 ANA Review Best Practices and Recommendations by MCC	
Benefit Delivery	**BC** should ensure that plan documents for all regions contain complete information about reconstructive breast surgery. The CRA requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as any surgical procedure on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast will only be covered if it occurs within five years of the date the reconstructive breast surgery was performed on the diseased breast. **BC** should also ensure that plan documents contain information concerning tissue transplants for members ages 21 years and older for all medically necessary and non-investigational/ experimental tissue transplants as covered by Medicare, or for members younger than 21 years of age as medically necessary in accordance with TennCare Kids requirements.
TCS	
Best Practices	
In 2019, **TCS** developed an internal system for capturing and trending member complaints concerning providers. The provider complaints dashboard uses data from four reporting warehouses (i.e., Medicare Advantage, BlueCare Plus, Commercial, and BC Tennessee/TennCare*Select*/CoverKids) and groups these data into specific complaint categories including access, attitude and service, billing and financial issues, quality of practitioner office site, quality of care, and all other complaints. This dashboard enables credentialing department staff and contracting and provider network management staff members to access provider complaint information through a single, enterprise-wide complaints repository. The information contained within the provider complaints dashboard can be aggregated to develop ad hoc reports and can be viewed by specialty, line of business, complaint category, and month or quarter. Reports can be generated for the Provider Participation Status Committee to evaluate during the recredentialing process. End users can search the database using a provider's tax identification number, and network managers can easily access the information when speaking to or meeting with practitioners.	
Recommendations	
Benefit Delivery	**TCS** should ensure that plan documents contain complete information about reconstructive breast surgery. The CRA requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as any surgical procedure on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast will only be covered if it occurs within five years of the date the reconstructive breast surgery was performed on the diseased breast. **TCS** should also ensure that plan documents contain information concerning tissue transplants for members ages 21 years and older for all medically necessary and non-investigational/ experimental tissue transplants as covered by Medicare, or for members younger than 21 years of age as medically necessary in accordance with TennCare Kids requirements.

Table 7. 2020 ANA Review Best Practices and Recommendations by MCC	
UHC	
Best Practices	
UHC's Enhanced Support Coordination model was developed to facilitate the success of the ECF CHOICES program goals. The primary goals are the preservation of community supports, placements, and tenure; encouragement of the full inclusion of individuals with intellectual/developmental disabilities (I/DD) in their communities; and assistance to prevent individuals with I/DD from experiencing unnecessary psychiatric admissions or institutional placements. Core features of clinical support include sound clinical assessment and comprehensive and ongoing staff and caregiver training, intervention, and support. At least one Board Certified Behavior Analyst (BCBA) in each Grand Region provides clinical support to the Support Coordinators (SCs). The BCBAs and SCs coordinate the care of individuals with I/DD who are referred to the ECF CHOICES program, many of whom present with maladaptive behaviors. This clinical support is provided via assessments; direct support staff training; interim or immediate behavior support; and linkages to appropriate BH clinicians, such as Applied Behavior Analysis providers.	
Recommendations	
Network Adequacy	**UHCE** achieved a score of 100% in 87 of 91 Network Adequacy measures. For performance improvement, **UHCE** should ♦ address the shortage of OB/GYN providers in Morgan and Polk counties; ♦ address the shortage of hospitals in Morgan County; and ♦ address the shortage of opioid use disorder treatment providers in Johnson and Sullivan counties. For CHOICES HCBS and ECF CHOICES provider types, **UHCE** should address the shortage of adult day care providers in Campbell, Claiborne, Cocke, Knox, McMinn, Rhea, Roane, Sevier, and Sullivan counties.
	UHCM achieved a score of 100% in 88 of 91 Network Adequacy measures. For performance improvement, **UHCM** should ♦ address the shortage of OB/GYN providers in Houston, Humphreys, Perry, Stewart and Wayne counties; ♦ address the shortage of outpatient non-MD services providers within 30 miles/45 minutes in Clay County; and ♦ address the shortage of opioid use disorder treatment providers in Stewart County. For CHOICES HCBS and ECF CHOICES provider types, **UHCM** should address the shortage of adult day care providers in Dickson, Maury, Robertson, Sumner, Warren, and Williamson counties.
	UHCW achieved a score of 100% in 86 of 91 Network Adequacy measures. For performance improvement, **UHCW** should ♦ address the shortage of OB/GYN providers in Benton, Decatur, and Henderson counties; ♦ address the shortage of hospitals in Fayette, Lake, and McNairy counties; ♦ address the shortage of outpatient treatment services in Hardin and McNairy counties; and ♦ address the shortage of opioid use disorder treatment providers in Dyer, Hardeman, Lake, and Obion counties. For CHOICES HCBS and ECF CHOICES provider types, **UHCW** should address the shortage of adult day care providers in Dyer, Gibson, Lauderdale, and Shelby counties.

Table 7. 2020 ANA Review Best Practices and Recommendations by MCC	
Benefit Delivery	♦ **UHC** must ensure that members in all regions receive consistent information related to age group frequencies for mammography screenings. ♦ **UHC** must ensure that providers in all regions receive correct information concerning the availability of physician outpatient services, community health clinic services, and other clinic services. ♦ **UHC** must inform providers in all regions about preventive care services. ♦ **UHC** must inform providers in all regions about benefits and coverage for medically necessary decision-making supports for ECF CHOICES members in Groups 4, 5, and 6.
DQ	
Best Practices	
DQ implemented three initiatives focused on increasing the efficiency of its provider communications. Provider communications, including newsletters, process change notices, benefit limitation changes, provider Medicaid registration, and other important information, were transitioned to email for faster, more efficient dissemination. Changing to email communication for information distribution allowed **DQ** to target the information to the email addresses of both the dentist and the office manager (or office). The provider newsletters were accessible through the provider portal, which required a practitioner to log in to his or her account to access information. To aid in the ease of accessibility to the quarterly **DQ** Digest TennCare Provider Newsletters, **DQ**'s public website was updated to create a space to house the newsletters, and an archive feature was added so that providers could access all past newsletters. Providers could access these newsletters on **DQ**'s public website without logging in. Additionally, **DQ** updated the **DQ** Digest TennCare newsletters to include a regular clinical corner article from its Dental Director and a section to outline any applicable Office Reference Manual (ORM) updates. These initiatives improved the efficiency of provider communications through increased speed of information dissemination through email, the opportunity to view newsletters on a public website without being required to log in to a secure portal, and the capability to reference archived newsletter information. The current and archived newsletters are located on the **DQ** website.	
Recommendations	
Network Adequacy	**DQ** achieved scores of 100% in five of six Network Adequacy measures. For improvement, **DQ** should address the shortage of ECF CHOICES dental providers in Lawrence County.

Annual Quality Survey (AQS)

Assessment Background

Qsource conducted the AQS pursuant to nationally recognized guidelines: (1) *NCQA 2018 Health Plan Accreditation Standards and Guidelines for Credentialing*; (2) CMS's *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations* (February 2012); and (3) additional state and federal regulations. The AQS was conducted from February through May 2020. Throughout the AQS, Qsource provided technical assistance to TennCare and its MCCs, and maintained ongoing, collaborative communication.

Technical Method of Data Collection and Analysis

The AQS is typically conducted in three phases for each plan: pre-onsite, onsite, and post-onsite. For 2020, however, TennCare approved the replacement of the onsite survey with a virtual survey for two MCOs (**BC** and **TCS**) and the DBM due to the COVID-19 pandemic.

Qsource's qualified EQRO survey team consisted of clinicians with expertise in QI and a healthcare data analyst. Qsource developed evidence-based oversight tools in consultation with TennCare and by referencing the State contracts with the plans:

- *Statewide Contract with Amendment 10—July 1, 2019* (**AG**, **BC**, and **UHC**)
- *An Agreement for the Administration of TennCareSelect between the State of Tennessee, d.b.a. TennCare and Volunteer State Health Plan, Inc.* (Amendments 1–45)
- *Contract #59802 Between the State of Tennessee, Department of Finance and Administration and DentaQuest USA Insurance Company, Inc.*

TennCare contributed in developing assessment tools and evaluating MCCs' planned improvements. AQS tools assess quality process (QP) standards for MCC policies and procedures (P&Ps), and performance activity (PA) file reviews for documentation in member files. Tool criteria, elements, and standards are updated annually—revised, added, and/or consolidated—with TennCare approval to reflect changes in contract references, better align with the State Quality Strategy, and facilitate data collection. Qsource provided the tools to the plans prior to the onsite/virtual surveys, giving each the opportunity to ask questions, submit requested documentation, and prepare for the survey.

Qsource's surveyor team first documented preliminary desktop review findings in the survey tools. During the onsite/virtual visits, they completed the survey tools, conducted interviews with plan staff, and obtained additional documentation to determine compliance with contractual requirements, explore issues not fully addressed in pre-assessment review, and increase overall understanding of plan performance. Surveyors closed the onsite/virtual visits by summarizing initial findings and recommendations with the plans.

After the onsite/virtual visits, Qsource compiled and analyzed compliance scores and reported results; identified MCC strengths, suggestions, and areas of noncompliance (AONs); and determined improvements made in AONs since the last AQS. Qsource uses tested protocols and scoring methods to calculate MCC compliance, analyzing each element of a QP standard using weighted point values to determine performance. All PAs have the same possible overall value.

Individual *2020 AQS Technical Papers* for each MCC were submitted as drafts within 30 days of each onsite/virtual survey completion and finalized, following TennCare and MCC feedback, within 60 days of the onsite/virtual survey. ANA review tools and findings for credentialing and recredentialing P&Ps and file reviews were incorporated into these reports. Only CHOICES (LTSS) providers' credentialing and recredentialing records were required to be reviewed for compliance, and were not conducted for **TCS** or **DQ** due to the plans' small CHOICES populations.

Onsite participants, documents requested before the onsite visit, and completed AQS tools (with surveyor comments and notes) were included in the individual plan reports as a comprehensive record of assessment activity. Additional details are available in those individual reports as well as the compiled findings in the *2020 AQS Summary Report*.

Description of Data Obtained

Table 8 presents the documentation that Qsource requested for desk review for the 2020 AQS.

Table 8. 2020 AQS Documentation Reviewed

MCOs and DBM
♦ Member Handbooks in English and Spanish
♦ Provider Manual
♦ Quality Improvement Program (QIP) Description
♦ Provider and Member Newsletters
♦ Quarterly EPSDT reports
♦ Utilization Management (UM) Program Description
♦ UM Program Evaluation of 2018 Activities
♦ QIP Evaluation of 2018 Activities
♦ Policies that define the MCC's time standards for handling all denials, complaints, and appeals
♦ 2019 corrective action plans and related documentation, if applicable
♦ All additional policies, procedures, and other documentation needed to answer survey tool elements
♦ Resumes of UM staff
MCOs only
♦ Current Population Health Program Descriptions
♦ 2019 Population Health Satisfaction Surveys
♦ Provider and Member Satisfaction Surveys
DBM only
♦ 2019 TennCare Kids Outreach Plan
♦ 2019 QIP Work Plan
♦ UM P&Ps
♦ Dental Service P&Ps

Additional documentation reviewed onsite included committee meeting minutes, quality studies, reports, and medical and provider records/files as needed to assess plan compliance with QP standards and PAs. Because NCQA accreditation is not mandated for the DBM and its service provisions are unique, its QP standards differed from the MCOs.

Comparative Findings

Results for QP standards and CHOICES credentialing/recredentialing file reviews are reported as one statewide score for each MCO. As shown in **Table 9**, MCOs earned 100% compliance for the vast majority of QP standards and all CHOICES credentialing/recredentialing file reviews in 2020. MCO compliance scores fell in only three QP standards compared to 2019: Network: Contracting, Availability, Access, and Documentation, for which **AG** achieved 97.1%; Non-Discrimination Compliance, for which **UHC** earned 95.0%; and Credentialing/Recredentialing P&Ps, for which **AG** earned 94.0% and **UHC** earned 97.0%.

Table 9. 2019–2020 AQS Compliance: MCO QP Standard and Credentialing/Recredentialing Results

QP Standards	AG		BC		TCS		UHC	
	2019	2020	2019	2020	2019	2020	2019	2020
Network: Contracting, Availability, Access, & Documentation	100%	97.1%	100%	100%	100%	100%	88.9%	97.1%
QI Activities	100%	100%	100%	100%	100%	100%	100%	100%
Clinical Criteria for Utilization Management (UM) Decisions	100%	100%	100%	100%	100%	100%	100%	100%
Member Rights and Responsibilities	100%	100%	100%	100%	100%	100%	100%	100%
EPSDT	100%	100%	100%	100%	100%	100%	100%	100%
TennCare Medical Services Grievance and Appeal Process	100%	100%	100%	100%	100%	100%	100%	100%
Non-Discrimination Compliance	100%	100%	100%	100%	100%	100%	100%	95.0%
Credentialing/Recredentialing P&Ps	100%	94.0%	100%	100%	100%	100%	100%	97.0%
CHOICES Credentialing/Recredentialing File Reviews[1]								
CHOICES Credentialing Files – Quantity[2]	83.3%	100%	88.9%	100%			100%	100%
CHOICES Credentialing Files – Quality[2]	100%	100%	100%	100%			100%	100%
CHOICES Recredentialing Files[1] – Quantity[2]	100%	100%	100%	100%			89.5%	100%
CHOICES Recredentialing Files[1] – Quality[2]	100%	100%	100%	100%			92.7%	100%

Scores in red indicate a decline for the 2020 review, while scores in green indicate increased or maintained scores compared to 2019. Cells in gray indicate that a measure was not assessed.

[1] *Not assessed for TCS due to its small number of CHOICES members.*

[2] *The quantity rating reflects the percentage of the sampled files available for review and the accuracy of the providers included in the sample; the quality rating reflects the accuracy and completeness of the credentialing documentation.*

PA file review scores are reported separately by operational region (**Table 10**). Once again, MCOs achieved 100% compliance with the vast majority of measures, only falling short in three PAs: UM Denials, for which **UHCE** achieved 97.5% compliance; Appeals, for which **UHCE** achieved 97.1%; and CHOICES Annual LOC Assessment, for which **UHCM** earned 95.0%.

Table 10. 2019–2020 AQS Compliance: MCO PA File Review Results

PAs	AGE		AGM		AGW		BCE		BCM		BCW		TCS		UHCE		UHCM		UHCW	
	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020
UM Denials (ages 20 and younger)	100%	100%	97.5%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97.5%	100%	100%	100%	100%
Appeals	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97.1%	100%	100%	100%	100%
EPSDT Information System Tracking[1]	100%	100%	100%	100%	100%	100%	100%		100%		100%		100%		100%	100%	100%	100%	100%	100%
CHOICES Annual LOC Assessment[2]	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			100%	100%	100%	95.0%	100%	100%
Transition of CHOICES Members Between MCOs[3]	100%	100%	100%	100%		100%	100%	100%	100%	100%	100%	100%			100%	100%	100%	100%	100%	100%

Scores in red indicate a decline for the 2020 review, while scores in green indicate increased or maintained scores compared to 2019. Cells in gray indicate that a measure was not assessed.

[1] *Not assessed for BC and TCS during the COVID-19 pandemic to avoid burdening providers with the additional task of retrieving medical records.*

[2] *Not assessed in 2019 or 2020 for TCS due to its small number of CHOICES members.*

[3] *Not assessed in 2019 for AGW because a sufficient number of files was not available for review. Not assessed in 2019 or 2020 for TCS due to its small number of CHOICES members.*

As shown in **Table 11,** **DQ**'s performance in the 2020 AQS mirrored its 2019 performance. The DBM only fell short of 100% compliance in one measure, the Appeals PA, for which it again scored 97.5%.

Table 11. 2019–2020 AQS Compliance: DBM Results

QP Standards	2019	2020	QP Standards	2019	2020
Written QMP Description	100%	100%	Utilization Review	100%	100%
Systematic Process of Quality Assessment & Improvement	100%	100%	Coordination of QM Activity w/ Other Management Activity	100%	100%
Accountability to the Governing Body	100%	100%	EPSDT	100%	100%
Active Quality Monitoring Program Committee	100%	100%	Non-Discrimination Compliance	100%	100%
Quality Monitoring Supervision	100%	100%	Credentialing/Recredentialing P&Ps	100%	100%
Adequate Resources	100%	100%	**PA File Reviews**	**2019**	**2020**
Provider Participation in the QMP	100%	100%	Appeals	97.5%	97.5%
Member Rights and Responsibilities	100%	100%	Complaints	100%	100%
Standards for Facilities	100%	100%	UM Denials (ages 20 years and younger)	100%	100%
Dental Records	100%	100%			

Scores in green indicate increased or maintained scores compared to 2019.

Conclusions

Strengths, Suggestions, and AONs

Scoring for each evaluated QP standard and file review reflects each plan's degree of compliance with applicable contractual, State, and federal requirements. In addition, Qsource identifies strengths, suggestions, and AONs to highlight areas in which an MCC excels, areas in which it could improve, and areas in which it must improve to achieve compliance, respectively. The lack of an identified strength should not be considered a deficiency. Qsource offers suggestions to help MCCs maximize quality efforts, even for measures in which a plan achieved 100% compliance. AONs are identified when a plan achieves less than 100% compliance on any given QP standard element or file review, and may be accompanied by recommendations for policy, procedure, or process changes. As shown in Table 12, this year, most suggestions involved updating P&Ps to include explicit statements about various requirements, or developing new P&Ps that could include such explicit statements. For improvement in AONs, several plans were instructed to ensure that timely member notifications are sent regarding provider terminations, UM denials, and appeal resolutions.

Table 12. 2020 AQS Strengths, Suggestions, and AONs	
AG	
Strengths	
Network: Contracting, Availability, Access, and Documentation	**Element #8, Initial Engagements**: **AG** proactively created the 2019 Opioid MAT Audit Program Annual Summary to analyze its process for the new network and TennCare requirements. The report included quarterly trends, comparisons between program structures, member-based assessments, and provider types.
QI Activities	**Element #20, High Utilization of Services**: **AG** had an effective and targeted approach to address high service utilization that included face-to-face visits with a case manager and care coordinators to determine member needs and make monthly treatment plan adjustments.
Early and Periodic Screening, Diagnostic, and Testing (EPSDT)	**Element #6: Targeted Activities for Smoking Cessation**: **AG** internally developed the Tennessee Smoking Cessation Tracker to compile information from several sources to provide a current snapshot of overall tobacco use and cessation activities among members and monitor activity effectiveness.
Suggestions	
Network: Contracting, Availability, Access, and Documentation	**Element #1, Specialist Termination**: **AG**'s P&P could explicitly state the member notification requirements for when a non-PCP is no longer with the MCO.
	Element #4, Subcontractor Audits: **AG** could explicitly state that, per the CFR requirement, the subcontractor's records and system are maintained for 10 years after the audit.
	Element #9, Subsequent Engagements: **AG** should update its P&P to note that it will provide at least two annual engagements for each provider after he or she has participated in the MAT network for two years.
CHOICES Annual Level of Care Assessment	**AGE**: The care coordinator could always include the date of the assessment on the LOC documentation.
	AGM: The care coordinator could ensure that the date of reassessment on the LOC documentation matches the actual date that the reassessment was conducted.
	AGW: The care coordinator could note the date the member was contacted to schedule a survey if the assessment took place beyond 365 days.
AONs	
Network: Contracting, Availability, Access, and Documentation	**Element #2, Notice of Provider Termination**: **AG** should ensure that it sends member notifications timely when a PCP ceases participation with the MCO.
Credentialing/ Recredentialing P&Ps	**Element #23, Credentialing Timeline: AG** should completely process credentialing applications within 30 calendar days of receipt of a completed credentialing application, including all necessary documentation, attachments, and a signed provider agreement.
	Element #24, Credentialing Timeline for Delegated Vendors: **AG** should ensure that it loads all providers submitted from the delegated credentialing agent into its provider files and claims processing system within 30 calendar days of receipt.

Table 12. 2020 AQS Strengths, Suggestions, and AONs	
BC	
Strengths	
Network: Contracting, Availability, Access, and Documentation	**Element #6, Prohibited Affiliations**: Policy: Monthly Screening of Federal Exclusion Databases Corporate Compliance stated that **BC** performed additional monthly exclusion screenings on the providers and their owners to ensure that no providers in the exclusion list were overlooked.
Suggestions	
Network: Contracting, Availability, Access, and Documentation	**Element #4, Subcontractor Audits**: **BC** could explicitly state that, per the CFR requirement, the subcontractor's records and system are maintained for 10 years after the final date of the contract period or the last audit, whichever is later.
	Element #9, Subsequent Engagement: **BC** could develop a procedure for meeting the MAT provider network CRA requirements.
Member Rights and Responsibilities	**Element #6, Communication Assistance Services**: **BC** could explicitly state in a policy that the Non-Discrimination Compliance Coordinator provides the language and cultural competence training.
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	**Element #15, Referral Providers List**: **BC** should have a policy that states providers have the right to request a hard copy of the provider referral directory at least 30 calendar days prior to their start date of becoming a contracted provider.
Non-Discrimination Compliance	**Element #4, Complaint Resolution and Reporting**: **BC** could explicitly state in the policy that the MCO would follow TennCare's non-discrimination complaint resolution. The MCO could also add an "Employee" tab to its quarterly Excel Non-Discrimination Compliance Reports to TennCare.
Appeals	**BCE**: The MCO should ensure that the latest State-mandated member letter template is used.
Transition of CHOICES Members Between MCOs	**BCM:** The MCO should ensure that, when an increase in member's needs is noted during the assessment, services are implemented in a timely manner.
No AONs were identified for BC in 2020.	
TCS	
Strengths	
Network: Contracting, Availability, Access, and Documentation	**Element #6, Prohibited Affiliations:** Policy: Monthly Screening of Federal Exclusion Databases Corporate Compliance stated that **TCS** performed additional monthly exclusion screenings on the providers and their owners to ensure that no providers in the exclusion list were overlooked.
Suggestions	
Network: Contracting, Availability, Access, and Documentation	**Element #4, Subcontractor Audits: TCS** could explicitly state that, per the CFR requirement, the subcontractor's records and system are maintained for 10 years after the final date of the contract period or the last audit, whichever is later.
	Element #9, Subsequent Engagement: TCS could develop a procedure for meeting the MAT provider network CRA requirements.
Member Rights and Responsibilities	**Element #6, Communication Assistance Services: TCS** could explicitly state in a policy that the Non-Discrimination Compliance Coordinator provides the language and cultural competence training.
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	**Element #15, Referral Providers List: TCS** should have a policy that states providers have the right to request a hard copy of the provider referral directory at least 30 calendar days prior to their start date of becoming a contracted provider.

Table 12. 2020 AQS Strengths, Suggestions, and AONs	
Non-Discrimination Compliance	**Element #4, Complaint Resolution and Reporting:** **TCS** could explicitly state in the policy that the MCO would follow TennCare's non-discrimination complaint resolution. The MCO could also add an "Employee" tab to its quarterly Excel Non-Discrimination Compliance Reports to TennCare.
No AONs were identified for TCS in 2020.	
UHC	
Suggestions	
Appeals	**All regions**: **UHC** could include its policy not to send member letters when an expedited appeal is upheld in its written appeals P&Ps.
Transition of CHOICES Members Between MCOs	**All regions**: **UHC** could update its policy to address instances when the required assessment cannot be completed within 30 days, and should document all contacts and efforts by the care coordinator to perform the review timely.
AONs	
Network: Contracting, Availability, Access, and Documentation	**Element #2, Notice of Provider Termination**: **UHC** should ensure timely notifications are sent to members after provider termination.
Non-Discrimination Compliance	**Element #2, Display of Non-Discrimination Information**: **UHC** should ensure that the required non-discrimination information is posted in conspicuous places that are accessible to all employees.
Credentialing/ Recredentialing P&Ps	**Element #12, Delegated Credentialing Reporting**: **UHC** should ensure that all subcontracts with delegated entities are presented to the appropriate committee for review and approval prior to establishing an effective date for the contract.
UM Denials	**UHCE**: The MCO should ensure that timely notifications are sent regarding UM denials. Issue noted in one file.
Appeals	**UHCE**: The MCO should ensure that timely member letters are sent regarding appeal resolutions. Issue noted in one file.
CHOICES Annual LOC Assessment	**UHCM**: The MCO should ensure that timely LOC assessments are conducted for each CHOICES member. Issue noted in one file.
No strengths were identified for UHC in 2020.	
DQ	
Suggestions	
Systematic Process of Quality Assessment and Improvement	**Element #2, Practice Guidelines:** The ORM could include practice guidelines that specifically address needs for I/DD members.
Member Rights and Responsibilities	**Element #6, Member Handbook Inclusions**: **DQ** could include a statement informing members that they can contact TennCare or the DBM with questions about TennCare.
	Element #14, Website: **DQ** could ensure that the Member Handbook posted on the website is always the most current version.
Non-Discrimination Compliance	**Element #4, Non-Discrimination Written Materials**: The Member Newsletters could state that translation and interpretation services are provided at no cost.
	Element #6, Complaint Resolution and Reporting: The Excel spreadsheet used to track details about discrimination complaints could identify whether members are enrolled in CoverKids or TennCare, since the same spreadsheet is used for both programs.
	Element #8, Provision of Services: **DQ** could explicitly note in a policy that it provides services to members, applicants, and participants in a non-discriminatory manner.

Table 12. 2020 AQS Strengths, Suggestions, and AONs	
AONs	
Appeals	One resolution letter was first sent to the incorrect member name; when the name was corrected in a second letter, it was sent outside the required timeframe. **DQ** should ensure that resolution letters include the correct member name and are sent timely.

No strengths were identified for DQ in 2020.

Improvements Since the 2019 AQS

Corrective action plans (CAPs) are designed to improve performance and give plans the opportunity to receive help with QI. TennCare may request CAPs at its discretion, but MCCs must submit a CAP for any QP standard element or file review scored less than 100% compliance, regardless of overall performance on the standard or activity. Qsource provided technical assistance to the MCCs completing CAPs, submitted CAP evaluations to TennCare for follow-up, and encouraged MCCs to monitor CAP activities throughout 2020 to ensure fully meeting stated goals and to close compliance gaps within documented timelines. **TCS** was not required to submit a CAP last year. All CAPs submitted after last year's AQS met objectives, as shown in **Table 13**.

Table 13. 2020 AQS: Improvements Since the 2019 AQS	
2019 AON	**2020 Improvements**
AG	
UM Denials—AGM The MCO should ensure that timely member notifications are sent to members after UM denial decisions are made; this issue was noted in one file.	The MCO conducted a refresher training for the staff regarding the UM prior authorization process and UM timeliness policy, and developed an audit tool to track the cases. **These actions satisfied the 2019 CAP.**
CHOICES Credentialing File Review (Quantity) The MCO should ensure that all files in the credentialing file sample are initial credentialing records rather than recredentialing records; this issue was noted in two files.	The MCO reviewed the CHOICES file sample data logic and determined that the two impacted providers were credentialed for multiple markets and the reporting captured the incorrect record for the Tennessee market credentialing event. The MCO revised the reporting logic to include a review of any multi-market provider files to ensure the reporting includes only the applicable status (initial credentialing or recredentialing) for Tennessee CHOICES provider files, and not for other files from other state markets in which the provider is credentialed. **These actions satisfied the 2019 CAP.**
BC	
CHOICES Credentialing File Review (Quantity) The MCO should ensure that all files in the credentialing file sample are initial credentialing records rather than recredentialing records; this issue was noted in one file.	The MCO added logic to compute the difference between the original credentialing date and the current date to ensure the accurate credentialing status of providers. The logic included a mechanism to identify suspicious data requiring additional review. BlueCare modified internal processes to review suspicious data monthly and evaluated all identified trends of suspicious data to discuss with internal management. BlueCare also implemented process stability monitoring until the 100% accuracy goal was maintained for three consecutive months. A root cause analysis determined the credentialing file sample issue to be a human error. The recredentialing date was logged as an initial credentialing date in the Cactus database. **These actions satisfied the 2019 CAP.**

Table 13. 2020 AQS: Improvements Since the 2019 AQS	
2019 AON	**2020 Improvements**
UHC	
Network: Contracting, Availability, Access, and Documentation **Element #1, Specialist Termination**: The MCO should ensure that timely notifications are sent to members after a specialist and/or specialty group terminates participation with the MCO.	The MCO stated that the Axiom Application enhancements have been implemented and are monitored weekly. To ensure timely member notification, results are analyzed monthly. The MCO also stated that when an improvement was identified, it would be documented and presented for further development. **These actions satisfied the 2019 CAP.**
Element #2, Notice of Provider Termination: The MCO should ensure that timely notifications are sent to members after a PCP terminates participation with the MCO.	
DQ	
Appeals The DBM should ensure it meets the time standard in resolving appeals; this issue was noted in one file.	A process change, in which an INC MCC request is forwarded to the Supervisor/Lead to assign to someone else to handle same day to ensure timelines are met in resolving appeals, was implemented in January 2019. **These actions satisfied the 2019 CAP.**

State Best Practices

Although the AQS is only federally required to be completed every three years, TennCare has helped ensure quality care for Medicaid members by requiring a full AQS to be completed annually. TennCare reduces the burden of this requirement by mandating MCCs attain NCQA certification, which eliminates the need for EQR of criteria inherently met through the NCQA. Additionally, while several State consent decrees were vacated in prior years with Medicaid program QI efforts, TennCare has continued to ensure improvements achieved are sustained by incorporating associated EPSDT and appeals mandates in MCC contracts and criteria in the QP standard and PA tools. TennCare and Qsource's collaborative CAP process and follow-up evaluations and technical assistance help ensure that MCC planned improvements in response to the AQS were effective and sustainable.

Performance Measure Validation (PMV)

Assessment Background

Qsource's PMV team consisted of both Certified HEDIS Compliance Auditors (CHCAs) and non-certified individuals selected for specified skills, including statistics, analysis, managed care operations, clinical expertise, performance measure reporting, IS assessments, and computer programming. Intended to measure achievement of TennCare's Quality and Performance goals and objectives and meet CMS requirements of *EQR Protocol 2*, the PMV draws findings from the *NCQA HEDIS Record of Administration, Data Management and Processes* (Roadmap) completed by the MCOs and an onsite visit by the Qsource team.

Technical Methods of Data Collection and Analysis

The PMV process includes an assessment of information systems (IS) capabilities, including the capture, transfer, and entry of data (e.g., medical services, enrollment, practitioner, and supplemental data). Medical services data are also assessed for sound coding methods. Validation included the following basic steps:

1. Pre-Onsite Activities: In addition to scheduling the onsite reviews and developing the agenda, the Qsource team prepared a data collection tool based on validation protocols and sent the HEDIS Roadmap packet to each MCO to facilitate its submission requirements. The team held conference calls with each MCO to follow up on any outstanding questions, and submitted a preliminary review to each MCO of its Roadmap and support documentation.

2. Onsite Reviews lasted one day and included an opening meeting, interviews with staff involved in performance measure reporting, a closing conference summarizing preliminary findings and recommendations and reviews of the following as related to performance measures:
   - System compliance, specifically the processing of claim, encounter, recipient, and provider data where applicable
   - Data integration and control procedures, including source code logic where applicable
   - How all data sources were combined and the method used to produce the analytical file for reporting

3. Validation Results: Based on all validation activities, results were determined for each performance measure following NCQA's HEDIS Compliance Audit protocol and a report of preliminary findings was prepared for each MCO. Following the MCOs' completion of audit follow-up requests and any applicable corrective actions, final rates submitted by the MCOs were approved by the auditor. A final report for each MCO was concluded with HEDIS Compliance Audit measure designations that includes *Reportable (R)*, which indicates a reportable rate was submitted for the measure,

and *Not Applicable (NA)*, which indicates the denominator was too small (less than 30) to report a valid rate. A complete list of designations was included in each *2020 PMV Report*.

Description of Data Obtained

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

- The Roadmap provided background information on MCO P&Ps and data in preparation for onsite PMV activities.
- When applicable, each MCO's Source Code (Programming Language) Performance Measures was reviewed for compliance with measure definitions if certified software was not used.
- Performance Measure Reports, prepared by each MCO, were reviewed, along with previous such reports, to assess trending patterns for any multiyear measures.
- Supportive Documentation included any additional information needed by the validation team to complete the PMV, including file layouts, system flow diagrams, system-log files, and data collection process descriptions.

For certified software, the vendor's certification report was reviewed to verify each HEDIS measure as certified by NCQA, and MCO oversight of the vendor was reviewed for accordance with NCQA's HEDIS Determination (HD) standards. Each MCO's information systems (IS), e.g., databases and software environment data collection procedures, supplemental databases, and abstraction, were reviewed to assess compliance with NCQA HEDIS standards to ensure reporting accurate and reliable rates and to identify aspects that could impact measure reporting. Noncompliance with the IS standards does not mean an MCO would not be able to report all measures.

For MY2019, TennCare MCOs were required to report a full set of HEDIS measures for NCQA-accreditation purposes, two of which were validated by Qsource in 2020—Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA), and Pharmacotherapy for Opioid Use Disorder (POD). Because TennCare only allowed reporting via administrative methodology, medical record review (MRR) was not applicable to the scope of the audit. The measure definitions from NCQA's *HEDIS 2020 Volume 2: Technical Specifications for Health Plans* are presented in Table 14.

Table 14. 2020 PMV Audit Measures	
Measure Name	**Measure Definitions**
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	The percentage of ED visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug abuse (AOD) or dependence, who had a follow-up visit for AOD. Two rates are reported. ♦ The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). ♦ The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).
Pharmacotherapy for Opioid Use Disorder (POD)	The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members ages 16 and older with a diagnosis of OUD. The measure is reported as a total rate as well as two age stratifications: 16-64 years and 65 years and older. *(Note: Rates for adults older than 65 years are Medicare provisions excluded from this report along with the total rate, which includes this age group.)*

Comparative Findings

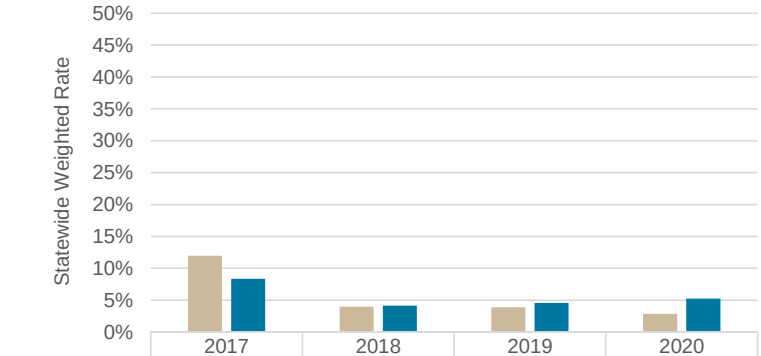
AG, **BC**, and **UHC** were compliant with the HEDIS Information Systems Standards and HEDIS Determination Standards, and continue to use NCQA-certified software vendors for HEDIS measure production. The MCOs calculated results for MY2019 and reported them to TennCare as statewide rates for the PMV rather than rates by operational region, as reported for HEDIS auditing. The DBM and PBM do not report performance measures, so were not included in validation. MCO-specific results appear in **Table 15**.

Table 15. 2020 PMV Results			
	AG	**BC**	**UHC**
Effectiveness of Care Measures: Behavioral Health			
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA):			
7-Day Follow-Up: 13–17 Years	0.00%	3.05%	4.65%
18 Years and Older	5.70%	5.12%	4.92%
Total	**5.39%**	**4.88%**	**4.90%**
30-Day Follow-Up: 13–17 Years	3.17%	4.88%	9.30%
18 Years and Older	9.28%	7.77%	7.81%
Total	**8.95%**	**7.43%**	**7.91%**
Pharmacotherapy for Opioid Use Disorder (POD):			
16–64 years	17.63%	20.61%	10.58%

Note: BC results include the statewide TCS.

Figures 6–9 compare statewide weighted rates for FUA for 2017–2020 by cohort. Because POD was a first-year measure, trending is not possible.

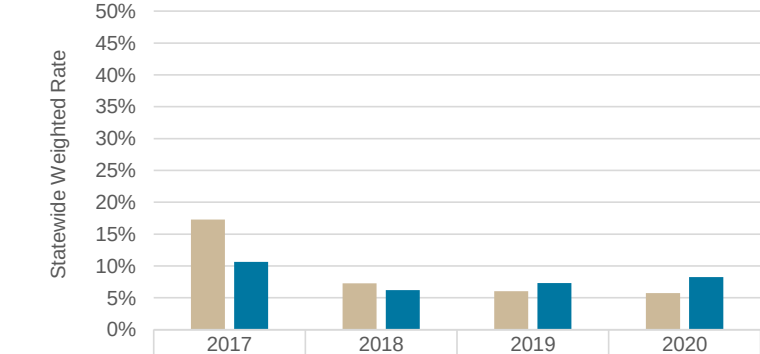
Figure 6. Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence (FUA)—7-Day Follow-Up



	2017	2018	2019	2020
13–17 years	11.96%	3.96%	3.90%	2.88%
≥18 years	8.37%	4.12%	4.58%	5.23%

Note: First-year measure in 2017. NCQA indicated trending with caution due to changes in measure specifications in 2018.

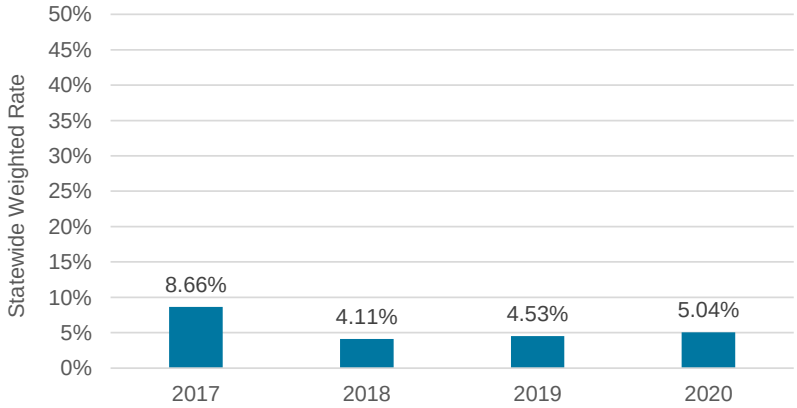
Figure 7. Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence (FUA)—30-Day Follow-Up



	2017	2018	2019	2020
13–17 years	17.28%	7.26%	6.03%	5.75%
≥18 years	10.64%	6.22%	7.31%	8.24%

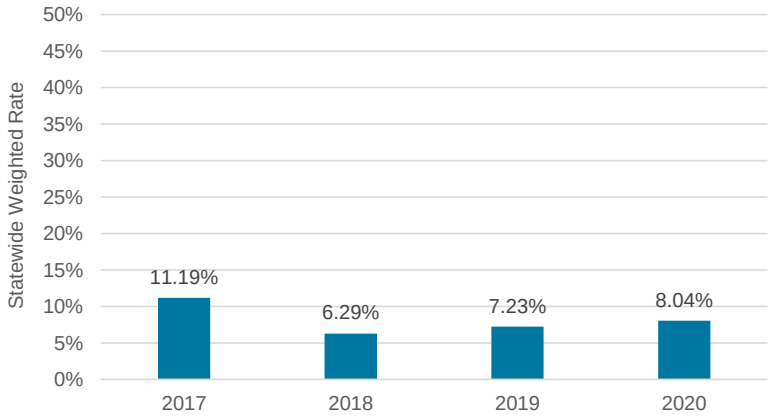
Note: First-year measure in 2017. NCQA indicated trending with caution due to changes in measure specifications in 2018.

Figure 8. Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence (FUA)—7-Day Follow-Up: Total



Note: First-year measure in 2017. NCQA indicated trending with caution due to changes in measure specifications in 2018.

Figure 9. Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence (FUA)—30-Day Follow-Up: Total



Note: First-year measure in 2017. NCQA indicated trending with caution due to changes in measure specifications in 2018.

Conclusions

All the MCOs evaluated passed the 2020 annual PMV audit, were determined to be in full compliance with all HEDIS standards (IS and HD), and received an *R* designation for all audited measures. **AG**, **BC**, and **UHC** continue to use NCQA-certified software vendors for HEDIS measure production. All submitted measures were prepared according to the HEDIS Technical Specifications and presented fairly, in all material, the MCOs' performances with respect to these specifications. All supplemental databases used by MCOs were approved for HEDIS 2020 reporting. All providers followed the fee-for-service payment model, so data completeness was not an issue. None of the MCOs had a backlog in processing enrollment data during the measurement year.

Because all MCOs were in full compliance with both the 2019 and 2020 audits, there were no deficiencies to report or improve for either year. Qsource did not identify particular strengths or best practices for any MCO during the 2020 PMV.

Performance Improvement Project (PIP) Validation

Assessment Background

The primary objective of PIP validation is to determine each PIP's compliance with the requirements set forth in the *Code of Federal Regulations* Title 42 § 438.330(d)(2), including:

- Measurement of performance using objective quality indicators
- Implementation of system interventions to achieve improvement in quality
- Evaluation of the effectiveness of the interventions
- Planning and initiation of activities to increase or sustain improvement

To evaluate PIPs, Qsource assembled a validation team of experienced clinical QI specialists, a healthcare data analyst, and a biostatistician with expertise in statistics, study design, and evaluation. For the 2020 PIP validation, 54 PIPs (24 unique topics) were conducted by nine regional MCOs, one statewide MCO, and the DBM (Table 17).

Technical Methods of Data Collection and Analysis

Each MCC is contractually required to annually submit PIP studies to TennCare as requested. Qsource developed a PIP Summary Form and a PIP Validation Tool to standardize the process by which each MCC provides PIP information to TennCare and how that information is assessed in compliance with and aligned to the 10 activities of CMS's *EQR Protocol 3: Validating Performance Improvement Projects (PIPs), Version 2.0* (September 2012). Each MCC submitted multiple PIP studies and supplemental information using the PIP Summary Form in July–September 2020.

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

The elements of each activity were scored as Met, Not Met, or Not Assessed. To ensure a valid and reliable review, 13 elements across eight activities were designated as "critical"— i.e., necessary to be Met, if applicable, for the MCC to assure accurate and reliable PIP results (see Table 16). Given the importance of the critical elements to this scoring methodology, any applicable critical element that received a Not Met status resulted in an overall validation status of Not Met and required future revisions of the PIP.

Validation scores were calculated by dividing the number of evaluation elements Met by the number assessed, including critical

elements, for an overall validation percentage. Critical elements were similarly calculated separately so that each MCC was given two scores; based on these, a validation status was determined that indicated confidence in study results.

Intervention strategies for each PIP in Remeasurement Year 1 or beyond, as written in unaltered language taken directly from MCC materials, can be found in Appendix A. More specific information on validation methodology is available in the individual, topic-and MCC-specific *2020 PIP Validation Technical Papers* as well as the *2020 PIP Validation Summary Report*.

Description of Data Obtained

PIP Summary Forms submitted by the MCCs included the necessary documentation detailing topic, population, and indicator selection; data collection methodologies; data analysis plans; interventions; and an interpretation of all results, including potential threats to validity.

Comparative Findings

TennCare plans achieved 100% critical element scores and a Met validation status for the vast majority of PIPs submitted in 2020. Of the 54 PIPs validated, 50 earned a Met validation status and 47 also earned overall element scores of 100%. All PIPs submitted by **AGE**, **AGM**, **AGW**, **BCE**, **BCM**, **BCW**, and **DQ** received a Met status and overall element scores of 100%. **TCS** received a Met status and overall element scores of 100% for five of its six submitted PIPs. **UHCE** and **UHCM** received a Met status for four of five submitted PIPs, and overall element scores of 100% for three of those five. **UHCW** achieved a Met status for five of six submitted PIPs, and overall element scores of 100% for four of those six.

Table 16. 2020 PIP Activities/Critical Elements

PIP Activities	Critical Elements
I. Choose the Study Topic(s)	Study topic… #6: Has the potential to affect member health, functional status or satisfaction
II. Define the Study Question(s)	Study question… #1: States the problem to be studied in simple terms #2: Is answerable
III. Use a Representative and Generalizable Study Population	Study population… #1: Is accurately and completely defined #3: Captures all members to whom the study question applies
IV. Select the Study Indicators	Study indicators… #1: Are well-defined, objective and measurable #3: Allow for the study question to be answered #5: Have available data that can be collected on each indicator
V. Use Sound Sampling Methods	Sampling methods… #5: Ensure a representative sample of the eligible population
VI. Use Valid and Reliable Data Collection Procedures	Data collection procedures include… #6: A data collection tool that ensures consistent and accurate collection of data according to indicator specifications
VII. Analyze Data and Interpret Study Results	Data analyses… #1: Are conducted according to the data analysis plan in the study design #2: Allow for generalization of results to the study population if a sample was selected
VIII. Include Improvement Strategies	Interventions are… #1: Related to causes/barriers identified through data analysis and quality improvement processes
IX. Assess for Real Improvement	No critical elements
X. Assess for Sustained Improvement	No critical elements

A summary of scores for both overall and critical elements and validation status is presented in **Table 17** by plan and PIP topic, along with study measurement year and study classification as either clinical (C) or non-clinical (NC). For studies conducted by more than one MCO region, scores and statuses listed in the table apply to each region.

Table 17. 2020 PIP Validation Results

PIP Study Title	Study Year	C/NC	Elements Met		Validation Status*
			Overall	Critical	
AGE, AGM, and AGW					
Improve EPSDT Screening Rates in the 18–20-Year-Old Age Group	R1	C	100%	100%	**Met**
Increase Percentage of Members with Documented In-Home Assessment of Nine Core Elements within 90 Days	R1	NC	100%	100%	**Met**
Increasing the Percentage of Complex Case Management and High-Risk OB Members that Complete the 2nd Quality of Life Survey (SF-12)	R3	NC	100%	100%	**Met**
AGE					
Improve East Grand Region Member Satisfaction with the Health Plan	B	NC	100%	100%	**Met**
AGW					
Improving Diabetic Screening Compliance for Members with Schizophrenia or Bipolar Disorder using Antipsychotic Medication (SSD)	B	C	100%	100%	**Met**
Increase West Grand Region Member Participation in the EPSDT Healthy Rewards Incentive Program	R2	NC	100%	100%	**Met**
BCE, BCM, and BCW					
Antidepressant Medication Management—Continuation (AMM-C)	B	C	100%	100%	**Met**
Decrease the Use of Opioids in High Dosages (HDO)	B	NC	100%	100%	**Met**
Social Determinants of Health Data Collection Process	B	NC	100%	100%	**Met**
*CHOICES Critical Incident Timeliness of Reporting***	R1	NC	100%	100%	**Met**
BCE, BCM, BCW, and TCS					
Improving Childhood Immunization Status (CIS) and Immunizations for Adolescents (IMA)	B	C	100%	100%	**Met**
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	R3	NC	100%	100%	**Met**
TCS					
Improving Comprehensive Diabetes Care (CDC) Blood Pressure Control for SelectCommunity	B	NC	100%	100%	**Met**
Plan All-Cause Readmissions (PCR)	B	NC	95.7%	87.5%	**Not Met**
Follow-Up after Hospitalization for Mental Illness (FUH)	R1	C	100%	100%	**Met**
Social Determinants of Health Data Collection Process	R1	NC	100%	100%	**Met**
UHCE, UHCM, and UHCW					
Increasing the Physical Health Provider Satisfaction Survey Engagement Rate	B	NC	96.0%	100%	**Met**
Perception of Care Coordination	R1	NC	100%	100%	**Met**

Table 17. 2020 PIP Validation Results					
PIP Study Title	Study Year	C/NC	Elements Met		Validation Status*
			Overall	Critical	
Impact of Member and Provider Outreach on Immunization Rates for CIS Combo 10	R1	C	100%	100%	**Met**
Transitions of CHOICES Individuals	R1	NC	94.9%	90.9%	**Not Met**
Impact of Provider Incentives on the Screening Rates for Adolescents Ages 12–21	R2	C	100%	100%	**Met**
UHCW					
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	B	C	100%	100%	**Met**
DQ					
Increasing Provider Use of Silver Diamine Fluoride (SDF) as a Preventive Measure	R2	C	100%	100%	**Met**
Decreasing TennCare Enrollees Receiving Opioid Prescriptions	R2	NC	100%	100%	**Met**

**Met indicates that the PIP is valid; Not Met indicates low confidence in the study's results.*
*** PIP was conducted by BC statewide, but the results are considered valid and reported for each region.*

Conclusions

Strengths, Suggestions, and AONs

To help improve PIP performance, Qsource identified strengths, suggestions, and/or AONs (**Table 18**) regardless of validation status.

Table 18. 2020 PIP Validation Strengths, Suggestions, and AONs	
AG	
Suggestions	
Improve EPSDT Screening Rates in the 18–20-Year-Old Age Group	**Activity IV. AGE/AGM/AGW**: The MCO could consider a benchmark closer to the State-required CMS-416 screening rate of 90%.
	Activity IX. AGM: The MCO could further explore the influence on the validity or comparability of findings of member enrollment changes and two locations closing.
Increase Percentage of Members with Documented In-Home Assessment	**Activity I. AGE/AGM/AGW:** The MCO should ensure that the cover page includes the correct start date for the study (1/1/18).
	Activity IV. AGE/AGM/AGW: The MCO could set the benchmark at 90% as described in the study indicator selection details.
	Activity VI. AGE/AGM/AGW: The MCO should select Administrative Only as the data source in the PIP Summary Form.
Increasing Completion of the 2nd Quality of Life Survey (SF-12)	**Activity VII. AGE/AGM/AGW:** The MCO could mention that the algorithm issue revealed in the retrospective analysis may have affected the validity of the measurements.
Improve East Grand Region Member Satisfaction with the Health Plan	**Activity III. AGE:** The MCO should align the narrative for this activity with the study indicator to appropriately reflect the continuous enrollment requirement in the HEDIS Technical Specifications.
	Activity IV. AGE: The MCO could specify that the baseline goal is specific to Medicaid.

No strengths or AONs were identified for any AGE, AGM, or AGW PIPs in 2020.

Table 18. 2020 PIP Validation Strengths, Suggestions, and AONs	
BC	
Strengths	
CHOICES Critical Incident Timeliness of Reporting	**Activity VII. BC Statewide:** The MCO provided a thorough and detailed explanation and various graphs regarding the critical incidence metrics for each region and by various timeframes, including monthly and at six-month intervals.
Suggestions	
Antidepressant Medication Management—Continuation (AMM-C)	**Activity I. BCE/BCM/BCW:** The MCO could clarify the narrative and/or bar graph to indicate whether the MCO rates are being compared to the 50th or 90th percentile national rates.
	Activity II. BCE/BCM/BCW: The MCO could expand the study question to allow for more than one intervention, and provide clarity by changing "improve" to "increase."
	Activity IV. BCE/BCM/BCW: The MCO should correctly define the denominator using HEDIS Technical Specifications.
CHOICES Critical Incident Timeliness of Reporting	**Activity IV. BC Statewide**: The MCO could have reported the baseline rate as the adjusted rate for the entire year, as reported in Activity IX (83.38%).
	Activity VII. BC Statewide: The MCO could improve its data analysis and interpretation by clearly labeling the information that addresses the statewide data, and clearly separating it from the regional results and the corresponding segmented timeframes.
	Activity IX. BC Statewide: The MCO should state that the remeasurement methodology was different from the baseline methodology, as described in Activity VII.
Social Determinants of Health Data Collection Process	**Activity IV. BCE/BCM/BCW**: The MCO could use the correct MCO name in the benchmark description for Study Indicator 3.
No AONs were identified in any BCE, BCM, or BCW PIPs in 2020.	
BC and TCS	
Suggestions	
Improving Childhood Immunization Status (CIS) and Immunizations for Adolescents (IMA)	**Activity I. TCS**: The MCO should ensure that the graph descriptions correlate with the graphs provided.
	Activity II. BCE/BCM/BCW and **TCS:** The MCO could improve the study question by broadening the wording to allow for more than one intervention, clarifying the age requirements, and focusing on influenza and HPV vaccination rates only. For example, "Do interventions targeted at providers result in increased influenza and HPV vaccination rates in children and adolescents?"
	Activity IV. BCE/BCM/BCW: The MCO could define the denominators more accurately by indicating whether regional data were used and allowable exclusions were applied. **TCS**: The MCO could define the denominators more accurately by indicating whether allowable exclusions were applied.
	Activity VI. BCE/BCM/BCW and **TCS**: The MCO could provide a detailed explanation of how the baseline rates for this PIP were developed, including an explanation of the optional exclusions. It could also explain the discrepancy between the baseline rate and the attached IDSS document for the CIS-10 measure, as well as clarify the use of optional exclusions for the IMA-2 measure.
No strengths or AONs were identified for any combined BCE/BCM/BCW/TCS PIPs in 2020.	

Table 18. 2020 PIP Validation Strengths, Suggestions, and AONs	
TCS	
Strengths	
Follow-Up After Hospitalization for Mental Illness (FUH)	**Activity VII. TCS**: The MCO attempted to identify the impact of the specific interventions through statistical analyses. In addition to the overall rate, the MCO reported monthly compliance rate results. The MCO illustrated all results through the narrative, a listing of metrics, and graphics. The MCO also attached documentation of the statistical analyses' results.
Social Determinants of Health Data Collection Process	**Activity VII. TCS:** The MCO provided graphic displays of the study indicators' results, which clearly illustrated the MCO's progress in meeting its goals for the PIP.
Suggestions	
Follow-Up After Hospitalization for Mental Illness (FUH)	**Activity IX. TCS**: The MCO could mention the additional analysis and results that assessed the interventions' effectiveness as described in Activity VII.
Improving Comprehensive Diabetes Care (CDC) Blood Pressure Control for SelectCommunity	**Activity III. TCS**: The MCO could ensure that it consistently states which HEDIS Technical Specifications were used to define the study population throughout the PIP Summary Form.
	Activity IV. TCS: The MCO could ensure that it does not include information in the PIP Summary Form that conflicts with the study populations described in Activity III.
	Activity VI. TCS: The MCO could provide detailed explanations for using 2019 HEDIS Technical Specifications instead of 2020 HEDIS Technical Specifications when using MY2019 data.
Social Determinants of Health Data Collection Process	**Activity VII. TCS**: The MCO should report information consistently throughout the PIP Summary Form regarding factors that affect the validity and comparability of results, ensuring that every instance includes the possible impacts of the five-month timeframe for data collection during the Baseline Year and the non-actionable SDoH tool questions.
	Activity VIII. TCS: The MCO could ensure that it describes each intervention under the correct measurement year.
	Activity IX. TCS: The MCO could state that the remeasurement methodology was not the same as baseline. The MCO should report the interpretation for improvement due to the interventions in Activity IX, not in Activity X.
Plan All-Cause Readmissions	**Activity II. TCS**: The MCO could restate the study question to ensure clarity and measurability, since improvement in the two measures is defined as decreasing for one measure and increasing for the other measure. As an example, rather than using the word "improve" in the first half of the study question, the MCO could use "reduce" or "decrease." In addition, the second half of the study question ("improve the predicted probability of an acute readmission") could be reworded to "increase the predicted probability of an acute readmission."
	Activity III. TCS: The MCO could include continuous enrollment, the allowable gap, and anchor date surrounding the index discharge date.
AONs	
Plan All-Cause Readmissions	**Activity IV. TCS**: The MCO should ensure that the study question is completely answered by either dropping the second part of the study question ("predicted probability of an acute readmission") or by adding a study indicator to measure that part of the study question.

Table 18. 2020 PIP Validation Strengths, Suggestions, and AONs

UHC	
Suggestions	
Transitions of CHOICES Individuals	**Activity I. UHCE/UHCM/UHCW**: The MCO should ensure that the study topic matches the study's focus on the net change in the population rather than the number of actual transitions so that it aligns with the study question and indicators.
	Activity II. UHCE/UHCM/UHCW: The MCO should provide a detailed rationale when a study question is modified from the previous measurement year.
	Activity IV. UHCE/UHCM/UHCW: The MCO should ensure that the denominators for Study Indicators 1 and 2 specify whether the populations are statewide or regional.
Impact of Member and Provider Outreach on Immunization Rates for CIS Combo 10	**Activity III. UHCE/UHCM/UHCW:** The MCO could include the anchor dates used to determine member age in the study population inclusion criteria.
	Activity VIII. UHCE/UHCM/UHCW: The MCO could clarify how it is conducting member outreach or add an intervention focused on such, as member outreach is included in the study topic and study question as one of the ways it hopes to increase its CIS Combo 10 rates.
Perception of Care Coordination	**Activity IX. UHCE/UHCM/UHCW:** The MCO could mention in this activity that adjustments were made to the calculation methodology to assure increased accuracy and validity of comparisons.
Increasing the Physical Health Provider Satisfaction Survey Engagement Rate	**Activity VI. UHCE/UHCM/UHCW**: The MCO should clearly define the data elements to be collected, including any requirements for a returned survey to be excluded or determined invalid. The MCO could include the dates that the surveys were sent to providers. The MCO could also provide a copy of the Excel data collection tool discussed in this activity.
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	**Activity I. UHCW**: The MCO could include a specific statement regarding the inclusion or exclusion of members with special healthcare needs.
	Activity IV. UHCW: The MCO should include the baseline measurement result in the PIP Summary Form and not only in the attachment.
AONs	
Transitions of CHOICES Individuals	**Activity III. UHCE/UHCM/UHCW**: The MCO should ensure that the study population is accurately and completely defined, and that information regarding continuous enrollment requirements is unambiguous and consistent for this activity and throughout the PIP Summary Form.
Increasing the Physical Health Provider Satisfaction Survey Engagement Rate	**Activity VI. UHCE/UHCM/UHCW**: The MCO should include a discussion of the IRR process, including information about the process, responsible parties, score required for passing, and corrective actions.

No strengths were identified for any UHCE, UHCM, or UHCW PIPs in 2020.

DQ	
Suggestions	
Decreasing TennCare Enrollees Receiving Opioid Prescriptions	**Activity II. DQ:** The DBM could ensure that the web links provided in the PIP Summary Form are current and active.
	Activity IV. DQ: The DBM should include an explanation for changing the Remeasurement 1 results from those provided in 2019.
	Activity VIII. DQ: The DBM could include a fishbone diagram to facilitate the description of root cause analysis and explain how the barriers were identified, ensure items in the List Intervention section are complete, and refrain from adding intervention actions as barriers.

Table 18. 2020 PIP Validation Strengths, Suggestions, and AONs	
Increasing Provider Use of Silver Diamine Fluoride (SDF) as a Preventive Measure	**Activity III. DQ**: The DBM could add the specific dates used for age identification in inclusion criteria to this activity in the PIP Summary Form.
	Activity VII. DQ: As noted in the 2019 validation for this PIP, the DBM could correctly report the percentage increase between Baseline and Remeasurement 1.
	Activity VIII. DQ: The DBM could ensure that the web link provided in the PIP Summary Form to the Toolkit is current and active; provide a narrative on how system changes are likely to induce permanent change; include detailed plans for standardizing and monitoring successful interventions in this activity instead of Activity VII: Analyze Data and Interpret Study Results; and ensure that barriers are not stated as improvements.

No strengths or AONs were identified for any DQ PIPs in 2020.

Improvements Since the 2019 PIP Validation

For studies that receive AONs for any element, Qsource provides technical assistance to help plans understand CMS protocol and revise PIPs as needed to improve performance. In subsequent validation years, plans should update their PIP Summary Forms with additional information to address any suggestions and elements assessed as Not Met. This year, MCOs made improvements to AONs identified in three study topics, as outlined in **Table 19**.

Table 19. 2020 PIP Validation: Improvements Since the 2019 PIP Validation		
PIP Topic	**2019 AON**	**2020 Improvements**
CHOICES Critical Incident Timeliness of Reporting	**Activity VI.** **BCE**, **BCM**, and **BCW** should identify the correct data source (Administrative Only for this PIP) in the PIP Summary Form.	All three regions identified the correct data source. This year, the PIP's overall element scores for all regions improved from 95.5% to 100% (its status was Met for all regions in both 2019 and 2020).
Perception of Care Coordination	**Activity V.** For Study Indicator 1, **UHCE** and **UHCM** should describe the sampling methodology, including confidence level, population size, and acceptable margin of error, as well as a description of how the sample was representative of the eligible population and how sampling techniques were used in accordance with generally accepted principles of research design.	**UHCE** and **UHCM** revised Study Indicator 1 to include all eligible members and did not require sampling. This year, **UHCE** and **UHCM**'s overall element scores for this PIP improved from 87.9% to 100%, and their critical element scores improved from 90.0% to 100%. The validation status changed for both regions from Not Met to Met.
Transitions of CHOICES Individuals	**Activity III**. **UHCE**, **UHCM**, and **UHCW** should ensure that the study population is accurately and consistently defined throughout the PIP Summary Form, particularly when describing the number and make-up of the population groups. The MCO should also ensure that information regarding continuous enrollment requirements is accurate in this activity and consistent throughout the PIP Summary Form.	All three regions revised the study question to better align with the study indicators, although issues with the indicators and study population remained. This year, the PIP's overall element score for all regions improved from 87.0% to 94.9%, and its critical element score improved from 75.0% to 90.9%. The validation status for all regions remained Not Met.

Table 19. 2020 PIP Validation: Improvements Since the 2019 PIP Validation		
PIP Topic	**2019 AON**	**2020 Improvements**
	Activity IV. **UHCE**, **UHCM**, and **UHCW** should ensure that each study indicator aligns with the study question and allows for it to be answered.	

For the 2020 PIP validation, TennCare required MCCs to submit a CAP for any AONs via a similar evaluation and monitoring process to the AQS CAP process. Three PIP topics (seven studies total) received an AON in 2020 and required CAPs, which will be evaluated next year: *Plan All-Cause Readmissions* (**TCS**), *Transitions of CHOICES Individuals* (**UHCE**, **UHCM**, and **UHCW**), and *Increasing the Physical Health Provider Satisfaction Survey Engagement Rate* (**UHCE**, **UHCM**, and **UHCW**).

Summary and Conclusions

Summary Results by Plan

Table 20 presents highlights of the results, recommendations, and strengths and improvements identified for each TennCare plan during the 2020 evaluation year.

Table 20. 2020 Results, Recommendations, and Strengths by Plan

AG		
Results	**ANA Review**	**AGE** earned an overall Network Adequacy score of 97.4%; **AGM** earned an overall Network Adequacy score of 97.8%; and **AGW** earned an overall Network Adequacy score of 97.7%. The three regions each earned a Benefit Delivery score of 99.5%.
	AQS	**AG** earned 100% compliance with all CHOICES credentialing/recredentialing file reviews and all QP standards except Network: Contracting, Availability, Access, and Documentation, for which it earned 97.1%, and Credentialing/Recredentialing P&Ps, for which it earned 94.0%. **AGE**, **AGM**, and **AGW** earned 100% compliance with all PA file reviews.
	PMV	**AG** passed the 2020 annual PMV audit, was determined to be in full compliance with all HEDIS standards (IS and HD), and received an R designation for all audited measures.
	PIP Validation	**AGE** earned 100% overall element scores and a Met validation status for all four submitted PIPs. **AGM** earned 100% overall element scores and a Met validation status for all three submitted PIPs. **AGW** earned 100% overall element scores and a Met validation status for all five submitted PIPs.
Recommendations	**ANA Review**	Network Adequacy: **AGE**, **AGM**, and **AGW** should address shortages of OB/GYNs, optometry providers, and hospitals in several counties. **AGE** should address the shortage of substance abuse outpatient treatment providers in one county. **AGM** should address the shortage of opioid use disorder treatment providers who meet the 45 miles/45 minutes standard in two counties, and **AGW** must address the shortage of opioid use disorder treatment providers who meet both the 45 miles/45 minutes and 60 miles/60 minutes standards in five counties. All three regions should address the shortage of CHOICES adult day care providers in several counties, and **AGE** should also address the shortage of CHOICES specialized consultation and training providers in several counties. Benefit Delivery: **AG**'s three regions must inform members about benefits related to reconstructive breast surgery, as well as provide consistent information about age groups and frequency of mammography screenings.
	AQS	**AG** should ensure that it sends timely notifications when a PCP ceases MCO participation; should completely process credentialing applications within 30 days of receipt; and load all providers submitted from the delegated credentialing agent into its provider files and claims processing system within 30 days of receipt. For improvement regardless of compliance scores, **AG** could address issues noted in the Network QP standard. **AGE**, **AGM**, and **AGW** could each address issues noted in the CHOICES Annual LOC Assessment PA.
	PMV	No deficiencies or recommendations for improvement were identified.
	PIP Validation	No AONs were identified. For improvement regardless of validation scores, **AGE**, **AGM**, and **AGW** could address issues noted in Activity IV for *Improve EPSDT Screening Rates*, and **AGM** could address an issue noted in Activity IX of the same PIP. **AGE**, **AGM**, and **AGW** could address issues noted in Activities I, IV, VI for *Increase Percentage of Members with Documented In-Home Assessment*, and in Activity VII for *Increasing Completion of the 2nd Quality of Life Survey*. **AGE** could address issues noted in Activities III and IV for *Improve East Grand Region Member Satisfaction*.

Table 20. 2020 Results, Recommendations, and Strengths by Plan		
Strengths & Improvements	**ANA Review**	**AG** was commended for developing a Very Important Provider (VIP) Provider Engagement Model that offered regional pillar providers and health systems an additional level of service.
	AQS	**AG** was commended for its performance in three QP standards: Network, for creating an Opioid MAT Audit Program Annual Summary; QI Activities, for taking an effective approach to addressing high service utilization; and EPSDT, for developing the Tennessee Smoking Cessation Tracker. Since the 2019 AQS, **AGM** conducted refresher training for staff regarding the UM prior authorization process and timeliness policy, and all three regions revised their data reporting logic to ensure reporting includes only applicable information for CHOICES provider files. This year, **AG** raised its CHOICES credentialing files quantity rating to 100%, and **AGM** raised its UM Denials score to 100%.
	PMV	No particular strengths or improvements were identified.
	PIP Validation	No particular strengths or improvements were identified.
BC		
Results	**ANA Review**	**BCE** earned an overall Network Adequacy score of >99.9%, and **BCM** and **BCW** each earned 99.9%. **BCE** earned an overall Benefit Delivery score of 97.8%; **BCM** and **BCW** each earned 99.5%.
	AQS	**BC** achieved 100% compliance with all QP standards and CHOICES credentialing/recredentialing file reviews. **BCE**, **BCM**, and **BCW** each achieved 100% compliance with all applicable PAs.
	PMV	**BC** passed the 2020 annual PMV audit, was determined to be in full compliance with all HEDIS standards (IS and HD), and received an R designation for all audited measures.
	PIP Validation	**BCE**, **BCM**, and **BCW** earned 100% overall element scores and a Met validation status for all six submitted PIPs.
Recommendations	**ANA Review**	Network Adequacy: **BCE** and **BCM** should address the shortage of hospitals in several counties combined. **BCE**, **BCM**, and **BCW** should each address the shortage of CHOICES adult day care providers in several counties. Benefit Delivery: **BC**'s three regions should ensure that plan documents contain complete information about reconstructive breast surgery. Plan documents should also contain information concerning tissue transplants for members ages 21 years and older as covered by Medicare, or for members younger than 21 years of age as medically necessary in accordance with TennCare Kids requirements.
	AQS	No AONs were identified. For improvement regardless of compliance scores, **BC** could address issues noted in four QP standards: Network; Member Rights and Responsibilities; EPSDT; and Non-Discrimination Compliance. **BCE** could address an issue noted in the Appeals PA, and **BCM** could address an issue noted in the Transition of CHOICES Members Between MCOs PA.
	PMV	No deficiencies or recommendations for improvement were identified.
	PIP Validation	No AONs were identified. For improvement regardless of validation scores, **BCE**, **BCM**, and **BCW** could address issues noted in Activities I, II, and IV for *AMM-C*; Activities IV, VII, and IX for *CHOICES Critical Incident Timeliness of Reporting*; Activity IV for *Social Determinants of Health Data Collection Process*; and Activities II, IV, and VI for *Improving CIS and IMA*.
Strengths & Improvements	**ANA Review**	**BC** was commended for developing an internal system for capturing and trending member complaints concerning providers.
	AQS	**BC** was commended for the Network QP standard for performing additional monthly exclusion screenings on providers. Since the 2019 AQS, **BC** added programming logic for CHOICES credentialing that included a mechanism to identify suspicious data requiring additional review, and implemented process stability monitoring until the 100% accuracy goal was maintained for three consecutive months. This year, **BC** raised its CHOICES credentialing files quantity rating to 100%.
	PMV	No particular strengths or improvements were identified.
	PIP Validation	**BCE**, **BCM**, and **BCW** provided a thorough and detailed discussion of the metrics for *CHOICES Critical Incident Timeliness of Reporting*. Each region also corrected the data source for the same PIP after the 2019 validation.

Table 20. 2020 Results, Recommendations, and Strengths by Plan

TCS		
Results	**ANA Review**	**TCS** earned an overall Network Adequacy score of 100% and an overall Benefit Delivery score of 99.0%.
	AQS	**TCS** earned 100% compliance with all QP standards and both applicable PAs.
	PMV	**TCS** (reported with **BC** results) passed the 2020 annual PMV audit, was determined to be in full compliance with all HEDIS standards (IS and HD), and received an R designation for all audited measures.
	PIP Validation	**TCS** earned 100% overall element scores and a validation status of Met for five of six submitted PIPs.
Recommendations	**ANA Review**	Benefit Delivery: **TCS** should ensure that plan documents contain complete information about reconstructive breast surgery. Plan documents should also contain information concerning tissue transplants for members ages 21 years and older as covered by Medicare, or for members younger than 21 years of age as medically necessary in accordance with TennCare Kids requirements.
	AQS	No AONs were identified. For improvement regardless of compliance scores, **TCS** could address issues noted in four QP standards: Network; Member Rights and Responsibilities; EPSDT; and Non-Discrimination Compliance.
	PMV	No deficiencies or recommendations for improvement were identified.
	PIP Validation	**TCS** should ensure the study question is able to be answered, either by revising the question or adding an indicator, for *Plan All-Cause Readmissions*. For improvement regardless of validation scores, **TCS** could address issues noted in Activities I, II, IV, and VI for *Improving CIS and IMA*; Activity IX for *FUH*; Activities III, IV, and VI for *Improving CDC Blood Pressure Control for SelectCommunity*; Activities VII, VIII, and IX for *Social Determinants of Health Data Collection Process*; and Activities II and III for *Plan All-Cause Readmissions*.
Strengths & Improvements	**ANA Review**	**TCS** was commended for developing an internal system for capturing and trending member complaints concerning providers.
	AQS	**TCS** was commended for the Network QP standard for performing additional monthly exclusion screenings on providers.
	PMV	No particular strengths or improvements were identified.
	PIP Validation	**TCS** was commended for its thorough statistical analyses and discussion of metrics and rates for its *FUH* PIP. The MCO was also commended for clearly illustrating indicator results and study progress for *Social Determinants of Health Data Collection Process*.
UHC		
Results	**ANA Review**	**UHCE** and **UHCM** each earned an overall Network Adequacy score of 99.9%, and **UHCW** earned >99.9%. For overall Benefit Delivery, **UHCE** and **UHCM** earned a score of 99.0% and **UHCW** scored >99.9%.
	AQS	**UHC** earned 100% compliance with all CHOICES credentialing/recredentialing file reviews and all but three QP standards, earning 97.1% for Network, 95.0% for Non-Discrimination Compliance, and 97.0% for Credentialing/Recredentialing P&Ps. **UHCE** achieved 100% compliance with three of five PAs, earning 97.5% for UM Denials and 97.1% for Appeals. **UHCM** achieved 100% with four of five PAs, earning 95.0% for CHOICES Annual LOC Assessment. **UHCW** achieved 100% compliance with all five PAs.
	PMV	**UHC** passed the 2020 annual PMV audit, was determined to be in full compliance with all HEDIS standards (IS and HD), and received an R designation for all audited measures.
	PIP Validation	**UHCE** and **UHCM** earned a Met validation status for four of five submitted PIPs, and a 100% overall element score for three of five submitted PIPs. **UHCW** earned a Met validation status for five of six submitted PIPs, and a 100% overall element score for four of six submitted PIPs.

Table 20. 2020 Results, Recommendations, and Strengths by Plan

Recommendations	**ANA Review**	Network Adequacy: **UHCE** should address shortages of OB/GYNs, hospitals, and opioid use disorder treatment in several counties. **UHCM** should address shortages of OB/GYNs, outpatient non-MD services, and opioid use disorder treatment providers in several counties. **UHCW** should address shortages of OB/GYN providers, hospitals, outpatient treatment services, and opioid use disorder treatment providers in several counties. All three regions should address shortages of CHOICES adult day care providers in several counties. Benefit Delivery: **UHC** must ensure for all regions that members receive consistent information related to age group frequencies for mammography screenings; that providers receive correct information regarding availability of physician outpatient, community health clinic, and other clinic services; and that providers are informed about benefits and coverage for medically necessary decision-making supports for ECF CHOICES members.
	AQS	**UHC** should ensure timely member notifications are sent after provider termination; that required non-discrimination information is posted in conspicuous and accessible locations; and that all subcontracts with delegated entities are presented to the appropriate committee for approval prior to establishing a contract effective date. **UHCE** should ensure that timely notifications are sent regarding both UM denials and appeal resolutions. **UHCM** should ensure that timely LOC assessments are conducted for each CHOICES member. For improvement regardless of compliance scores, all **UHC** regions could address issues noted in two PAs: Appeals and Transition of CHOICES Members Between MCOs.
	PMV	No deficiencies or recommendations for improvement were identified.
	PIP Validation	**UHCE**, **UHCM**, and **UHCW** should clarify information on the study population and continuous enrollment requirements for *Transitions of CHOICES Individuals*. All three regions should also provide information on the inter-rater reliability process for *Increasing the Physical Health Provider Satisfaction Survey Engagement Rate*. For improvement regardless of validation scores, all three regions could address issues noted in Activities I, II, and IV for *Transitions of CHOICES Individuals*; Activities III and VIII for *Impact of Provider Outreach on Rates for CIS Combo 10*; Activity IX for *Perception of Care Coordination*; and Activity VI for *Increasing Physical Health PSS Engagement Rate*. **UHCW** could address issues in Activities I and IV for *SAA*.
Strengths & Improvements	**ANA Review**	**UHC** was commended for its Enhanced Support Coordination model, which it developed to facilitate the success of ECF CHOICES program goals.
	AQS	No particular strengths were identified. Since the 2019 AQS, **UHC** implemented enhancements to its system for notifying members of specialist and PCP terminations. The MCO raised its score for the Network QP standard by 8.2 percentage points, and raised both its quantity and quality ratings for CHOICES recredentialing file reviews to 100%.
	PMV	No particular strengths or improvements were identified.
	PIP Validation	No particular strengths were identified. Since the 2019 validation, **UHCE** and **UHCM** addressed an AON regarding the study indicator for *Perception of Care Coordination*. **UHCE**, **UHCM**, and **UHCW** also addressed AONs regarding the study population and indicators for *Transitions of CHOICES Individuals*, although some problems with the PIP remained.
DQ		
Results	**ANA Review**	**DQ** earned an overall Network Adequacy score of >99.9% and an overall Benefit Delivery score of >99.9%.
	AQS	**DQ** earned 100% compliance with all applicable QP standards and two of three PA file reviews. For the Appeals PA, **DQ** earned 97.5%.
	PIP Validation	**DQ** earned 100% overall element scores and a Met validation status for both submitted PIPs.

Table 20. 2020 Results, Recommendations, and Strengths by Plan		
Recommendations	**ANA Review**	**DQ** should address the shortage of ECF CHOICES dental providers in one county.
	AQS	**DQ** should ensure that appeal resolution letters include the correct member name and are sent on time. For improvement regardless of compliance scores, **DQ** could address issues noted in three QP standards: Systematic Process of Quality Assessment and Improvement; Member Rights and Responsibilities; and Non-Discrimination Compliance.
	PIP Validation	No AONs were identified. For improvement regardless of validation scores, **DQ** could address issues noted in Activities II, IV, and VIII for *Decreasing TennCare Enrollees Receiving Opioid Prescriptions*, and Activities III, VII, and VIII for *Increasing Provider Use of SDF*.
Strengths & Improvements	**ANA Review**	**DQ** was commended for implementing three initiatives focused on increasing the efficiency of its provider communications.
	AQS	No particular strengths were noted. Since the 2019 AQS, **DQ** instituted a process change to improve timeliness in resolving appeals.
	PIP Validation	No particular strengths or improvements were identified.

Conclusions and Recommendations for the State

The results of 2020 EQR activities demonstrate that TennCare's managed care plans are well qualified and committed to facilitating timely, accessible, and high-quality healthcare for TennCare members. Achieving high or perfect compliance scores in all assessment activities, implementing innovative and successful programs and initiatives for improvement, and acting quickly to correct any noted deficiencies, the plans exemplify TennCare's Core Values and strive continuously to fulfill the goals of its Quality Strategy.

These results further indicate that TennCare's Quality Strategy serves as a comprehensive and effective guide for plans in setting clear goals and measuring achievements. TennCare's requirement that MCOs must achieve NCQA accreditation, that the AQS be conducted annually rather than every three years, as well as its stipulations regarding the number and focus of PIPs that plans must conduct, indicate that the State is committed to a higher level of quality monitoring and accountability for its plans. Qsource recommends that TennCare continue to use stringent measures from the ANA review, AQS, HEDIS audit, and PIP validation as the primary means for assessing the Quality Strategy's success as applied to the integrated physical and behavioral health services delivered by its plans. The 2020 EQR assessment results, including the identification of plan strengths, recommendations, and CAPs, attest to the positive impact of TennCare's strategy in monitoring plan compliance, improving quality, and aligning healthcare goals.

APPENDIX A | 2020 PIP Improvement Strategies

Verbiage quoted from the MCCs' PIP Summary Forms appears in italics and is included to capture MCCs' strategies in their own words. Acknowledgements, abbreviations, acronyms, and initialisms that appear only in quoted text are not added to the list in the front of this report.

Table A-1. 2020 PIP Validation: Improvement Strategies by MCC—AG

Increase Percentage of Members with Documented In-Home Assessment of Nine Core Elements within 90 Days

Baseline to Remeasurement 1 (all regions)

LTSS and QM Staff completed a barrier analysis (fishbone diagram) to identify causes for low compliance rates and to set interventions for 2019.

NCQA Learning Collaborative Pilot: Amerigroup participated in the NCQA Learning Collaborative in 2019, which allowed additional discussion on NCQA's interpretation of the HEDIS Specifications, and clarified the way compliance should be determined. This re-education, participation in the collaborative, and resource can be attributed to the significantly improved re-audited baseline and 2019 compliance rates.

Re-audit of the 2018 Sample: Amerigroup originally misinterpreted one (1) of the nine (9) core elements when completing the initial audit, which produced compliance rates below 2%. For a file to be deemed compliant, compliance in all nine core elements needed to be achieved. Based on discussions with NCQA, Amerigroup correctly interpreted and understood core elements #1, 2, 3, 5, 6, 7, 8 and 9. Core element #4 states "Assess cognitive function using a standardized tool. Documenting that the member is too cognitively impaired to self-report in a standardized tool meets the element." Amerigroup understood this to mean that the Plan needed to use a professional standardized tool, however upon discussion with NCQA it was deemed that the 2060 Task and Hour Guide could be considered a standardized tool as it was used with every individual assessed by care coordination staff. The 2060 Task and Hour Guide contains questions related to cognitive function, which allowed this core element to be considered met. The 2018 statewide compliance score for core element #4 was 1.22%, and after the same sample files were re-audited based on the ability to use the 2060 Task and Hour Guide as a "standardized tool", the statewide compliance score for that element rose to 69.34%. Following the re-audit of the CAU sample, the statewide compliance score rose from less than 2% to 58%, which was acknowledged as correct by NCQA. Regional breakdown rates were calculated and included in the Remeasurement data analysis below. The findings of this re-audit identified the need to reestablish the baseline to ensure consistent methodology and comparisons between baseline and Remeasurement years going forward.

Updated Audit Tools: There was a significant increase in the compliance rate from 2018 to 2019, which is attributed to more focused work on internal auditing related to HEDIS standards. The internal audit tool used to audit Care Coordination staff was updated to include HEDIS standards to ensure assessments were including the nine (9) core elements. This tool allowed for feedback and reinforcement to ensure staff's understanding of the HEDIS standards and expectations. During 2019, the following internal audit process and tools were updated to better streamline audit feedback and increase compliance with Person Centered Support Plan (PCSP) requirements, including the HEDIS standards:

1. *Updated audit tool to include NCQA elements and embedded automated workflows within audit tool to increase functionality*
    a. *Automatic syncing/saving of completed audit tool to centralized network location, along with automated email notification sent to Manager and PCSP Remediation mailbox for tracking purposes.*

Table A-1. 2020 PIP Validation: Improvement Strategies by MCC—AG

b. *Streamlined remediation process for Manager to easily notify audit team of corrected PCSP documentation, if required*

c. *Each Care Coordinator receives a minimum of one PCSP audit within the year, which includes final audit score and whether remediation of the PCSP is required to reach compliance score threshold. These audit results are also provided to the Manager.*

d. *Final audit score is escalated to Director if score remain below 90% after remediation is completed and PCSP is re-audited.*

2. *Created and designated a new shared e-mail box for consistent timely PCSP auditing communication and remediation.*
3. *Designated one full-time employee to manage prompt communication/tracking of audit scores, remediation and reporting requirements between LTSS Care and Support coordination teams and LTSS auditing team.*
4. *PCSP audit scores and trends sent to LTSS leadership monthly.*

Enhanced training: Enhanced Training for NCQA standards and assessment expectations for the Person-Centered Support Plan (PCSP) of the care coordination staff reinforced knowledge of HEDIS standards and increased compliance rates due to enhanced awareness of the Care Coordinators to understand the elements required in the Person Centered Support Plans and by the LTSS reviewers evaluating the PCSPs for compliance.

A significant increase in the compliance rate from the initial 2018 baseline to the reestablished baseline is credited primarily to accurately applying NCQA's interpretative guidelines to the assessment of cognitive function in the PCSP. Significant improvement was also achieved from the reestablished baseline to Remeasurement year 1 based on revision of training and audit tools to standardize accurate assessment of compliance with the cognitive function element. Success in the continuous improvement of compliance rates is due to continuous monitoring and feedback as well as enhanced training and standardized tools for care coordination staff and the PCSP compliance reviewers. A new goal of 98% was established for 2020 due to the significant improvement in rates.

Increase West Grand Region Member Participation in the EPSDT Healthy Rewards Incentive Program

Baseline to Remeasurement 1 (AGW only)

Health plan staff from the Tennessee Healthcare Management and Quality Management departments, along with feedback obtained from Provider Relations and the Corporate Healthy Rewards team completed a barrier analysis (Attachment O) to formulate interventions that addressed barriers. The same barriers were identified statewide and therefore interventions were developed to address those same barriers in all three grand regions. Lack of member awareness of the Healthy Reward EPSDT Incentive was a barrier to engagement in the program. The Healthy Reward Corporate program mailed quarterly incentive information to EPSDT members' ages 2-20 in an effort to inform members of an award for completing an EPSDT screening. Mailings in Q1-Q2-Q3 were sent to members that did not have an EPSDT screening completed (non-compliant) and a mailing in Q4 were sent to all members aged 2-20. In addition, a monthly mailing to all non-compliant members were mailed during the months of July, August, and September. Language that informed members about the incentive was added to the member invitations that are mailed out in advance of scheduled EPSDT screenings. In addition, the Healthy Rewards member incentive flyer was also added to the invitations that outlines all the member incentives available through Healthy Rewards, including the EPSDT incentive. Letters to members that sought care for a recent sick visit were mailed. The letter reminded the member (ages 18-20) or member's parent/guardian (ages 0-17) to schedule an EPSDT screening and included information on how to collect a Healthy Reward Incentive for that screening. Returned mail and incorrect member addresses were another barrier as some mailed incentive information may not be received and/or read. To address this barrier, Amerigroup-Tennessee contracted with the vendor HealthCrowd to conduct member outreach to EPSDT members via Interactive Voice Recorded (IVR) calls and text messaging. The IVR calls and text messages inform the

Table A-1. 2020 PIP Validation: Improvement Strategies by MCC—AG

member about the incentive award for obtaining an EPSDT screening, as well as providing education to the member regarding the importance of wellness visits. EPSDT screening incentive information for members ages 2-20 was also placed also on Member Portal- www.myamerigroup.com for members that prefer to view information online.

Remeasurement 1 to Remeasurement 2

From Remeasurement year 1 to 2, the West Region increased participation from 1.9% to 8.8%; although, AGP did not meet the 25% participation goal. During 2019, AGP stopped mailing the Healthy Rewards flyer and instead starting communicating with members via SMS and IVR to educate about the Healthy Rewards Program. The new member text included information about the Healthy Rewards program and this intervention helped improve the rates in the West Region. There were a few barriers that prevented AGP from hitting the overall goal of 25% participation. During 2019 members were required to opt into the program in order to receive an award, and retroactive rewards were no longer given. Additionally, there were issues with the vendor that included long wait times to resolve issues and the time it took for the card to be mailed out. Lastly, a delay in the award was due to the length of time it look for AGP to receive the claim from the provider.

Letters were mailed to members with EPSDT Screening Exam gaps who visited their health care provider because of an illness. The letters reminded members the EPSDT screening exams were available at no cost along with the availability of the Healthy Rewards program and of the $20 reward available for completing an annual EPSDT visit. The average percentage of gaps in care closed of the members receiving the Sick Visit Mailing was 14% for the West Grand Region. The number of members who received the letter was less than 1% of the total eligible West EPSDT population and reflects less than a 1/2 percent to total screenings completed from the mailing (589 letters mailed with 81 gaps closed). Although a direct correlation between the mailings and Healthy Rewards participation was not evaluated, the mailing was discontinued based on the limited impact to EPSDT Screening gap closures.

Improve EPSDT Screening Rates in the 18–20-Year-Old Age Group

Baseline to Remeasurement 1 (all regions)

- *Amerigroup's Quality Management Provider Engagement Visit initiative launched 1/1/19. During provider engagement visits, quality management staff educated the provider on EPSDT, coding and billing and the available member incentives. Providers were also given a gap in care list and quality management staff assisted in the strategic plan to close gaps. A total of 238 Providers were visited with 2,456 providers affected. EPSDT improvement was observed in 95 of the Providers (64.2% of groups visited) with an EPSDT impact of 3,304 gap closures. (Attachment K)*
- *The KMH Pilot Program incentivized providers $20 for each FY19 (10/1/18 – 9/30/19) claim received by 11/30/19 for EPSDT Screening gap closures above their baseline screening rates. Incentive is contingent on the provider meeting a 10 percentage point improvement threshold. Providers with > 100 member gaps in the 5+25 counties for both PCMH and non-PCMH provider groups were invited to opt-in to the program on 11/22/18. Baseline rates were distributed to the providers in January 2019. Each month, status updates of each providers current screening rate, comparison to their baseline and potential financial incentives were sent to providers via email. Gap in Care lists were distributed to each participating provider upon request. Overall rates for the participating East providers increased 1.08%. Results reflect that the intervention had a positive impact and was marginally successful in the pilot year. The pilot program was expanded for FY2020 (10/1/19 – 9/30/20) along with provider engagement enhancements. Participating KMH providers were assigned to Provider Engagement staff who reached out monthly to ensure the provider received the EPSDT Screening Rate Status Update and gap in care list, were aware of the incentive opportunity and tracking to goal. Amerigroup provider engagement staff are available to answer questions and provide support to bolster EPSDT screenings. FY20 KMH Results will be available in January 2020. (Attachment K)*

Table A-1. 2020 PIP Validation: Improvement Strategies by MCC—AG

- *Members were invited to opt-in to the Healthy Rewards program by phone or website to earn a $20 reward for an annual EPSDT screening visit. In 2019, Amerigroup vendor Welltok mailed members a reloadable card upon member opt-in and each reward was electronically added to the card upon confirmation of an EPSDT Screening visit claim. Members may redeem the rewards for health and wellness related items at a variety of retailers. In 2019, 251 Healthy Rewards were awarded to member's ages 18-20 years old in the East Grand Region. Historical data is not available for this age group. (Attachment K)*
- *Member Outreach for 18-20 year olds was accomplished via vendor Health Crowd. 16,678 member outreach attempts were initiated for the following campaigns: Adolescent Well Care Visit (AWC), Screening Events, EPSDT Overdue screening visits and EPSDT New Member Welcome. The messages were tailored for young adults. Between IVR and SMS text messages member outreach 3991 Members with EPSDT Screenings overdue were successfully contacted and of those members 731 (18%) EPSDT Screening Gaps were closed. (Attachment K)*
- *5,396 Member EPSDT Service Reminder Mailings Birthday Cards were mailed to members ages 18-20 with 1,333 (25%) EPSDT Screening gap closures. (Attachment K)*
- *Member Outreach for 18-20 year olds was accomplished via vendor Health Crowd. 15,871 member outreach attempts were initiated for the following campaigns: Adolescent Well Care Visit (AWC), Screening Events, EPSDT Overdue screening visits and EPSDT New Member Welcome. The messages were tailored for young adults. Between IVR and SMS text messages 3604 Members with EPSDT Screenings overdue were successfully contacted and of those members 630 (17%) EPSDT Screening Gaps were closed. (Attachment K)*
- *5,541 Member EPSDT Service Reminder Mailings Birthday Cards were mailed to members ages 18-20 with 1,104 (22%) EPSDT Screening gap closures. (Attachment K)*
- *All of the 2019 interventions appear to have contributed to increasing our EPSDT Screening Rates for the East and West Grand Regions and will be continued for 2020 in all 3 Grand Regions. Amerigroup is moving from our current Healthy Rewards member incentive vendor (Welltok) to a new platform (Chip) which includes a digital gift card option. In addition, our Keeping Members Healthy (KMH) provider incentive program has been adjusted to include a KMH bonus to incentivize providers for incremental rate improvement as well as to bolster enthusiasm towards attaining the 10 percentile rate improvement goal.*

Increasing the Percentage of Complex Case Management and High-Risk OB Members Who Complete the 2nd Quality of Life Survey (SF-12)

Baseline to Remeasurement 1 (all regions)

In December 2016, a workgroup comprising health plan associates from the Health Care Management Team (HCM), and Quality Management (QM) Team reviewed the historical SF-12 survey completion rates, conducted a barrier analysis (fishbone diagram) and developed interventions to implement in 2017.

The plan recognized the significance of member outreach efforts and successful contacts made with members in completing 2nd SF 12 surveys. As a result, interventions were formulated to address identified barriers. Successful member contact was diminished due to the large portion of members that utilize cell phones only. The federal Telephone Consumer Protection Act (TCPA) rules prevent phones that are considered auto dialers from calling member cell phones. AGP-TN use Avaya phones that are considered auto dialers. To improve communication efforts with members, AGP-TN acquired business cell phones for case management staff that conduct outreach to members within the TCPA guidelines.

Table A-1. 2020 PIP Validation: Improvement Strategies by MCC—AG

Healthcare management (HCM) staff also mailed "unable to contact letters" with members when unsuccessful contacts are made. To ensure that plan staff have a full understanding of the importance of completing SF-12 surveys with members, all new hires are provided with SF-12 training, as well as annual refresher training for all case managers. Reports currently available with Quality Metric did not include the case manager's name, so it was difficult to determine who was completing or omitting survey completion. HCM leaders met with Quality Metric and revised AGP-TN contract to add this reporting capability, which allows managers to run reports for case manager follow-up and coaching. SF-12 survey completion was also added as a component to the case manager's annual performance evaluation. Managers review SF-12 completion on a quarterly basis with each case manager. Finally, results of HCM efforts with respect to percentage of surveys completed are shared with HCM staff each quarter.

Remeasurement 1 to Remeasurement 2

At the end of 2017, a barrier in completing second SF-12 surveys was identified as an educational deficit and/or a miscommunication with case managers. It was determined that some case managers were not completing second surveys if a case was closed prior to the 60 day case management mark, resulting in a potential loss of second surveys that could have been completed. As a result, training sessions with case management staff increased from annual to semi-annual, and SF-12 training materials were updated to address survey completion when a case is closed prior to the 60th day of case management. In October of 2018, a review of Q1-Q3 results was completed in the health plan's Health Care Management/ Quality Management work group. Identified was a lag in results in the West Grand Region behind the East and Middle Regions. A barrier analysis (fishbone) was completed to identify barriers in the West that were impeding results. As a result, a standard naming convention for all case managers, in all regions were placed into the Quality Metric system which made auditing of case managers easier. Also in October of 2018 an audit trail report was created to audit SF-12 surveys for determination of case manager trends in completion and non-completion of surveys. A monthly audit trail report is sent to managers for review and follow-up. This was implemented statewide in order to improve the completion of 2nd surveys in all regions. A desktop process was also created to ensure the audit tool was used correctly. Monthly audits of SF-12 surveys to determine case manager trends in completing surveys was implemented. Additionally, meetings were held between HCM staff and Quality Metric to better understand all of the reporting capabilities that Quality Metric has regarding SF-12 surveys. Staff continued to use cell phones for outreach to members enrolled in case management as outlined in the TCPA guidelines, as well as mailing "Unable to Contact" letters when unable to reach a member for case management services and survey completion. SF-12 survey completion also remains a component of the case manager's annual performance evaluation and individual results are shared with the case manager.

Remeasurement 2 to Remeasurement 3

Interventions previously identified as opportunities for improvement continued in 2019. The SF-12 survey completion remains a component in the case manager's annual performance evaluation. "Unable to contact letters" continued to be sent to members if phone outreach was unsuccessful and staff continued to use cell phones for outreach to members enrolled in case management as outlined in the TCPA guidelines. Training materials for case managers remain current and semi-annual trainings on SF-12 surveys were completed with staff. Monthly audits of completed surveys to determine which case managers were completing them consistently also continued. These audit reports were sent to the case management managers to use in associate 1:1 meetings at which time results are shared with case managers. Although there were no new interventions implemented in 2019, all previously implemented interventions were continued throughout 2019.

Table A-2. 2020 PIP Validation: Improvement Strategies by MCC—BC and TCS

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Baseline to Remeasurement 1 (all BC regions and TCS)

BlueCare transitioned from 1 day community outreach events to focused campaigns with providers. BlueCare is able to target specific providers based on the EPSDT dashboard, a system utilized to track EPSDT performance of individual providers. Through partnering with providers, BlueCare has identified barriers to getting EPSDT screenings and has developed interventions to address the identified barriers. Campaigns with providers allow BlueCare to continuously assess for barriers, identify opportunities for improvement and provides more flexibility when scheduling members for care. The1 day outreach events had barriers related to the limited time within the day to screen members. The focused campaigns will yield longer timeframes to schedule members for EPSDT screenings which makes it more flexible for the member's schedules.

The interventions that were implemented were culturally and linguistically appropriate for the population being studied.

The targeted provider interventions listed below address the provider knowledge deficit related to best practices, billing/coding, missed visit opportunities and real time member incentives. Missed visit opportunities were identified through population analysis which identified an opportunity to educate providers regarding the completion of EPSDT screenings during other visit types, completing the screenings on schedule and to include all recommended components along with proper coding/billing and overall awareness. Each intervention was completed as education through different outlets such as emails, mailings and meetings. Targeted providers included internal medicine, nurse practitioners, pediatricians, family medicine, federally qualified health centers and general providers statewide. The interventions were successful and BlueCare saw an increase in the EPSDT screening rate for BlueCare East, Middle and West. FFY 2017 CMS 416 EPSDT rates in BlueCare East was 76%, Middle was 76%, and West was 73%. Email blasts, mailings, face to face education to THCII PCMH and THL providers and MCO collaborations are a standardized part of the EPSDT Strategy and effectiveness will continue to be monitored. The Backpack Initiative allowed members to receive incentives at the time of service and the campaign was active during August and September, which allowed more flexible scheduling for members.

1. *Provider Educational Email Blasts: Four (4) email blasts were sent to providers between April and September 2017. The messages focused on the overall awareness of EPSDT, the importance of closing gaps in the periodicity table, community resources, missed visit opportunities and best practices. The direct internet link to the periodicity chart was provided. Providers were informed that BlueCare would like to host a community outreach event with them and BlueCare contact information was provided. Converting sick visits, sports physicals and other visit types was discussed and a link to the appropriate codes was given.*
2. *Provider Educational Mass Mailings: Mass mailings included the EPSDT Awareness Letter, EPSDT Coding Reminder Flier, American Academy of Pediatrics (AAP)/Bright Futures Periodicity Chart, EPSDT Best Practices Flier and EPSDT Outreach Resources. The EPSDT Awareness Letter informed providers that only 70% of children receive their EPSDT and asked providers to assist BlueCare push that rate above 80%. The importance of following the recommended schedule by AAP/Bright Futures and coding sick visits along with well visits was addressed. The coding reminder flier covered the recommended EPSDT schedule and the seven components of the screening. EPSDT CPT and ICD-10 codes, immunization administration codes, key EPSDT procedure codes and common modifiers were given. Codes for screening tools were also reviewed. Examples of how to utilize the codes were also given. EPSDT best practice education, via a flier, addressed converting sports physicals into an EPSDT screening and combining an EPSDT with other visit types including, but not limited to illness and prescription refills. Education included proper coding/billing as well as free training resources via the Tennessee Chapter of the American Academy of Pediatrics (TNAAP). The importance of completing EPSDTs on schedule per the AAP Periodicity Chart and links to the periodicity chart and the actual chart was included in many provider educational communications. Scheduling recommendations such as pre-scheduling newborns and alternative/extended office hours, and assigning staff to check records, contact members and triage sick visits that can be converted to EPSDTs. The Outreach Resource Flier informed providers that BlueCare would like to host a community outreach*

Table A-2. 2020 PIP Validation: Improvement Strategies by MCC—BC and TCS

event with them. They were also made aware of BlueCare capabilities to identify members who are overdue, schedule appointments and send automated phone messages to members. Incentives and provider participation was noted as motivators for member attendance.

3. *Provider Education at 2017 All Blues Workshops: BlueCross BlueShield of Tennessee hosts six (6) All Blues, provider workshops annually. During 2017, presentation slides educating providers on AAP/Bright Futures recommended screening schedule, best practices, medical record documentation, missed visit opportunities and coding/billing resources. Best practice education included appointment reminders, partnering with BlueCare for outreach campaigns, documenting all components of the screening and using appropriate billing/coding. Providers were reminded to document all seven components of the exam including: comprehensive health and developmental history, comprehensive unclothed physical exam, vision and hearing screening, laboratory tests/procedures, immunizations and health education/anticipatory guidance. If the child is uncooperative during the exam or if the parent refuses, this should be documented in the record. Providers were encouraged to use the AAP Refusal to Vaccinate Form if immunizations are refused and document if the child is on a catch-up schedule. Missed visit education included reminders that children with special needs still require an EPSDT screening, sports physicals do not take the place of an EPSDT screening and both can be done during the same visit. Providers were also informed that a sick visit and EPSDT screening can be billed for the same visit, use the proper codes and modifiers and additional coding information can be obtained at **www.tnaap.org**.*
4. *Billing/Coding Webinars with Tennessee American Academy of Pediatrics (TNAAP): Coding/billing and reimbursement webinar trainings were provided to all Federally Qualified Health Centers (FQHCs). The webinars were held in conjunction with TNAAP. Education also included the Bright Futures/American Academy of Pediatrics recommendations for preventive services, seven (7) components of EPSDT, medical record documentation and how to convert sports physicals/sick visits into EPSDT screening visits.*
5. *Provider Education at the Clinical Advisory Panel: The BlueCare EPSDT Strategy was presented to the panel meeting. The strategy includes a 5 prong approach of provider, member, community agency partners, and employee and data analytics. The provider strategy focused on missed visit opportunities, practice engagement with large groups, provider office staff education and MCO collaborative events. Outreach opportunities to address specific age bands, community outreach events and leveraging relations with summer camps and health departments comprised the member strategy. Leveraging existing relationships with community agencies such as United Way was the community agency partner strategy. Evaluating system workflows to close EPSDT gaps and mandatory EPSDT training was included in the employee strategy. The EPSDT Best Practices Flier and the AAP/Bright Futures Periodicity Chart was also provided.*
6. *Face to Face Tennessee Health Care Innovation Initiative (THCII) and Tennessee Health Link (THL) Provider Education: Face to face meetings with THCII occurs quarterly. Providers were given a power point presentation that included an overview of EPSDT. Education included the seven (7) components of EPSDT, missed visit opportunities, transportation assistance for members and billing/coding. Outreach efforts such as telephonic and mailers included health education for preventive services and gift cards for completed screenings. During these meetings providers are informed that BlueCare is available to partner with them to engage members and they are also encouraged to review the best practices online identified by BlueCare.*
7. *Tennessee Primary Care Association (TPCA) / Managed Care Organization (MCO) Collaborative - Backpack Initiative: The Backpack Initiative was a collaborative initiative between TPCA and BlueCare, Amerigroup and United Healthcare. The Federally Qualified Health Centers (FQHCs) suggested real time member incentives, incentives given to members at the time the EPSDT is completed, instead of waiting to receive the incentive via mail. Backpacks containing school supplies were provided to members as an incentive for obtaining an EPSDT. Monthly each MCO provides the FQHCs with a list of non-compliant members. Backpacks were given to the members once the EPSDT screenings were completed. Due to the success of this initiative, TPCA along with the MCOs made the decision to repeat it in FFY2018.*

Table A-2. 2020 PIP Validation: Improvement Strategies by MCC—BC and TCS

There is an EPSDT Strategies group that meets monthly to review the EPSDT rates, action plan and interventions/ activities.

Remeasurement 1 to Remeasurement 2

The following interventions are ongoing from Baseline to Remeasurement 2, as described above: Provider Educational Email Blasts; Provider Educational Mass Mailings; Provider Education at All Blues Workshops; Billing/coding Training Webinar TNAAP; Provider Education at the Clinical Advisory Panel (CAP); Face to Face THCII PCMH Provider Education; Face to Face THCII THL Provider Education; EPSDT Missed Visit Education for Providers; and TPCA/MCO Collaborative-Backpack Incentive.

In remeasurement period 2 great strides were made towards improving EPSDT screening. BlueCare collaborated with an integrated appointment scheduling platform in order to improve appointment scheduling rates. This allows BlueCare Member Education Specialists to directly access provider appointment inventory while on the phone with members. This allows BlueCare staff to schedule the member immediately, instead of relying on the member to schedule at a later time. This platform streamlines the process of scheduling by eliminating the need for the BlueCare staff to call the provider office and coordinate appointment scheduling while simultaneously on the phone with the office and the member. By utilizing this platform, the BlueCare Specialists can place the member directly onto provider office schedule. This allows an easier process that improves the experience for the provider office, member, and Blue Care staff. Phone call times decreased by 9 minutes, and appointment scheduling increased by 104%. By making this change, BlueCare was able to increase the number of members receiving the EPSDT screenings that are vital to their healthcare.

Additionally, this platform provides text/email/call reminder capability for providers that may not have this resource. The platform also automates transportation scheduling and appointment reminders. Providers are able to report appointment attendance using this technology. As another benefit, providers receive face-to-face support and education regarding this technology and workflow. This has provided an opportunity to build relationships with providers and to identify needs and opportunities for partnerships. 100% of participating providers reported that the platform was valuable to their practice and they would recommend other providers to work with BlueCare.

Also in 2018, provider education was conducted in the form of 3 webinars. BlueCare collaborated with TNAAP to present these educational webinars for THCII, PCMH and THL practices. This education was provided to help increase awareness of appropriate EPSDT coding and associated best practices. The webinars were titled "How to Succeed with EPSDT Well-Child Visits". These sessions were provided in hopes of bringing awareness regarding importance of appropriate well-child screening in order to give support to providers and ultimately improve health care for members.

Remeasurement 2 to Remeasurement 3

The following interventions were ongoing from Baseline to Remeasurement 3, as described above: Provider Educational Email Blasts; Provider Educational Mass Mailings; Provider Education at All Blues Workshops; Billing/coding Training Webinar TNAAP; Provider Education at the Clinical Advisory Panel (CAP); Face to Face THCII PCMH Provider Education; Face to Face THCII THL Provider Education; EPSDT Missed Visit Education for Providers; TPCA/MCO Collaborative-Backpack Incentive; Integrated Appointment Scheduling Platform; Provider Education with TNAAP.

Also, in the 1Q2019 BlueCare began the Supersizing initiative which incentivizes providers to capitalize on sick visits. Some members only see their provider for sick visits. In order to leverage that encounter with the member, providers are encouraged to convert sick visits to well visits in order to provide needed preventive care for members. Providers are incentivized for converting a sick visit by performing an EPSDT visit to address preventive care. This addresses barriers that the provider may have related to getting the patient back for a preventive visit after a sick visit, by utilizing the member encounter to address both the current health concern and preventive care at the same time. This also addresses member barriers that may make it difficult for the member to attend two separate visits.

Table A-2. 2020 PIP Validation: Improvement Strategies by MCC—BC and TCS
In May of 2019, BlueCare began a pilot with Le Bonheur Emergency Department (ED) by embedding a Member Resource Coordinator (MRC) within the Le Bonheur ED. The embedded MRC sees every BlueCare member seen in the ED for non-emergent reasons. The MRC can help address Social Determinants of Health (SDoH) and can help make appointments with the member's PCP and schedule transportation all through the Integrated Appointment Scheduling platform (described in previous section). For members not seen by the MRC, Health Navigators (HN) receive face sheets with member information, and they call the members to follow-up. The HN's also address SDoH and can make appointments with PCPs and schedule transportation for members. This intervention addresses SDoH barriers, as well as barriers related to appointment scheduling and transportation.

Table A-3. 2020 PIP Validation: Improvement Strategies by MCC—TCS
Follow-Up After Hospitalization for Mental Illness (FUH)

Baseline to Remeasurement 1

1. *Medical and Behavioral Health Provider Education*
   - *This intervention addressed provider knowledge barriers related to Behavioral Health measures. Behavioral Health Quality Management Specialists developed and delivered an educational WebEx for Behavioral Health and Medical providers. This event covered all Behavioral Health HEDIS measures, including FUH, and how to increase compliance and improve care.*
   - *In 3Q2019 brochures were given to providers with educational information related to Follow-Up After Hospitalization for Mental Illness.*
2. *Department of Children's Services Education*
   - *This intervention addressed DCS knowledge barriers related to Behavioral Health measures and the importance of ensuring follow-up appointments occur. Behavioral Health Quality Management Specialists developed and delivered an educational WebEx covering Behavioral Health HEDIS measures, including FUH. The targeted audience included those working with the DCS population, such as case managers, nurses, etc. FUH education focused on the importance of follow-up appointments in order to provide best care for members.*
3. *Integrated Appointment Scheduling Platform*
   - *The integrated appointment scheduling platform allows the health plan to access appointment inventory to schedule members for needed care. This eliminates the need for phone calls between the health plan and participating provider offices for scheduling. Transportation scheduling and appointment reminders are automated through the platform, eliminating long call times and reminder calls from BlueCare staff. If available appointment inventory does not meet the member needs, an electronic request for an appointment is sent to the provider to follow up with the member. The request is complete with pre-scheduling transportation and appointment reminders to be scheduled once the provider completes the request. If a member or provider needs to reschedule the appointment, the update can be made by the provider through the platform and transportation and reminders are automatically rescheduled. THL providers have available inventory to allow our team to assist members with engaging with their THL or scheduling FUH appointments. Lakeside Behavioral Health Hospital was included in the platform September of 2019 to directly schedule FUH appointments and share discharge paperwork with the THL prior to our members discharging from their facility. This platform addresses member barriers related to getting appointments and transportation. It also decreases appointment scheduling burden for providers and the health plan.*

Table A-3. 2020 PIP Validation: Improvement Strategies by MCC—TCS

4. *Merakey Allos*
   - *This intervention was not listed in the grid above, because the actual vendor/provider intervention was not implemented during 2019. BlueCare has developed a partnership with a vendor who will complete the 7 day follow-up appointment for members in the FUH 7 day measure. This vendor will function as a single provider (Statewide) who will outreach to and complete the follow-up appointment with the member. In 2019 BlueCare worked extensively on contract development and revisions, building relationships, and implementing the groundwork to begin partnership with this vendor, in order to provide quality follow-up care to BlueCare members. The vendor is expected to begin implementation in June 2020 for the BlueCare line of business.*
   - *It should be noted that 12/1/2019, Member Outreach implemented a new logic to their process for identifying these members for outreach.*

Social Determinants of Health Data Collection Process

Baseline to Remeasurement 1

1. *Formation of multi-disciplinary workgroup and development of modified SDoH assessment*

- *A multi-disciplinary workgroup was formed with physician oversight to develop a tool to collect SDoH by case managers. They met monthly to complete this task.*
- *The collection of SDoH assessment questions will be developed from the PRAPARE tool to capture member data from the five key domains of SDoH.*
- *A modified tool was developed from the PREPARE tool so that only questions pertinent to meet the needs of the population that we serve were left in place as part of the assessment. This will ensure anaccurate and complete data that is an integral component in addressing individually specified needs of the TennCareSelect population.*
- *This new assessment tool aims to develop a data collection process to capture and identify health care disparities. Data accuracy and completeness fundamentally enhance the health plan's capability to more effectively understand the needs of the TennCareSelect population.*
- *The SDoH data collection significantly expands the scope and bandwidth in gaining an in-depth understanding of the needs of the individual and population served and provides the opportunity to identify improvements needed within the realms of member-centered health care.*

2. *Education for all case managers on the use/documentation of the new modified SDoH tool in CareAdvance*

- *The internal clinical education team created an educational training to educate all case managers on the process for use of the new modified tool.*
- *The education included new SDoH Assessment in CareAdvance, which will give the clinician the ability to collect and analyze social needs data to formulate a plan of care and implement the plan with member specific interventions. It also has the ability to track and measure enrollee outcomes by assessing social, environmental and behavioral barriers.*

Table A-3. 2020 PIP Validation: Improvement Strategies by MCC—TCS
♦ *All TennCareSelect members will have an SDoH assessment completed in CareAdvance. The assessment will be completed with new members in the management phase and at a minimum of annually. This SDoH assessment will replace previous documentation of social determinants of health.* ♦ *Case Managers can provide our members with resources and self-management tools that address their essential needs that directly affect their health outcomes.* 3. *Community Resource Tool* ♦ *This tool was built due to the need for a resource for all staff to utilize that provides them with all resources available for members.* ♦ *A repository of community resources was built that can identify resources by category needs, county and zip code.* ♦ *This tool is for all staff to utilize for the member's social determinants identified.* 4. *Data Collection Process* ♦ *Information Delivery developed a process to pull information from the internal documentation system (CareAdvance) that the case managers use to document the SDoH assessment that are completed.* ♦ *Before implementation of the modified assessment tool, there was not a way to pull social determinants from one single location in the documentation system. This new modified tool will make it easier to pull the information moving forward so that there is monitoring for successful member outcomes in meeting social determinants.*

Table A-4. 2020 PIP Validation: Improvement Strategies by MCC—UHC
Impact of Provider Incentives on Screening Rates for Adolescents Ages 12–21
Baseline to Remeasurement 1 (all regions) *The health plan incentive-based provider interventions are designed to change provider practice behavior by tying performance directly to outcomes. To achieve the goal of improving EPSDT screening rates, interventions are implemented to incentivize providers and their office staff directly for their efforts to make member outreach to complete EPSDT screenings on their patients with identified open gaps in care.* *From baseline to remeasurement 1, UHCCP intervention initiatives to incentivize providers for EPSDT screening completion included the value-based contracting program, TennStar, as well as quarterly educational efforts for participating program providers. Our Clinical Practice Consultants worked with all TennStar providers to regularly identify open gaps in care, methods for closing those gaps in care, reviewed methods for closing gaps in care, educated on potential earnings, as well as provided reports on current progress.* *Our incentive pilots were designed to encourage staff and providers, by utilizing a tiered reward system that was linked directly to EPSDT gap closure rates. The first pilot ran from 3/1/2018 - 3/31/2018 and offered group experiences while and meals, the second pilot ran from 8/1/2018-8/31/2018 offered monetary incentives. This allowed us to compare engagement across the pilots in an attempt to identify the most effective or meaningful incentives for the office staff.*

Table A-4. 2020 PIP Validation: Improvement Strategies by MCC—UHC

Remeasurement 1 to Remeasurement 2

During Remeasurement 2, UHCCP increased the incentive amount for improvements associated with the AWC and Well Care measures for our statewide TennStar value based contracting program in an effort to achieve our planned goals. Our Clinical Practice Performance Consultants provided both education and support to our providers regarding these changes.

To assist with member outreach and engagement efforts, UHCCP also targeted the six largest counties across TN, spanning all three regions. We identified those members in the AWC measure who had not accessed services of any kind in the previous 12 months. These members received a live telephonic outreach offering a gift card in exchange for receiving their well child screening.

Transitions of CHOICES Individuals

Baseline to Remeasurement 1 (all regions)

For the purposes of analysis, all data mining and interventions are consistently applicable for all regions of the state unless otherwise stated specifically.

Nursing Facility Population

During the first year of remeasurement, we were unable to meet our 1 percentage point reduction in the NF Population. We identified several barriers that affected our ability to meet our goal. There was a reduction in total enrollment for CHOICES for UHC assigned persons by the state partner but a higher percentage of NF enrollment due to member medical acuity and the presence of community barriers that prevented transition to community.

In efforts to address those barriers that affect movement of the NF population, we have implemented the following interventions:

- *NF Census Reviews: A review of all existing population at NF by internal Transition Team with Assigned Facility Coordinator for potential new transition referrals in all regions, with mandated review for all newly enrolled members in facilities within 10 days of enrollment. This intervention allows review of all newly enrolled NF members to determine their medical acuity and if NF placement is their accurate setting of care.*
- *NCQA Inpatient and Readmission Case Reviews: Cases reviewed during Manager and Coordinator meetings to decrease hospital stays as inpatient admissions and subsequent Skilled Nursing Facility stays mark the most vulnerable time for placement in in a NF. We have also implemented short term stay reviews of the members and visits to those members who have a short term stay in a NF after an acute hospitalization, to make sure those members are progressing toward discharge from the NF. We hope this intervention will decrease our NF population and ensure the member is served in their most appropriate setting of care.*
- *Community Barrier to Transition Reviews: Reviews conducted with the UHC Medical Director, the Coordinator and Manager, Member Advocates and Provider Relations Advocates to review members who are a candidate for transition out of a NF but have a barrier that may prevent them from a successful and maintained transition. Once those barriers for the member are determined, collaboration with community resources, provider availability and specific skillset, available housing options, and missing social determinants of health are all addressed to ensure a successful transition to the community. Community barriers such as housing, skilled nursing needs, bariatric needs, caregiver support and community living support availability all pose risk to allowing a successful transition. We hope to improve this intervention with collaboration with workgroups with our state partner to change the CHOICES benefit to allow more prevention of these barriers.*

We will continue our efforts to decrease the NF population rates going forward by improving on our interventions implemented during this measurement period to meet our baseline goal for this measure.

Table A-4. 2020 PIP Validation: Improvement Strategies by MCC—UHC

HCBS Population

During the first year of remeasurement, we were unable to meet our baseline goal of a 1 percentage point increase in the HCBS Population. Although we were able to slightly increase the HCBS population with transitions completed from the Nursing Facility, the goal was unable to be met. We identified several similar barriers and independent barriers that prevented an increase in the HCBS population to meet the goal. We were successful in implementing interventions that could improve this rate going forward. In relation to increasing the HCBS population, there was a reduction in total enrollment for CHOICES for UHC assigned persons by the state partner, that decreased our overall HCBS population. There was also higher number of disenrollments from the CHOICES program due to a hold of the redetermination process of eligibility determination by our state partner, which allowed more individuals to be discharged from the HCBS setting. There was also the presence of community barriers that prevented several transitions to the community setting.

In efforts to address those barriers that would prevent and increase in the HCBS population, we have implemented the following interventions:

- *NF Diversion Activities: This intervention mandates a Manager review of all community persons requesting transition to Nursing Facility prior to approval and submission to state partner in all regions. We developed a report that identified HCBS individuals with red flags for diagnoses and claims related to risk of NF placement. The more flagged diagnoses and claim related identified risk factors for a member placed them in a high risk category for NF placement. A tool was also developed as a guide for wrapping additional support services around the member to prevent or mitigate that transition to the NF. We plan to continue to improve this intervention through use of evidenced based guidelines to find more flags that identify a person as being high risk for NF placement and as an inter-relator reliability tool for a standard of identification and assessment.*
- *Internal process for identification of disenrollments: We developed a report using our care management system that will identify all potential disenrollments for reasons related to eligibility. This intervention allowed us to have line of sight into upcoming disenrollments to try and work with members to complete any necessary requirements or documents to continue their eligibility. We identified that we still face challenges in identification of a disenrollment due to financial eligibility of the member, but how to improve this intervention in working with our state partner to identify key identifiers in the state mandated redetermination process that will allow us to assist the member in completing requirements for maintaining active eligibility in a timely manner.*
- *Community Barrier to Transition Reviews: As implemented for our NF population, we conduct reviews with the UHC Medical Director, the Coordinator and Manager, Member Advocates and Provider Relations Advocates to review members who are a candidate for transition out of a NF but have a barrier that may prevent them from a successful and maintained transition. By implementing this intervention also for our HCBS population, we in turn allow development and availability of increased housing, SDOH resources, and Provider collaboration, which decreases the existing barriers to increase our HCBS population. This will allow more availability of these things in the community to create an existing resource in the community and decrease the existence of the barrier.*

We believe our efforts and intervention improvement strategies to increase the HCBS population rates will be successful in reaching our goal in future remeasurement periods. We will continue with the interventions implemented during this measurement period to meet our baseline goal for this measure.

Impact of Member and Provider Outreach on Immunization Rates for CIS Combo 10

Baseline to Remeasurement 1 (all regions)

Based on the identified needs for continual education and provider support with our childhood immunization measures, UHCCP designed our intervention strategy around our value-based contracting (VBC) programs; Patient Centered Medical Home (PCMH) and TennStar. We utilize our

Table A-4. 2020 PIP Validation: Improvement Strategies by MCC—UHC

provider facing teams to educate, partner with, and regularly meet with our network providers participating in VBC. This education combined with other efforts such as our UHCOnAir is used to support these providers in their efforts to incrementally improve their targeted quality metrics. As a result, improvement in these quality metrics results in provider incentives that can potentially be reinvested in their own internal outreach efforts.

During Remeasurement 1, the childhood immunization measure associated with our PCMH program was changed from CIS Combo 3 to CIS Combo 10 in an effort to more adequately align with our planned goals. Our Clinical Transformation Consultants educated the providers of this change and worked with each group individually to identify potential opportunities and interventions for outreach and engagement with their members.

Also, during Remeasurement 1, UHCCP increased the incentive amount for improvement associated with the CIS Combo 10 measure for our TennStar participating providers. Our Clinical Practice Education Consultants met regularly with all TennStar providers to identify open gaps in care, established methods for closing those gaps in care, discuss their earning potential, as well as to review their current progress to date.

With our interventions tied to value based contracting programs, ample implementation time is needed for providers to make the necessary changes and effectively impact outcomes for the CIS Combo 10 indicator. While no statistically significant improvement is indicated between baseline and remeasurement 1, it is believed that improvement will be reflected over time.

Perception of Care Coordination

Baseline to Remeasurement 1 (all regions)

For each of our indicators, our intervention strategy between baseline and remeasurement 1 focused on the current design of our internal Care Management (CM) team and the need to restructure and realign so that we could better support our providers and their care coordination efforts. The movement of our CM team to sit within our Population Health structure allows for central alignment of our Health Plan goals for care coordination. It allows for additional oversight and a more focused approach for supporting both our members and providers with care coordination.

Once the CM team was realigned, we were able to create a total of 18 Community Care Teams (CCTs) that are comprised of one Registered Nurse and three Community Health Workers (CHWs). With a total of six CCTs per region, each is assigned to specific counties or geographical areas. This regular and centralized focus area allow the CCT staff to engrain themselves in the area and with the providers that they work with to enhance the relationships all while promoting and supporting care coordination activities. This geographical proximity even allows CCT staff to attend provider visits with members as necessary.

This multi-step process includes Health Plan changes to encourage and support behavioral changes at the provider level to improve member outcomes and ultimately, improve care coordination activities along with the perception of both members and providers on this coordination as reported in each of the three study indicators.

While we began planning ach of the changes or interventions in the beginning stages of remeasurement 1, they did take time to plan out accordingly so that they were executed correctly. They launched later during the Remeasurement Year, during the 3rd and 4th Quarters of 2019. We anticipate that improvement in outcomes will not be as evident until Remeasurement 2.

Each of these improvement strategies and associated interventions have been applied statewide across each of the three regions.

Table A-5. 2020 PIP Validation: Improvement Strategies by MCC—DQ
Decreasing TennCare Enrollees Receiving Opioid Prescriptions
Baseline to Remeasurement 1
Provider toolkit was published and publicized after 10/15/17 as described in Activity I. Opioid prescription hard edit provider limitations were effective 1/16/18, and accompanying notice was sent to all providers, which heightened provider awareness regarding the innate consequences in prescribing opioids. Both of these contributed to the significant decrease in providers prescribing opioids to treat DQ members. On-going education to providers regarding dangers of and alternatives to opioids will continue to decrease the percentage of providers prescribing opioids, especially to our under-21 population for acute temporary pain.
Remeasurement 1 to Remeasurement 2
The only new intervention completed for CY 2019 was a presentation to graduating dental students about the dangers of and alternatives to opioids for dental pain. However, DQ is aware that this will not have effects for several years, as these dentists will just be entering the work force. It is hoped that training new dentists about opioid alternatives before they gain a habit of prescribing opioids can have long term effects on treatment choice. *For CY 2019, DQ expected to repeat a significant decrease in opioid prescriptions to members similar to that of 2018 due to the toolkit and widely publicized information about the dangers of and alternatives to opioids. However, the results show us that members receiving opioid prescriptions only dropped 1% for this measurement period, which was not significant. Because of these results, we plan to implement a series of new interventions targeting providers who are outliers in opioid prescribing as shown by the pharmacy data. We hope that targeting these high-volume providers will have the most effect on decreasing the number of opioid prescriptions for TennCare children*
Increasing Provider Use of Silver Diamine Fluoride (SDF) as a Preventive Measure
Baseline to Remeasurement 1
Provider toolkit was published and publicized after 10/15/17 as described in Activity I. Letter was sent 1/1/18 describing changes to CDT code which heightened provider awareness. Both of these contributed to the significant increase in provider use of SDF to treat DQ members. On-going education to providers regarding clinically proven outcomes of SDF will continue to contribute to increase in provider use of SDF. *In addition, provider utilization compared to peers was added as a metric on the quarterly Provider Performance Report on 7/1/18. This metric allows providers to compare their utilization of SDF both among their patient population and also as compared to their peers.*
Remeasurement 1 to Remeasurement 2
In May 2019, DentaQuest awarded a provider incentive payment or "bonus" as a result of our ability to share in TennCare's claim savings over the previous contract year. The metrics for the bonus were not announced prior to the bonus being issued. Providers were bonused based on their usage of preventive measures, including SDF. Number of provider applications of SDF to unique members were directly correlated with a dollar amount. Providers who did not get the bonus were encouraged to increase their use of preventives including SDF. *In December 2019, at TennCare's direction, DentaQuest modified our clinical criteria for hospitalization of a member for dental work. Our hospital readiness form, to be filled out by providers before being approved to take a member to the OR, was amended to require either documented use of SDF on the member or explanation why the provider did not use SDF on the member (tooth too decayed, parent declined, etc.). Because this was only implemented in December 2019, we expect the majority influence of this initiative to take effect during 2020.*