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# State of Tennessee
# Department of Finance and Administration
# Bureau of TennCare

# UnitedHealthcare Plan of the River Valley, Inc. (AmeriChoice-East)

## 2010 Annual Quality Survey

## June 2010

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# Updates to AQS Terminology

Beginning with the 2010 AQS, the following terms have been changed at TennCare's request:

- **enrollee** is referred to as **member**
- **area of opportunity** is referred to as **area of noncompliance**
- **Plan of Correction (POC)** is referred to as **Corrective Action Plan (CAP)**

This new wording is used in all instances throughout this report, including references to items from the 2009 AQS.

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# Acronyms, Abbreviations and Initialisms

ANA ..... Annual Network Adequacy
..... also known as Annual Provider Network Adequacy and Benefit Delivery Review
AQS ..... Annual Quality Survey
BBA ..... *Balanced Budget Act of 1997*
C/N ..... Concurrent or Non-Concurrent (*Grier*)
CAP ..... Corrective Action Plan
CD ..... Consent Decree
CEO ..... Chief Executive Officer
CFR ..... *Code of Federal Regulations*
CM ..... Case Management
CMS ..... Centers for Medicare & Medicaid Services
CRA ..... Contractor Risk Agreement
d.b.a. ..... doing business as
DBM/DBMC ..... Dental Benefits Manager/DBM Contract
DDS ..... Doctor of Dental Surgery
E/R ..... Expedited or Routine (*Grier* file review)
ED ..... Emergency Department
EPSDT ..... Early and Periodic Screening, Diagnosis, and Treatment (federal standard)
..... also used in reference to the *John B. Consent Decree* (state mandate)
..... and to TENNderCare (Tennessee's EPSDT program)
EQR/EQRO ..... External Quality Review/External Quality Review Organization
*Grier* ..... *Grier Revised Consent Decree* (state mandate)
..... also used in reference to member appeals
HIPAA ..... *Health Insurance Portability and Accountability Act*
IEP ..... Individual Education Plan
IRR ..... Inter-Rater Reliability
IS ..... Information System
ISO ..... International Organization for Standardization
LEP ..... Limited English Proficiency
MCC/MCO ..... Managed Care Contractor/Managed Care Organization
MR/MRR ..... Medical Record/MR Review
NA ..... Not Applicable
NCQA ..... National Committee for Quality Assurance
OCCP ..... Office of Contract Compliance and Performance
ORR ..... On Request Report
P&P ..... Policy and Procedure
PA ..... Performance Activity
PAS ..... Provider Affairs Subcommittee
PCP ..... Primary Care Physician/Provider
PEP ..... Provider Evaluation of Performance

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PHI ..... Protected Health Information
PIHP ..... Prepaid Inpatient Health Plan
POC ..... Plan of Correction
Q ..... Quarter
QI ..... Quality Improvement
QM/QMP ..... Quality Management/Quality Management Program
QOC ..... Quality of Care
QP ..... Quality Process
SEC ..... Sentinel Event Committee
TCA ..... Tennessee Code Annotated
TDMHDD ..... Tennessee Department of Mental Health and Developmental Disabilities
TennCare ..... Tennessee Department of Finance and Administration, Bureau of TennCare
UM ..... Utilization Management
UTD ..... Universal Tracking Database

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# Executive Summary

*for **AmeriChoice-East***

## *Introduction*

As the External Quality Review Organization (EQRO) for the Tennessee Department of Finance and Administration, Bureau of TennCare (TennCare), QSource is required by the *Balanced Budget Act of 1997* (BBA) to assess each TennCare health plan's "…strengths and weaknesses with respect to the quality, timeliness, and access to healthcare services furnished to Medicaid recipients" (42 *Code of Federal Regulations* [CFR] 438.364[a][2]). One requirement of the External Quality Review (EQR) contract with TennCare is to conduct an Annual Quality Survey (AQS) of each Managed Care Organization (MCO), and the Dental Benefits Manager (DBM), collectively referred to as the state's Managed Care Contractors (MCCs). This is the fifth year that QSource has performed the AQS. The purpose of the AQS is to determine the extent to which each TennCare MCC is in compliance with:

- its Contractor Risk Agreement (CRA) with the State of Tennessee, Bureau of TennCare;
- 42 CFR Parts 417.106, 430, 433, 434 and 438; and
- other quality standards established by the state of Tennessee.

In addition, QSource's review of MCCs incorporates two state mandates that address services and due process for managed care Medicaid members: *John B. Consent Decree* (supports the federal Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] standard of care for children age 20 and younger) and the *Grier Revised Consent Decree* (governs contested denials).

QSource also follows the Centers for Medicare & Medicaid Services (CMS) *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs), Final Protocol, Version 1.0*, February 11, 2003. In compliance with these protocols, this *UnitedHealthcare Plan of the River Valley, Inc. (**AmeriChoice-East**) 2010 Annual Quality Survey* (herein referred to as the *2010 AQS Report)* includes the Executive Summary and the following sections:

- Methodology
- Evaluation of Plan Process
- Evaluation of Plan Results
- Summary and Recommendations
- Appendices

## *Methodology*

The general scope of AQS assessment activity was previously defined by 10 state-specific MCO quality process (QP) standards and five performance activities (PAs). All MCOs under contractual obligation with TennCare have now achieved accreditation from the National Committee for Quality Assurance (NCQA). This accreditation reduced the number of QP

standards and PAs requiring EQRO assessment, preventing duplication of activities as prescribed by federal guidelines. **Table 1-1** lists all QP standards assessed for the 2010 AQS.

| Table 1-1. 2010 AQS QP Standards for AmeriChoice-East |
|---|
| Quality Improvement (QI) Program |
| Network: Contracting, Availability, Access and Documentation |
| QI Activities |
| Clinical Criteria for Utilization Management (UM) Decisions |
| Member Rights and Responsibilities |
| *John B. Consent Decree* (EPSDT) |
| *Grier Revised Consent Decree* |
| Non-Discrimination Compliance |

Two QP standards/PAs—**Credentialing/Recredentialing** and **Benefit Delivery Review**—were assessed as part of the 2010 Annual Provider Network Adequacy and Benefit Delivery Review (ANA); results were detailed in **AmeriChoice-East**'s *2010 ANA Report* and, as such, do not appear here.

The PAs for the **AmeriChoice-East** 2010 AQS appear in **Table 1-2**. Because all MCOs are now NCQA accredited, complaint review is no longer required. Additionally, the *Newberry Dispute Resolution* that mandated a review specific to home health denials has expired. UM denials pertain to members age 20 years and younger only.

| Table 1-2. 2010 AQS PAs for AmeriChoice-East |
|---|
| **MCO Activity by Standard** |
| Clinical Criteria for UM Decisions: Denial File Review (age 20 and younger only) |
| *John B. Consent Decree* (EPSDT): Information System Tracking Review |
| *Grier Revised Consent Decree*: Appeal File Review |

Detailed lists of all 2010 MCO evaluation elements are presented in **Tables 2-2** and **2-3** of the Methodology section.

## *Evaluation of Plan Process*

Plan performance values/star ratings for the 2010 AQS are indicated in **Table 1-3**.

| Table 1-3. AQS Rating Scale Key | | |
|---|---|---|
| **Plan Performance** | **Level of Compliance** | **Star Rating** |
| 90—100% | Total Compliance | ☆☆☆☆☆ |
| 80—89% | Substantial Compliance | ☆☆☆☆ |
| 65—79% | Partial Compliance | ☆☆☆ |
| 55—64% | Minimal Compliance | ☆☆ |
| 0—54% | Noncompliance | ☆ |

# *Evaluation of Plan Results*

## Scores and Ratings

**Table 1-4** summarizes **AmeriChoice-East**'s specific compliance percentage for each QP standard assessed for the 2010 AQS review. The health plan's star ratings from the 2010 AQS are also included by QP standard. A single score for *all* QP standards, as well as multi-year trending, is no longer calculable due to the reduction of standards and elements following NCQA accreditation.

**Table 1-4. 2010 QP Standard Scores and Ratings for AmeriChoice-East**

| MCO Standard | Percent Compliant | Star Rating |
|---|---|---|
| Quality Improvement (QI) Program | 100% | ☆☆☆☆☆ |
| Network: Contracting, Availability, Access and Documentation | 100% | ☆☆☆☆☆ |
| QI Activities | 100% | ☆☆☆☆☆ |
| Clinical Criteria for Utilization Management (UM) Decisions | 100% | ☆☆☆☆☆ |
| Member Rights and Responsibilities | 95.0% | ☆☆☆☆☆ |
| *John B. Consent Decree* (EPSDT) | 95.6% | ☆☆☆☆☆ |
| *Grier Revised Consent Decree* | 100% | ☆☆☆☆☆ |
| Non-Discrimination Compliance | 94.4% | ☆☆☆☆☆ |

**Table 1-5** summarizes **AmeriChoice-East**'s specific compliance percentage for each PA assessed for the 2010 AQS review. The health plan's star ratings from the 2010 AQS are also included by PA. As with QP standards, neither an overall PA score nor trending can be calculated due to NCQA accreditation, which eliminated complaint file review, and the expiration of the *Newberry Dispute Resolution*, which required the review of home health denials. UM denials pertain to members age 20 years and younger only.

**Table 1-5. 2010 PA Scores and Ratings for AmeriChoice-East**

| MCO Activity by Standard | Percent Compliant | Star Rating |
|---|---|---|
| Clinical Criteria for UM Decisions: Denial File Review (age 20 and younger only) | 100% | ☆☆☆☆☆ |
| *John B. Consent Decree* (EPSDT): Information System Tracking Review | 100% | ☆☆☆☆☆ |
| *Grier Revised Consent Decree*: Appeal File Review | 100% | ☆☆☆☆☆ |

## Corrective Action Plan Process

TennCare requires the MCO to submit a Corrective Action Plan (CAP) for *any* QP standard element or PA that has been identified as an area of noncompliance (i.e., less than 100 percent compliance), regardless of overall performance on the corresponding QP standard or PA. At the direction of TennCare, CAPs will also be required for deficiencies noted in the unscored elements of the QI Activities standard. CAPs are considered On Request Reports (ORRs),

meaning that TennCare may request them at its discretion and not solely based on the MCO's performance outcomes. All CAPs must be designed to improve performance in areas of noncompliance.

**AmeriChoice-East** did not achieve full compliance on:

- Member Rights and Responsibilities, Element #6: Notification of changes to written materials.
- *John B. Consent Decree* (EPSDT):
  - Element #6: Undeliverable mail
  - Element #10: Community contacts approved
- Non-Discrimination Compliance, Element #3: Display of non-discrimination posters

A CAP will be required for each of these items. Within 14 days of the posting notification of its final AQS report, the **AmeriChoice-East** must electronically submit all required CAPs to **OCCP.Reports@tn.gov** with copies to **Judy.M.Womack@tn.gov**, **Pauline.S.McIntyre@tn.gov** and **aqs-cap@qsource.org**. CAPs will not be considered submitted if they are not received by all four parties within the required time frame.

## *Summary and Recommendations*

The health plan achieved 100 percent compliance on five of eight QP standards, and on all PAs. Where full compliance was not met, the MCO's performance ranged from 94.4 to 95.6 percent. The following section summarizes the areas of noncompliance, strengths and suggestions that QSource identified during the 2010 AQS. These are discussed in greater detail in the full-length **Summary and Recommendations** of this report, as are the health plan's medical-behavioral health integration efforts.

### Integration of Medical-Behavioral Services

**AmeriChoice-East**'s policies and procedures (P&Ps) helped ensure the coordination of medical and behavioral health activities. The roles and responsibilities of primary care providers (PCPs) and mental health/substance abuse treatment providers were well defined. Collaboration was promoted via the health plan's P&Ps, processes, Provider Manual, website and provider newsletters. Screening tools were utilized to identify the need for case management (CM) and to assess the behavioral health needs of those already in CM. **AmeriChoice-East** used multiple tools to evaluate provider performance in these areas, and evidence produced on-site demonstrated collaboration, the monitoring of implementation and outcomes, and follow-up for members at least every 30 days.

There were distinct P&Ps for adverse occurrences, which were reported, reviewed, investigated and addressed through corrective action by the Provider Affairs Subcommittee (PAS). QSource verified these actions in staff interviews and document review. **AmeriChoice-East**

demonstrated compliance with tracking and trending, reporting requirements and the availability of MCO adverse occurrence documentation to TennCare.

The health plan's coordination efforts for children were also evident. Family involvement, accessible services, and follow-up after inpatient or residential treatment were just a few of the actions noted for TENNderCare members.

## Areas of Noncompliance

Areas of noncompliance were identified where **AmeriChoice-East** achieved less than 100 percent compliance. This includes the unscored elements in the QI Activities QP standard. Areas of noncompliance reflect what the health plan *should do* and may be accompanied by recommended policy, procedure or process changes from QSource. **AmeriChoice-East**'s areas of noncompliance centered primarily on member communication, outreach approval/documentation and display of non-discrimination posters. Upon changing the policies regarding co-pay rates, the MCO failed to notify members 30 days in advance, as is required by TennCare. Also, the MCO did not ensure that undeliverable mail was followed up on with attempts to locate family members within required time frames. The MCO should make sure to secure approval for and accurately document community outreach activities with TennCare prior to the events; they should also ensure that events are documented accurately in quarterly EPSDT reports. The MCO is also required to display non-discrimination posters that contain all of the federally required statutes regarding employee rights and obligations. The posters located in the MCO's breakroom did not have information on the *Omnibus Budget Reconciliation Act of 1981*.

All areas of noncompliance addressed during the 2009 AQS report were successfully resolved.

## Strengths

Strengths indicate that the MCO demonstrated particular proficiency on a given QP standard element or PA and can be identified independent of 100 percent compliance. QSource documented strengths under the *John B. Consent Decree* during the 2010 AQS. The MCO chose to conduct new member calls on all new members despite having exceeded the required screening rate standard.

Another strength in the same area was attributed to program coordination. As part of the Emergency Department (ED) Diversion program, the MCO identified children with more than five ED visits in a seven- month period to determine if they had a medical home. During this process, several members were identified whose "troublesome patterns of service utilization" ultimately resulted in referrals and coordination with the Department of Children Services.

## Suggestions

During the 2010 AQS, QSource made suggestions that are encouraged for **AmeriChoice-East** but not required. These are detailed in the full-length Summary and Recommendations section of this report.

# Methodology

*for* ***AmeriChoice-East***

## *Purpose of the Evaluation*

The Tennessee Department of Finance and Administration, Bureau of TennCare (TennCare) contracts with QSource to perform Annual Quality Survey (AQS) evaluations, which provide meaningful information that TennCare and **AmeriChoice-East** can use for:

1. measuring the quality of both the healthcare and services that it provides to its members;
2. evaluating its application of the *John B. Consent Decree* and the *Grier Revised Consent Decree* state mandates;
3. evaluating its policies, tracking processes and rates of compliance with the activities of TENNderCare, TennCare's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program;
4. identifying variations in healthcare services across Tennessee; and
5. implementing proactive measures for more effective/efficient service delivery.

To complete these components for the 2010 AQS, QSource assembled a team of experienced health plan surveyors to collect and analyze data; complete a review of contractual, clinical and administrative outcomes; and prepare a report for TennCare and **AmeriChoice-East**.

## *Results Evaluated*

This *2010 AQS Report* documents the evaluation of **AmeriChoice-East**'s compliance with its *Contractor Risk Agreement (CRA) between the State of Tennessee, doing business as (d.b.a.) TennCare and UnitedHealthcare Plan of the River Valley, Inc. (AmeriChoice-East)–East/West CRA–May 19, 2008–With Amendment 1 (September 1, 2009),* and the quality process (QP) standards and performance activities (PAs) derived from it. The *2010 AQS Report* also documents compliance with:

- QP standards derived from the *John B. Consent Decree* (EPSDT), *Grier Revised Consent Decree,* and for non-discrimination;
- PAs derived from the *John B. Consent Decree* (EPSDT) and *Grier Revised Consent Decree*; and an additional PA regarding UM Denials File Review;
- 42 *Code of Federal Regulations* (CFR) Parts 417.106, 430, 433, 434 and 438; and
- other quality standards established by the state of Tennessee.

## *Quality Assessment Activities*

For each Managed Care Contractor (MCC), the AQS includes a pre-assessment documentation review, an on-site visit and post-on-site analyses. QSource developed the AQS tools to be used on-site and forwarded them to **AmeriChoice-East**. The pre-assessment phase gave both

QSource and the health plan an opportunity to ask questions before the on-site visit. QSource surveyors conducted **AmeriChoice-East**'s on-site visit **April 20–22, 2010**. **Table 2-1** details the assessment activities QSource performed for the AQS.

| Table 2-1. 2010 AQS Activities Performed |
|---|
| **Step 1: Establish survey schedule.** |
| ♦ Before the on-site visit, QSource submitted the survey schedule to TennCare for approval. |
| **Step 2: Prepare data collection survey tools and submit them to TennCare for review/approval.** |
| ♦ QSource developed evidence-based oversight/monitoring tools in consultation with TennCare representatives to ensure CRA-specific criteria were met and all data sought were collected.<br>♦ Approved tools completed for **AmeriChoice-East** are in **Appendices A** and **C.** |
| **Step 3: Submit survey tools to the MCC.** |
| ♦ QSource forwarded the survey tools to the health plan, giving it the opportunity to gather the required data and facilitate process streamlining for the on-site visit. |
| **Step 4: Prepare/Submit the Pre-Assessment Documentation List to the MCC.** |
| ♦ QSource sent a letter to TennCare MCCs requesting that specific desk review documents be submitted to QSource. The Pre-Assessment Documentation List was accompanied by instructions on how to organize and prepare the documents for the surveyors. |
| **Step 5: Respond to MCC questions/information requests prior to on-site review.** |
| ♦ QSource remained in contact via telephone and e-mail to respond to questions and to provide additional information as needed to key **AmeriChoice-East** personnel and TennCare representatives, particularly concerning clarification of the **Pre-Assessment Documentation List** and the on-site assessment process. |
| **Step 6: Receive pre-assessment documentation and gather information before the on-site visit.** |
| ♦ QSource used the survey tools to examine and document all information received before the on-site visit to offer surveyors insight into **AmeriChoice-East**'s structure, member population, providers, services, operations, resources and delegated functions to enable initial compiling of data.<br>♦ From the PA data submitted by the health plan, QSource abstracted a random sample of files, including an oversample, for desk review.<br>♦ During the desk review process, the surveyors:<br>(1) took notes to assist in the completion of the survey tools and guide determination about compliance with the regulatory provisions;<br>(2) identified those areas and issues requiring further clarification or follow-up during the on-site interviews; and<br>(3) clarified which requested information was not found in the pre-assessment documentation. |
| **Step 7: Develop an on-site agenda.** |
| ♦ QSource surveyors developed a general agenda to assist the **AmeriChoice-East** staff in participation planning, documentation gathering and addressing logistical issues (such as arranging locations for surveyors to conduct document reviews and interviews). |
| **Step 8: Discuss the on-site agenda with the MCC.** |
| ♦ Through setting the tone and expectations in an on-site agenda and discussing it with **AmeriChoice-East** in preparation for the on-site assessment, QSource helped ensure that all participants understood the time frames involved so that the process was more efficient and effective. |

| Table 2-1. 2010 AQS Activities Performed |
|---|
| **Step 9: Conduct the on-site visit.** |
| ♦ During the on-site document assessment, **AmeriChoice-East** staff was available to answer questions or assist the QSource review team in locating specific documents or information sources.<br>♦ QSource coordinated interviews/discussions with staff to maximize results while minimizing disruption to plan operations, as document review alone is generally insufficient to determine compliance since content and actual performance of the procedures outlined in the documents can typically be determined only by interaction and interviews with plan staff.<br>♦ The review team interacted with staff to determine the degree of compliance with contract requirements, to explore any issues not fully addressed in the documents reviewed and to increase overall understanding of **AmeriChoice-East**'s performance. |
| **Step 10: Review information and documentation using the survey tools.** |
| ♦ Throughout the documentation review and on-site assessment processes, QSource reviewers used the survey tools to obtain information and to document findings regarding **AmeriChoice-East**'s compliance with set standards through a review of policies/procedures, committee minutes, quality studies, reports, medical record/file review and other related health plan documentation.<br>♦ Surveyors took notes during staff interviews and document review to obtain the required data. (These notations were included in the completed survey tools in this report as **Appendices A** and **C** to serve as a comprehensive record of the assessment activity.) |
| **Step 11: Summarize findings at the completion of the survey.** |
| ♦ As a final step for completing the on-site survey, QSource met with **AmeriChoice-East** to summarize initial findings and recommendations. |
| **Step 12: Calculate the individual ratings for the MCC's performance.** |
| ♦ For comparing performance and determining **AmeriChoice-East**'s compliance with QP standards and program requirements, QSource incorporated nationally recognized guidelines from:<br>(1) *Standards and Guidelines for the Accreditation of Health Plans* from the National Committee for Quality Assurance (NCQA);<br>(2) protocols of the Centers for Medicare & Medicaid Services (CMS); and<br>(3) state and federal regulations.<br>♦ QSource analyzed every element in the survey tools using weighted point values to determine **AmeriChoice-East**'s performance on each standard. |
| **Step 13: Prepare a report of findings and recommendations.** |
| ♦ After completing data analyses, QSource prepared this report of the review findings and recommendations. A draft AQS report was due 30 days after the survey was completed, with the final AQS report due 60 days after completion of the survey. Both reports were forwarded to TennCare for approval within these deadlines. |
| **Step 14: Provide post-survey support to the MCC.** |
| ♦ QSource provided **AmeriChoice-East** with technical assistance as needed to foster performance improvement. |

## *Standards and Measures Reviewed*

As part of the 2010 AQS, QSource's surveyors evaluated the elements of the QP standards and PAs identified in **Tables 2-2** and **2-3**. *Please note that the element titles in these tables do not necessarily reflect*

*the entirety of the content reviewed for each QP standard or PA identified. Also, recall that Credentialing/Recredentialing and Benefits Delivery Review were included in* ***AmeriChoice-East****'s* 2010 Annual Network Adequacy (ANA) Report *and, as such, are not included in this* 2010 AQS Report.

| Table 2-2. QP Standard Elements for AmeriChoice-East | |
|---|---|
| **Quality Improvement (QI) Program** | |
| 1) Member safety and quality | |
| **Network: Contracting, Availability, Access and Documentation** | |
| 1) Specialist termination | 2) Notice of provider termination |
| **QI Activities** | |
| 1) Coordination between physical and behavioral health<br>2) Adverse occurrences policies and procedures<br>3) Adverse occurrences definition<br>4) Adverse occurrences to be reported | 5) Adverse occurrences and quality of care issues<br>6) Adverse occurrence tracking and trending<br>7) Adverse occurrence reporting requirements<br>8) Availability of adverse occurrence documents |
| **Clinical Criteria for Utilization Management (UM) Decisions** | |
| 1) Availability of criteria | 2) Transition to other care |
| **Member Rights and Responsibilities** | |
| 1) Member Handbook development and distribution<br>2) Complaint procedures<br>3) Communication of rights and responsibilities in Member Handbook | 4) Member Handbook inclusions<br>5) Notice of right to file a complaint<br>6) Notification of changes to written materials<br>7) Translation services<br>8) Translated vital documents |
| ***John B. Consent Decree* (EPSDT)** | |
| 1) New member calls<br>2) Outreach contacts<br>3) Documenting outreach<br>4) Declined services<br>5) Re-notification if no services used<br>6) Undeliverable mail<br>7) Accurate provider lists<br>8) Targeted activities<br>9) Outreach to illiterate, blind, deaf and LEP<br>10) Community contacts approved<br>11) Prenatal appointment assistance<br>12) Referrals from one level of screening to another<br>13) Notify MCO if unable to make referral<br>14) Medically necessary services<br>15) Rehabilitation and maintenance services<br>16) Medical necessity<br>17) Limitations/Capitations/Delays<br>18) Qualified UM personnel | 19) Services without prior authorization<br>20) Specialist list<br>21) MCO CM<br>22) Medically necessary CM services<br>23) CM central function<br>24) Family involvement and accessible services<br>25) Follow-up after inpatient or residential treatment<br>26) Screening components including follow-up<br>27) Interperiodic screen<br>28) Prior authorization prohibited<br>29) Screening standards met<br>30) Transportation<br>31) Program coordination<br>32) IEPs<br>33) Tracking system<br>34) EPSDT language in contracts<br>35) EPSDT contract review |
| ***Grier Revised Consent Decree*** | |
| 1) Appeals unit | 2) *Grier*/Appeals procedures |

| Table 2-2. QP Standard Elements for AmeriChoice-East | |
|---|---|
| **Non-Discrimination Compliance** | |
| 1) Non-Discrimination Compliance Plan<br>2) Assurance of Non-Discrimination<br>3) Display of non-discrimination posters<br>4) Non-discrimination written materials<br>5) Written policy and procedure | 6) Complaint resolution and reporting<br>7) Member Handbook notification and Complaint Form<br>8) Quarterly newsletter notification<br>9) Subcontractor compliance education |

| Table 2-3. PAs by Standard for AmeriChoice-East |
|---|
| **MCO Activity by Standard** |
| Clinical Criteria for UM Decisions: Denial File Review (age 20 and younger only) |
| *John B. Consent Decree* (EPSDT): Information System Tracking Review |
| *Grier Revised Consent Decree*: Appeal File Review |

## *Conducting the Survey*

QSource worked closely with TennCare and with the health plan throughout the survey process, ensuring a supportive and coordinated approach in carrying out survey activities. All tools were approved by TennCare prior to conducting the survey.

Before the on-site visit, QSource contacted **AmeriChoice-East** to exchange information, to set dates for the visit, and to discuss other activities needed to complete the evaluation methodically and accurately. Dates for the contract term, the reporting period under review and QSource's on-site visit to **AmeriChoice-East** are detailed in **Table 2-4**.

| Table 2-4. Principal Dates for the AmeriChoice-East 2010 AQS | |
|---|---|
| **Key Stages** | **Time Span** |
| Contract Term | May 19, 2008 – Present |
| Reporting Period Under Review | January 1—December 31, 2009 |
| Dates of Review | April 20—22, 2010 |

## *Producing and Delivering the Survey Report*

In compliance with CMS protocol, this report includes:

- a detailed assessment of **AmeriChoice-East**'s strengths regarding the quality, timeliness and accessibility of its healthcare services;
- specific areas of noncompliance to help the health plan improve performance; and
- QSource's assessment to ensure the health plan's continued improvement on standards with less than 100 percent compliance.

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**AmeriChoice-East** had the opportunity to respond to the draft of this report. No comments were received, as indicated in **Appendix D**.

## *MCO Scores*

The total point value assigned to the QP standards section was 63.6 points (51.5 percent), and the total point value assigned to the PA section was 60 points (48.5 percent). The processes used for calculating QP standards and PA scores are detailed below.

### QP Standards–Element Scores

Using specific criteria, each QP standard score was calculated by adding its individual evaluation element scores (see **Table 2-2**). For example, *John B. Consent Decree* (EPSDT) has a total value of 39.50 points, which represents the sum of its 35 evaluation element scores (ranging from 0.500 to 3.000 each). The scored QP standard review tool for **AmeriChoice-East** is located in **Appendix A**.

### PA Scores

Each PA evaluation is unique and, as such, has its own distinct review tool. Each of the PAs was assigned a 20-point value. The scored PA tools for **AmeriChoice-East** are in **Appendix C**. Any tool component considered not applicable (NA) was excluded from scoring.

### Rating Determination

A rating of one to five stars was assigned for every QP standard and PA based on the percentage of total points earned for each. **Table 2-5** provides a summary.

**Table 2-5. AQS Rating Scale Key**

| Plan Performance | Compliance Rating | Star Rating |
|---|---|---|
| 90—100% | Total Compliance | ☆☆☆☆☆ |
| 80—89% | Substantial Compliance | ☆☆☆☆ |
| 65—79% | Partial Compliance | ☆☆☆ |
| 55—64% | Minimal Compliance | ☆☆ |
| 0—54% | Noncompliance | ☆ |

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# Evaluation of Plan Process

*for **AmeriChoice-East***

Using Centers for Medicare & Medicaid Services (CMS) protocol for External Quality Review Organizations (EQROs), QSource reviewed documentation from **AmeriChoice-East** and conducted on-site interviews to identify the health plan's progress toward quality standard goals set in 2009. This protocol, and QSource's 2010 survey tools, helped to determine the Managed Care Organization's (MCO's) compliance with contractual standards specified in the Contractor Risk Agreement (CRA); 42 *Code of Federal Regulations (*CFR*)* Parts 417.106, 430, 433, 434 and 438; and other quality standards established by the state of Tennessee.

QSource has met the federal qualifications for EQROs set forth in 42 CFR § 433.354. In brief, these include demonstrated experience and knowledge of Medicaid as well as managed care policies, processes, and data systems. The organization is a 501(c)(3) not-for-profit whose survey staff includes registered nurses, master's level public health and healthcare administration professionals, and those experienced in research design and statistical analysis. QSource holds a 9001:2008 quality management certification from the International Organization for Standardization (ISO) and is certified by the state of Tennessee as a utilization review agent. QSource has met all standards of independence required of EQROs in their contracts with governmental and/or other agencies.

## *Pre-Assessment Review*

To expedite the 2010 Annual Quality Survey (AQS), QSource sent a written request for documentation to each Managed Care Contractor (MCC) of the Tennessee Department of Finance and Administration, Bureau of TennCare (TennCare), prior to the scheduled on-site survey. The request included a Pre-Assessment Documentation List of items pertaining to the quality process (QP) standards and performance activities (PAs) to be evaluated.

Pre-assessment documentation review facilitates a more efficient on-site survey and helps surveyors conduct better MCC staff interviews in the time allotted. **AmeriChoice-East** was compliant in providing the requested pre-assessment information in a timely manner.

The documentation QSource requested and reviewed consisted of the following:

1. Member Handbooks in English and Spanish
2. Provider Manual
3. 2009 Quality Improvement (QI) Program Description
4. QI Program Evaluation of 2008 activities
5. TENNderCare Program Description
6. All provider and member newsletters
7. 2009 quarterly and annual EPSDT reports
8. 2009 Utilization Management (UM) Program Description

9. UM Program Evaluation of 2008 activities
10. All provider and member satisfaction surveys
11. Information and documentation related to 2009 AQS Corrective Action Plan (CAP) activities and interventions
12. Policies that define the MCC's time standards for handling all denials and appeals
13. Completed table of time standards used for the resolution of UM denials and appeals

In addition to these pre-assessment documents, QSource asked that **AmeriChoice-East** have available on-site all curricula vitae/resumes for UM staff involved in medical necessity decision-making, as well as:

- 15 UM denial files (EPSDT-eligible members only)
- 15 EPSDT files
- 15 appeal (*Grier*) files

# *On-Site Review*

## Survey Participants

The MCC representative interview is integral to the AQS. Interview participants supplement, clarify and confirm what is learned during the pre-assessment review; they supply further evidence that what the MCC documents and what it practices are congruent. **Table 3-1** lists the on-site surveyors and the **AmeriChoice-East** staff members they contacted during the survey.

**Table 3-1. Participants in the AmeriChoice-East 2010 AQS**

| Name | Credentials | Title |
|---|---|---|
| **QSource On-Site Surveyors** | | |
| Ginger Botts | RN, BSN | QI Clinical Specialist |
| Michelle North | RN, BSN | QI Clinical Specialist |
| Swapna Jamode | MHA | Health Analyst |
| **AmeriChoice-East Staff Facilitating the Evaluation** | | |
| Amanda Hamblen | | Manager, DM |
| Beth Fortenberry | RN, BSN | Associate Director, Clinical Medical Operations |
| Charles Nails | BSW | Quality Specialist |
| Christa Thomas | RN | Manager, Case Management (CM); Private Duty Nurse |
| David O. Hollis | MD, FACP | Chief Medical Officer |
| Elliot Sparks | MSW, LMSW | Manager, Behavioral Health CM |
| Hayley Clothier | BA | Quality Manager |
| Jerry Sullivan | PsyD | Executive Director, Behavioral Health |
| Judith Black | RN | Director, Special Projects |
| Kim Seay | BS | Senior Director, Quality Management |

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| Table 3-1. Participants in the AmeriChoice-East 2010 AQS | | |
|---|---|---|
| **Name** | **Credentials** | **Title** |
| Lisa Ellis | RN,BSN, MSA | Southeast Regional Director, Integrated Care Coordinator, Teen-Medicaid |
| Sandy Sanderson | RN | Manager, Care Management |
| Sara (Dusti) Williams | RN, BSN | Manager, EPSDT & Preventive Health |
| Sarah Marcel | MBA | Manager, TennCare Compliance |
| Stephanie McNeal | RN | Associate Director, Appeals/Clinical Letter Compliance |
| Tristin Blade | | Health Coach II, Healthy First Steps (HFS) |

## On-Site Documentation

Once on-site, QSource surveyors examined additional documents (detailed in **Table 3-2**) that were not included in the pre-assessment review.

**Table 3-2. On-Site Documentation for the AmeriChoice-East 2010 AQS**

1) 2009 QI Work Plan
2) Adverse Incident Work Guide
3) Adverse Occurrence Investigation Files and Tracking Log
4) Appeals Organization Chart
5) Availability of Behavioral Health Practitioners and Providers - 2009 Annual Analysis
6) Behavioral Health Inter-Rater Reliability (IRR) Vignettes
7) Completed Medical Record Audit Tool
8) Desk Audit Tool
9) Documentation Requirement for Letter (East Only)
10) Emails Regarding:
    - QM Health Programs to be Posted to Web in 2009 (email chain from 12/2/08 – 12/4/08)
    - TennCare Approval of Policies and Procedures (P&P)
11) Final Version of P&P #HS UM 10: Prior Authorization and/or Referral Exceptions
12) IEP Tracking Database Screenshots
13) Member Care Management Notes (6/1/09-12/31/09) East
14) New Member Packet Monthly Log
15) Postal Confirmation Forms on Annual Member Packets Mailing
16) Regional Sample of CM Case Notes for Member's Home Health Care Providers that would Term with MCO
17) Sarbanes-Oxley UM Audit Process Summary
18) UM Quality Audit Examples; Redesign Workshop PowerPoint; and Staff List, Licenses and Resumes

## *Overview of Findings*

During the review, QSource surveyors used the tools in **Appendices A** and **C** – along with personal observations, interviews with key health plan staff and on-site file/document reviews – to facilitate analyses and compilation of findings. The results include:

- quality process (QP) standard evaluation results (**Table 4-1**)
- performance activity (PA) evaluation results (**Table 4-2**)
- QP standard strengths and opportunities (**Table 4-3**)
- PA strengths and opportunities (**Table 4-4**)

**AmeriChoice-East**'s individual element and PA file compliance scores can also be found in **Appendices A** and **C**.

### Scores and Ratings

**Table 4-1** summarizes **AmeriChoice-East**'s specific compliance percentage for each QP standard assessed for the 2010 Annual Quality Survey (AQS). The Managed Care Organization's (MCO's) star ratings from the 2010 AQS are also included by QP standard. A single score for all QP standards, as well as multi-year trending, is no longer calculable due to the reduction of standards and elements following National Committee for Quality Assurance (NCQA) accreditation.

As shown, **AmeriChoice-East** achieved 100 percent compliance on five of eight QP standards. On the remaining standards, performance ranged from 94.4 to 95.6 percent.

**Table 4-1. 2010 QP Standard Scores and Ratings for AmeriChoice-East**

| MCO Standard | Percent Compliant | Star Rating |
|---|---|---|
| Quality Improvement (QI) Program | 100% | ☆☆☆☆☆ |
| Network: Contracting, Availability, Access and Documentation | 100% | ☆☆☆☆☆ |
| QI Activities | 100% | ☆☆☆☆☆ |
| Clinical Criteria for Utilization Management (UM) Decisions | 100% | ☆☆☆☆☆ |
| Member Rights and Responsibilities | 95.0% | ☆☆☆☆☆ |
| *John B. Consent Decree* (EPSDT) | 95.6% | ☆☆☆☆☆ |
| *Grier Revised Consent Decree* | 100% | ☆☆☆☆☆ |
| Non-Discrimination Compliance | 94.4% | ☆☆☆☆☆ |

**Table 4-2** summarizes **AmeriChoice-East**'s specific compliance percentage for each PA evaluated for the 2010 AQS review. Star ratings for the 2010 AQS are also included. As with QP

standards, neither an overall PA score nor trending can be calculated due to NCQA accreditation, which eliminated complaint file review, and the expiration of the Newberry Dispute Resolution, which required the review of home health denials. UM denials pertain to members age 20 years and younger only.

**AmeriChoice-East** achieved 100 percent compliance on all PAs.

| Table 4-2. 2010 PA Scores and Ratings for AmeriChoice-East | | |
|---|---|---|
| **MCO Activity by Standard** | **Percent Compliant** | **Star Rating** |
| Clinical Criteria for UM Decisions: Denial File Review (age 20 and younger only) | 100% | ☆☆☆☆☆ |
| *John B. Consent Decree* (EPSDT): Information System Tracking Review | 100% | ☆☆☆☆☆ |
| *Grier Revised Consent Decree*: Appeal File Review | 100% | ☆☆☆☆☆ |

## Strengths and Areas of Noncompliance

The AQS aids QSource and the Tennessee Department of Finance and Administration, Bureau of TennCare (TennCare) in the identification of strengths and areas of noncompliance to benefit **AmeriChoice-East**. **Strengths** indicate that the health plan demonstrated particular proficiency on a given QP standard element or PA, and can be identified independent of 100 percent compliance. The lack of an identified strength should not be interpreted as a shortcoming on the part of **AmeriChoice-East**.

**Areas of noncompliance** were identified where **AmeriChoice-East** achieved less than 100 percent compliance. They reflect what the health plan *should do* and may be accompanied by recommended policy, procedure or process changes from QSource. A score of 100 percent on a standard indicates that **AmeriChoice-East** fully met the criteria and, therefore, is in full compliance. **Tables 4-3** and **4-4** detail **AmeriChoice-East**'s strengths and areas of noncompliance for the 2010 AQS. No areas of noncompliance items repeated from the 2009 survey.

| Table 4-3. 2010 QP Standard Strengths and Areas of Noncompliance for AmeriChoice-East | |
|---|---|
| **Strengths** | **Areas of Noncompliance** |
| **Quality Improvement (QI) Program** | |
| **AmeriChoice-East** was in full compliance with this standard. | |
| **Network: Contracting, Availability, Access and Documentation** | |
| **AmeriChoice-East** was in full compliance with this standard. | |
| **QI Activities** | |
| **AmeriChoice-East** was in full compliance with this standard. | |

| Table 4-3. 2010 QP Standard Strengths and Areas of Noncompliance for AmeriChoice-East | |
|---|---|
| **Strengths** | **Areas of Noncompliance** |
| **Clinical Criteria for Utilization Management (UM) Decisions** | |
| **AmeriChoice-East** was in full compliance with this standard. | |
| **Member Rights and Responsibilities** | |
| | **Element #6: Notification of changes to written materials.** The MCO had updates to the policy regarding co-pay changes effective 01/01/2010, but the members were not provided the written notice 30 days in advance. |
| ***John B. Consent Decree* (EPSDT)** | |
| **Element #1: New member calls.** The MCO chose to conduct new member calls on all new members despite having exceeded the required screening rate standard.<br><br>**Element #31. Program Coordination.** As part of the Emergency Department (ED) Diversion program, the MCO identified children with more than five ED visits in a seven- month period to determine if they had a medical home. During this process, several members were identified whose "troublesome patterns of service utilization" ultimately resulted in referrals and coordination with Department of Children Services. | **Element #6: Undeliverable mail.** The MCO should ensure that, when mail is returned as undeliverable, both attempts to find family occur within the required time frames.<br><br>**Element #10: Community contacts approved.** The MCO should ensure that all community events involving member outreach/interaction receive appropriate approval from TennCare. The MCO should also ensure that events are documented accurately in quarterly EPSDT reports. |
| ***Grier Revised Consent Decree*** | |
| **AmeriChoice-East** was in full compliance with this standard. | |
| **Non-Discrimination Compliance** | |
| | **Element # 3: Display of non-discrimination posters.** The MCO should include the information on the posters located in their breakrooms informing their employees regarding the Omnibus Budget Reconciliation Act of 1981. The MCO should continue to include the current information like employees' rights and obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990 and the Age Discrimination Act of 1975. |

| Table 4-4. 2010 PA Strengths and Areas of Noncompliance for AmeriChoice-East | |
|---|---|
| **Strengths** | **Areas of Noncompliance** |
| **Clinical Criteria for UM Decisions: Denial File Review (age 20 and younger only)** | |
| **AmeriChoice-East** was in full compliance with this PA. | |
| ***John B. Consent Decree* (EPSDT): Information System Tracking Review** | |
| **AmeriChoice-East** was in full compliance with this PA. | |
| ***Grier Revised Consent Decree*: Appeal File Review** | |
| **AmeriChoice-East** was in full compliance with this PA. | |

## *Corrective Action Plan Process*

CAPs are designed to improve performance in areas of noncompliance. TennCare requires that the MCO submit a CAP for *any* QP standard element or PA that has been identified as an area of noncompliance (i.e., less than 100 percent compliance), regardless of overall performance on the corresponding QP standard or PA. At the direction of TennCare, CAPs will also be required for deficiencies noted in the unscored elements of the QI Activities standard. The AQS represents an opportunity for health plans to receive technical assistance – from TennCare or QSource – while developing a CAP for areas that require improvement. CAPs are considered On Request Reports (ORRs), meaning that TennCare may request them at its discretion and not solely based on the MCO's performance outcomes.

Within 14 days of the posting notification of its final AQS report, **AmeriChoice-East** must electronically submit all required CAPs to the following:

- TennCare Office of Contract Compliance and Performance (OCCP): **OCCP.Reports@tn.gov**
- TennCare Division of Quality Oversight:
  - Director: **Judy.M.Womack@tn.gov**
  - Assistant Director: **Pauline.S.McIntyre@tn.gov**
- QSource: **aqs-cap@qsource.org**

CAPs will not be considered as submitted if they are not received by all four parties within the required time frame. Following CAP evaluation, TennCare will send the health plan either a letter of approval or a denial with a request for additional clarifying information.

**AmeriChoice-East** did not achieve full compliance on:

- Member Rights and Responsibilities, Element #6: Notification of changes to written materials.

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- *John B. Consent Decree* (EPSDT):
  - Element #6: Undeliverable mail
  - Element #10: Community contacts approved
- Non-Discrimination Compliance, Element #3: Display of non-discrimination posters

A CAP will be required for each of these items. Each CAP must address and meet the intent of the identified area of noncompliance, show progress made in meeting the CAP, include an intended completion date, and the titles of those responsible for its completion.

## *Quality Improvements since the Previous AQS*

Each year, the AQS summarizes the quality improvements made by each MCC since the previous year's survey. As detailed in **Tables 4-5** and **4-6**, this summary includes areas of noncompliance that were identified by QSource in 2009 and **AmeriChoice-East**'s planned action as described in its CAP(s). With its CAPs, the MCO satisfied all areas of noncompliance identified during the 2009 AQS. For more detailed results, see **AmeriChoice-East**'s *2009 AQS Report*.

| Table 4-5. QP Standard Improvements since the 2009 AQS | | |
|---|---|---|
| **2009 Area of Noncompliance** | **AmeriChoice East's Planned Action** | **Action Accomplished** |
| **Member Rights and Responsibilities** | | |
| **Element #5: Translation services.** All quarterly member newsletters should include the procedure on obtaining information in alternative formats or how to access interpretation services. The health plan should continue to mention that these services are free. | Review current practice of Member Newsletters and add to all Member Newsletters as a standard article/procedure. | All quarterly member newsletters included the procedure on obtaining information in alternative formats or how to access interpretation services. The newsletters also indicated that these services are free. This satisfies this area of noncompliance. |
| **Comment:** None. | | |
| ***John B. Consent Decree* (EPSDT)** | | |
| **Element #27: Individual education plans (IEPs).** After receipt of the IEP, the MCO should send a copy of it and any related information (e.g., action taken by the MCO in response to receipt of the IEP, action the MCO expects the provider to take) to the primary care provider/physician (PCP). | A tracking log is maintained on a common drive so that all IEPs are documented and tracked in one central location.<br><br>One of the tracking elements includes documentation of the date the copy of the IEP was sent to the PCP. Quality audits are conducted in the Medical CM [Care Management] Dept. on a monthly basis.<br><br>As part of the monthly Quality audit - the region manager will review the assigned CM CareOne notes for all new IEPs for that month to be certain that the notification/IEP was sent to the member's PCP. | Quality audits occurred monthly until October 2009, at which time the corporate standard transitioned to quarterly audits. The CM Manager showed online examples at her desk of audit results from 2009. The audits included an evaluation of CareOne documentation by CMs, in which documentation regarding IEPs was included. The IEP Tracking Database contained all pertinent dates related to the IEP process, including the date of PCP contact for member evaluation and the date the IEP was sent to the PCP. This satisfies the CAP for 2009. |
| **Comment:** None. | | |

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| Table 4-6. PA Improvements since the 2009 AQS | | |
|---|---|---|
| **2009 Area of Noncompliance** | **AmeriChoice East's Planned Action** | **Action Accomplished** |
| **Utilization Review: Denial File Review (age 20 and under only)** | | |
| **AmeriChoice-East** should ensure the appropriate processes are implemented to make decisions related to utilization management as well as ensuring members are notified timely. | Completed Inpatient Care Management staff training on medical necessity criteria and timeliness as part of Utilization Management role-based training March 24-26, 2009. Monthly monitoring is ongoing and performed to evaluate compliance with the following activities: Case addressed within one (1) business day of receipt, initial review completed within a 24 hour period after notification pending receipt of clinical information; communication of the denial made verbally and in writing to the member and/or facility/provider. One-on-One education provided on a monthly basis and documented for specific Inpatient Care Managers. Staff specific Corrective Action Plans are developed, reviewed with staff and updated based upon progress towards goals. Results of audits are evaluated each month to assess for trends and need for system-wide training. New template and job aid under development for documentation of decision making and denial process for roll-out to Inpatient Care Management staff when approved. | A PowerPoint presentation on UM Redesign Workshop provided the staff with training on medical necessity criteria and timeliness as a part of Utilization Management Role-based training on 3/24/09 and 3/26/09. Sarbanes-Oxley Utilization Management Audit Process Summary from March to December 2009 was provided. The monthly monitoring included information on timeliness, notification documentation and one-on-one sessions. Staff-specific CAPs were developed, reviewed with staff and updated based upon progress towards goals. The audit results were evaluated on a monthly basis to assess for trends and the need for systemwide training. Instead of a template, documentation was provided, addressing the decision-making and denial process. It included the requirements for the appeal notification letter mandated by the *Grier Consent Decree*. This action satisfies the 2009 CAP. |
| **Comment: None.** | | |

# Summary and Recommendations

*for **AmeriChoice-East***

Overall, **AmeriChoice-East** demonstrated a commitment to quality and TennCare contractual compliance. The health plan achieved 100 percent compliance on five of eight quality process (QP) standards, and on all performance activities (PAs). Where full compliance was not met, the Managed Care Organization's (MCO's) performance ranged from 94.4 to 95.6 percent. This section includes a comparison with the previous year's compliance results and a detailed discussion of areas of noncompliance, strengths and suggestions identified during the 2010 Annual Quality Survey (AQS).

## *Integration of Medical-Behavioral Services*

**AmeriChoice-East**'s policies and procedures (P&Ps) helped ensure the coordination of medical and behavioral health activities. The roles and responsibilities of primary care providers (PCPs) and mental health/substance abuse treatment providers were well defined. Collaboration was promoted via the health plan's P&Ps, processes, Provider Manual, website and provider newsletters. Screening tools were utilized to identify the need for case management (CM) and to assess the behavioral health needs of those already in CM. **AmeriChoice-East** used multiple tools to evaluate provider performance in these areas, and evidence produced on-site demonstrated collaboration, the monitoring of implementation and outcomes, and follow-up for members at least every 30 days.

There were distinct P&Ps for adverse occurrences, which were reported, investigated and addressed through corrective action by the Provider Affairs Subcommittee (PAS). QSource verified these actions in staff interviews and document review. **AmeriChoice-East** demonstrated compliance with tracking and trending, reporting requirements and the availability of MCO adverse occurrence documentation to TennCare.

The health plan's coordination efforts for children were also evident. Family involvement, accessible services, and follow-up after inpatient or residential treatment were just a few of the actions noted for TENNderCare members.

## *Areas of Noncompliance*

Areas of noncompliance were identified where **AmeriChoice-East** achieved less than 100 percent compliance. This includes the unscored elements in the QI Activities QP standard. Areas of noncompliance reflect what the health plan *should do* and may be accompanied by recommended policy, procedure or process changes from QSource. **AmeriChoice-East's** areas of noncompliance centered primarily on member communication, outreach approval/documentation and display of non-discrimination posters. Upon changing the policies regarding co-pay rates, the MCO failed to notify members 30 days in advance, as is required by TennCare. Also, the MCO did not ensure that undeliverable mail was followed up on with attempts to locate family members

within required time frames. The MCO should make sure to receive appropriate approval for all community outreach activities with TennCare prior to the events; they should also ensure that events are documented accurately in quarterly reports of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) efforts. The MCO is also required to display non-discrimination posters that contain all of the federally required statutes regarding employee rights and obligations. The posters located in the MCO's breakroom did not have information on the *Omnibus Budget Reconciliation Act of 1981*.

All areas of noncompliance addressed during the 2009 AQS report were successfully resolved.

## Strengths

Strengths indicate that the MCO demonstrated particular proficiency on a given QP standard element or PA and can be identified independent of 100 percent compliance. QSource documented strengths under the *John B. Consent Decree* during the 2010 AQS. The MCO chose to conduct new member calls on all new members despite having exceeded the required screening rate standard.

Another strength in the same area was attributed to program coordination. As part of the Emergency Department (ED) Diversion program, the MCO identified children with more than five ED visits in a seven- month period to determine if they had a medical home. During this process, several members were identified whose "troublesome patterns of service utilization" ultimately resulted in referrals and coordination with the Department of Children Services.

## Suggestions

During the 2010 AQS, QSource made suggestions that are encouraged for **AmeriChoice-East** but not required. The MCO should consider including a statement in the quarterly member newsletter indicating the availability and location of safety and quality performance information. To further enhance its outreach efforts, the MCO should consider revising its TENNderCare/EPSDT policy (#HS QM PWE 1) to more specifically address outreach to members who have not used services in more than two years. Telephone scripts used with these members could remind them that they have not used services in a two-year time period.

To further ensure that PCPs use the online list of TENNderCare members who are not up-to-date on their screenings, the MCO could include more specific instructions in newsletters and training materials that direct providers to the health plan website.

Additionally, to aid non-discrimination compliance, the health plan's policy and procedure regarding language and interpretation services could more clearly state that assistance is available to visually impaired or blind members.

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# APPENDIX A | *Quality Process Standard Survey Tool*

*for **AmeriChoice-East***

This section contains the completed Annual Quality Survey (AQS) Quality Process (QP) Standard Survey Tool for Managed Care Organizations (MCOs), 2010 Edition.

Each evaluation element is referenced with the relevant paragraphs/sections of the Contractor Risk Agreement (CRA) and/or other applicable state or federal rules or laws.

# 2010 Annual Quality Survey - Quality Process Standards

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Quality Improvement (QI) Program** | | | | |
| **1 Member safety and quality** | | | 0.750 | 0.750 |
| The MCO has a written plan for collecting and providing information on member safety that includes actions taken to:<br>● document provider efforts to improve member safety; and<br>● make performance data available for members and practitioners. | ☑ Plan for collecting<br>☑ Plan for distributing | 0.375<br>0.375 | | |

*CRA § 2.15.1.3 (E/W, Middle and TCS)*

The health plan's 2009 QI Program reported supporting the prevention and elimination of healthcare errors through a commitment to the practice of evidence-based medicine using a variety of mechanisms, including but not limited to measurement tools and reporting metrics focused on patient safety, evidence-based claims and prescription reports to identify adverse events, quality of care (QOC) referrals, and databases that identify, track and address safety concerns. The QI Program also stated that patient safety goals are developed and integrated into the QI Work Plan annually. The 2009 Work Plan was reviewed on-site and evidenced that the Managed Care Organization (MCO) is addressing member safety through activities such as on-site office assessments of primary care provider (PCP) initial credentialing, pharmacy audits (e.g., audits of quarterly prescribing pattern, narcotic drug utilization review program and polypharmacy program), and preventive/ambulatory screening of all age members throughout the year. Also, the Provider Manual addressed many areas of patient safety, including preventive initiatives, hospital safety and medication safety. The website (uhcrivervalley.com) was accessed by reviewers and found to contain a link that directed the member to The Joint Commission website to compare hospital and provider quality. Also, the 2nd quarter (Q2) member newsletter, Health Talk, featured an article titled "We Make Sure You Get Great Care and Service." At the end of the article, members were referred to the health plan's website for additional information on their quality management, utilization management, MCO structure, etc.

SUGGESTION: The MCO could include a statement in the quarterly member newsletter informing members that information on safety and quality performance is available on the website or by making a request to Customer Service.

**Total Score: 0.750 out of 0.750 = 100 % Compliance**

# 2010 Annual Quality Survey - Quality Process Standards

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AmeriChoice-East

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Network: Contracting, Availability, Access and Documentation** | | | | |
| **1 Specialist termination** | | | 0.250 | 0.250 |
| Contracts with specialists and specialty group practices require timely notification (no less than 30 days prior when possible) to MCO members affected by the termination of a specialist or the entire specialty group. | ☑ Yes<br>☐ No | 0.250<br>0.000 | | |

*CRA § 2.11.8.1.4 (E/W and TCS); CRA § 2.11.9.1.4 (Middle)*

The section on Term and Termination in the Tennessee Program Network Practitioner Provider Agreement Between UnitedHealthcare Plan of the River Valley, Inc., and [Contracting Practitioner] as well as the Tennessee Program Network Practitioner Group Provider Agreement Between UnitedHealthcare Plan of the River Valley, Inc. and [Contracting Practitioner Group] stated that the contracting practitioner and contracting practitioner group shall provide 60 days written notification of termination of the agreement to MCO members.

| | | | | |
|---|---|---|---|---|
| **2 Notice of provider termination** | | | 0.250 | 0.250 |
| If a Primary Care Physician (PCP) ceases participation in the MCO, the MCO immediately provides written notice--no less than 30 days prior to the effective date of the termination and no more than 15 days after receipt or issuance of the termination notice--to each member who has chosen the provider as his/her Primary Care Provider (PCP). | ☑ Yes<br>☐ No | 0.250<br>0.000 | | |

*Notice template provided by TennCare;*
*CRA § 2.11.8.1.2 (E/W and TCS); CRA § 2.11.9.1.2 (Middle)*

Policy and Procedure (P&P) #GR AC 2: Member Notification of Physician Change or Termination addressed that if a PCP or non-PCP provider no longer provides services for health plan members, the health plan will notify members at least 30 calendar days prior to the effective termination date. It also included that, in those instances when the practitioner leaves the network without prior notice of termination, the members who had chosen the provider as his/her PCP will be notified no more than 15 calendar days after termination.

**Total Score: 0.500 out of 0.500 = 100 % Compliance**

# 2010 Annual Quality Survey - Quality Process Standards

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **QI Activities** | | | | |
| **1 Coordination between physical and behavioral health** | | | 5.500 | 5.500 |
| The MCO has policies and procedures and ensures coordination between physical and behavioral health services by including key elements to the right: | ☑ Screening for behavioral health needs | 0.500 | | |
| | ☑ Referral to physical and behavioral health providers | 0.500 | | |
| | ☑ Exchange of information | 0.500 | | |
| | ☑ Confidentiality | 0.500 | | |
| | ☑ Assessment | 0.500 | | |
| | ☑ Treatment plan development | 0.500 | | |
| | ☑ Collaboration | 0.500 | | |
| | ☑ Case Management (CM) and Disease Management (DM) | 0.500 | | |
| | ☑ Provider training | 0.500 | | |
| | ☑ Monitoring implementation and outcomes | 0.500 | | |
| | ☑ Encourages PCPs and other providers to use state-approved behavioral health screening tool | 0.500 | | |

*CRA § 2.9.5.1 and 2.9.5.3.2 (E/W and TCS);*
*CRA § 2.9.8.1 and 2.9.8.3.2 (Middle)*

P&P #HS GEN 7: Coordination of Physical and Behavioral Health Services described in detail the roles and responsibilities for both PCPs and specialty care providers (e.g., mental health providers and substance abuse providers). These roles were clearly outlined in the Provider Manual as well. PCPs were responsible for assessing members' mental health and substance abuse problems using screening tools such as the Behavioral Health Toolkit (available on the provider website). P&P #HS GEN 7 Attachments A (Provider Evaluation of Performance [PEP] Plan), B (audit tool) and C (medical record review tool) were used to evaluate the provider's performance. CM processes were discussed with the Manager of Care Management in detail regarding coordination of physical and behavioral health. The process was reported to include behavioral health screening for all members, using the screening tool to determine if there is a behavioral component present. In addition to the behavioral screening tool, it was reported that a health risk assessment was performed. When a behavioral problem is identified with the screening, it was noted that the member is offered participation in the internal behavioral health CM program. It was further reported that when the internal program is declined, the member is offered outside assistance opportunities (e.g. community counseling, outreach assessment, behavioral providers.) The Manager of Care Management reported that, once the assessment is completed, the screening tool auto-populates an easily customized plan of care for the member. She also provided a case to validate collaboration between DM and Behavioral Health; there was evidence of collaboration and monitoring of implementation and outcomes as well. There was a follow-up at least every 30 days, or more frequently as the situation required. Newsletters for both members and providers addressed coordination of behavioral healthcare. The MCO website was also accessed, and it provided detailed information on coordination of physical and behavioral services. The PEP Plan provided evidence that the MCO reviewed provider records to ensure that behavioral health and substance abuse screening was performed and that coordination of care occurred. P&P #HS GEN 7 also cited the following tools and resources to inform clinicians and facilities of the requirement to communicate, coordinate and collaborate healthcare delivery with other active healthcare providers: Provider Manual, provider newsletters, provider trainings and the health plan website.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **QI Activities** | | | | |
| **2 Adverse occurrences policies and procedures** | | | 0.000 | 0.000 |
| The MCO has policies and procedures in place for reporting, investigating and managing adverse occurrences (also known as sentinel events and critical incidents) related to the provision of behavioral services. | ☑ Yes<br>☐ No | 0.000<br>0.000 | | |

P&P #HS QM 10: Addressing Potential Quality of Care/Quality of Service stated that "all potential…QOC…complaints and referrals will be handled in a professional and timely manner in accordance with applicable legal and governing bodies requirements. The information will be maintained in a manner consistent with preserving peer review privilege when it applies, protecting Protected Health Information from improper use and disclosure as required by federal law." The policy further stated that behavioral health issues would be referred to appropriate behavioral health resources in the health plan or in a United Behavioral Health Regional Center. P&P #BH: Peer Review of Behavioral Health Adverse Occurrences defined an adverse event and outlined the scope, purpose and process for this occurrence. The Provider Affairs Subcommittee (PAS) minutes were reviewed and documented on-site, they showed the PAS reported and investigated QOC/Quality of Services for each quarter of 2009 with their determination/severity level and any corrective action that was required.

| | | | | |
|---|---|---|---|---|
| **3 Adverse occurrences definition** | | | 0.000 | 0.000 |
| The MCO identifies what constitutes an adverse occurrence, sentinel event or critical incident that requires reporting and review. | ☑ Yes<br>☐ No | 0.000<br>0.000 | | |

P&P: BH Peer Review of Behavioral Health Adverse Occurrence defined an adverse occurrence as "an unexpected occurrence involving death or serious physical injury or the risk thereof that occurs during the course of a member receiving behavioral health treatment. For the purpose of this policy occurrences are defined as any of the following or the risk thereof: Completed suicides on either an outpatient or inpatient basis; homicides attributed to members; assault, including an alleged assault, of a patient while in treatment at an inpatient, partial hospitalization or residential mental health or substance abuse facility; death or serious injury of a patient while in treatment at an inpatient, partial hospitalization, or residential mental health or substance abuse facility." The Adverse Occurrence Provider Letter reviewed on-site defined adverse occurrence for the provider, cited examples to be reported, and outlined the steps to be taken when reporting an adverse occurrence. The report form was included with the letter as well as a reference to its location on the website. The quarterly Adverse Occurrence Reports for all three regions were also reviewed in a grid format. The report was broken down into the number of occurrences for that quarter, a summary of the findings and any intervention required.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **QI Activities** | | | | |
| **4 Adverse occurrences to be reported** | | | 0.000 | 0.000 |
| The MCO collects reports on adverse occurrences, including but not limited to the events listed at right: | ☑ Unexpected death of a member | 0.000 | | |
| | ☑ Suicide or attempted suicide | 0.000 | | |
| | ☑ Suspected physical, sexual or mental abuse of a member while the member is undergoing treatment, or if it is alleged that the suspected abuse was done by a provider or employee of a provider | 0.000 | | |
| | ☑ Injury sustained by a member while in a behavioral health treatment facility | 0.000 | | |
| | ☑ Medication errors involving a member | 0.000 | | |

P&P: BH Peer Review of Behavioral Health Adverse Occurrences identified adverse occurrence events as: unexpected death of a member, incomplete or completed suicides in either an inpatient or outpatient setting, suspected physical, sexual, or mental abuse during the course of treatment of the member that was alleged to be due to the actions of a provider or employee of the provider; or injury sustained by a member while in a behavioral health treatment facility. The Adverse Occurrence Provider Letter cited treatment complications (adverse medication errors and reaction), accidents or injuries to the member, death and attempted suicide, as well as suspected physical, sexual, or mental abuse while undergoing treatment as examples of occurrences to be reported. The 2009 Adverse Occurrence Report documented all reported occurrences on a quarterly basis with a synopsis of the findings for each quarter.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **QI Activities** | | | | |
| **5 Adverse occurrences and quality of care issues** | | | 0.000 | 0.000 |
| The MCO shows evidence that it uses data related to adverse occurrences to identify and address potential and actual quality of care and/or health and safety issues through the following actions: | ☑ Identifying adverse occurrences; | 0.000 | | |
| | ☑ Tracking adverse occurrences; | 0.000 | | |
| | ☑ Reviewing adverse occurrences; and | 0.000 | | |
| | ☑ Analyzing adverse occurrences. | 0.000 | | |

P&P: BH Peer Review of Behavioral Health Adverse Occurrences stated that adverse occurrences must be reported by network providers to all appropriate agencies as required by licensure and state/federal laws within specified time frames required immediately following the event. The health plan noted that it required network providers to report adverse occurrences, that it peer reviews adverse occurrences and submits a quarterly report of all adverse occurrences in a format prescribed by the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD). Examples of adverse occurrences cited in the P&P included but were not limited to: treatment complications (including medication errors and adverse medication reactions); accidents or injuries to the member; morbidity; suicide attempts; death of the member; allegations of physical abuse or sexual abuse, neglect; mistreatment, and/or verbal abuse; abuse of isolation, mechanical restraint or physical holding restraint. The following documents were reviewed on-site: PAS minutes, Adverse Occurrence Report and Adverse Occurrence Tracking log. All documents validated that the adverse occurrences were being properly reported, reviewed, investigated, and sent to Medical Director review for determination and assignment of a severity level. It was noted when appropriate corrective actions were taken. In some situations/adverse occurrence cases were taken for peer review.

| | | | | |
|---|---|---|---|---|
| **6 Adverse occurrence tracking and trending** | | | 0.000 | 0.000 |
| The MCO regularly reviews the number and types of adverse occurrences (including, for example, the number and type of adverse occurrences across settings, providers, and provider types) and findings from investigations by both the MCO and agencies external to the MCO. It identifies trends, patterns and opportunities for improvement, and develops and implements strategies to reduce the occurrence of these incidents. | ☑ Regularly reviews the number and types of adverse occurrences | 0.000 | | |
| | ☑ Reviews findings from investigations by MCO and external agencies | 0.000 | | |
| | ☑ Identifies trends and patterns | 0.000 | | |
| | ☑ Identifies opportunities for improvement | 0.000 | | |
| | ☑ Develops and implements strategies to reduce occurrences | 0.000 | | |

P&P: BH Peer Review of Behavioral Health Adverse Occurrences stated that the health plan required network providers to report all adverse occurrences. The health plan was noted to have peer-reviewed adverse occurrences and submitted a quarterly report of all adverse occurrences in a format prescribed by TDMHDD. The PAS Sentinel Event Committee (SEC)…"will serve as the peer review committee for adverse occurrences and will review all such occurrences and make recommendations for improving patient care and safety." The scope, purpose and procedure were outlined in detail in this P&P. The following documents were reviewed on-site: PAS minutes, Adverse Occurrence Reports and tracking log; all documents supported that the MCO was reviewing adverse occurrences within standard time frames and reporting them on a quarterly basis. When adverse occurrences were confirmed, appropriate action was noted to be taken with the provider.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **QI Activities** | | | | |
| **7 Adverse occurrence reporting requirements** | | | 0.000 | 0.000 |
| The MCO requires staff and providers to report adverse occurrences in accordance with applicable requirements. The MCO requires its staff and providers to report, respond to and document adverse occurrences in a manner specified by the MCO. The MCO develops and implements an adverse occurrence reporting process, including the form to be used to report adverse occurrences and reporting time frames. | ☑ MCO requires staff and providers to report adverse occurrences | 0.000 | | |
| | ☑ MCO requires staff and providers to respond to and document adverse occurrences | 0.000 | | |
| | ☑ MCO has a reporting process and form in use | 0.000 | | |

P&P: BH Peer Review of Behavioral Health Adverse Occurrences stated: "Adverse Occurrence reports must be reported by network providers to all appropriate agencies as required by licensure and state/federal laws within the specified time frames required immediately following the event. Per the P&P, health plan Care Management staff are required to report all adverse occurrences to the Chief Medical Officer and Behavioral Health Medical Director who, within three business days, was required to begin administrative review of the case and complete a written summary on the proper form. The PAS and SEC were reported to serve as the peer review committee for adverse occurrences, providing review of all such occurrences and making recommendations for improving patient care and safety. The P&P noted that results of any reviews may be used to make recommendations to suspend, terminate, conduct a site audit, and/or alter the participation status of programs, providers, and/or practitioners. On-site review of the Adverse Occurrence Provider Letter documented that physicians were provided a copy of the form to be submitted when reporting an adverse occurrence. The letter also directed the provider to the MCO website to obtain the adverse report form. PAS minutes documented behavioral health adverse actions/sentinel events reported and related discussions at each committee meeting.

| | | | | |
|---|---|---|---|---|
| **8 Availability of adverse occurrence documents** | | | 0.000 | 0.000 |
| The MCO makes available for review to TennCare or its designated contractor all minutes, files, notes and committee actions related to the reporting and review of adverse occurrences. | ☑ Yes | 0.000 | | |
| | ☐ No | 0.000 | | |

PAS minutes, Adverse Occurrence Reports, and Investigation Files for adverse occurrences were provided for review on-site and evidenced that they were available for review by TennCare.

**Total Score: 5.500 out of 5.500 = 100 % Compliance**

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Clinical Criteria for Utilization Management (UM) Decisions** | | | | |
| **1 Availability of criteria** | | | 1.000 | 1.000 |
| The MCO includes the following information in its provider manuals:<br>● medical necessity standards and clinical practice guidelines; and<br>● prior authorization, referral and other UM requirements and procedures. | ☑ Medical necessity standards and clinical practice guidelines included | 0.500 | | |
| | ☑ Prior authorization, referral and other UM requirements included | 0.500 | | |

*CRA § 2.18.5.1.7 and .10 (E/W and TCS); CRA § 2.18.5.3.8 and .16 (Middle)*

The MCO's Provider Manual stated medical necessity was determined using nationally recognized review criteria (e.g., Milliman), and appropriateness using internal criteria (e.g., Level of Care guidelines). All criteria were reported to be reviewed on an annual basis. The Provider Manual also stated that other criteria may be used when there is published peer-review literature that supports admission or continued stay criteria. Updates were noted to be provided to the MCO as they were developed by Milliman, on an annual or as-needed basis. In the July 2009 Network Bulletin, the MCO was reported to have "gone live" with the 13th Edition of Milliman Care Guidelines. The internal guidelines, however, were noted to be reviewed and revised annually with a review of the literature. The medical necessity criteria and clinical guidelines were noted and reviewed on the website (uhcrivervalley.com/10Provider) or may be requested from the Customer Service Department. Prior authorization, referral and other UM procedures were also found in the Provider Manual and on the website above.

| | | | | |
|---|---|---|---|---|
| **2 Transition to other care** | | | 0.500 | 0.500 |
| The MCO has policies and procedures and shows evidence it assists with either a member's transition to other care or to another provider when the current provider has terminated participation with the MCO. | ☑ Yes | 0.500 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.9.3.1 (E/W and TCS); CRA § 2.9.4.1 (Middle)*

P&P #HS GEN 3: Transitional Care for Members of Terminated Providers stated that there was a "defined process in place to provide for an orderly transfer of care to appropriate network providers, with attention to the individual needs of the member, timely information exchange between providers and maintaining the member confidentiality; while minimizing disruption in the care process." The P&P detailed the process that would take place in the event such a transition occurred. The policy stated the health plan "is responsible for the cost of continuation of medically necessary services the member is receiving. Continuation of such services is covered up to 90 calendar days or until the member may be transferred without disruption, whichever is less. No prior approval is necessary for the first 30 days, regardless as to whether such services are being provided by a contracted or non-contracted provider." The MCO provided a regional sample (one member case from each grand region documenting the transition from a terminated provider to the new in-network provider) that showed evidence of compliance with this element. The CM's clinical notes documented that continuous care was available or given from a provider who would cover the term at the end of the year until the transition to the new provider.

**Total Score: 1.500 out of 1.500 = 100 % Compliance**

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Member Rights and Responsibilities** | | | | |
| **1 Member Handbook development and distribution** | | | 1.000 | 1.000 |
| The Member Handbook is:<br>● developed and updated annually based on TennCare-provided templates;<br>● distributed to members within 30 days of receiving notice of enrollment in the MCO;<br>● distributed to all contracted providers upon initial credentialing; and<br>● re-distributed to all members and providers annually and as updates occur. | ☑ Developed/Updated using TennCare templates | 0.200 | | |
| | ☑ Sent to members within 30 days of enrollment | 0.200 | | |
| | ☑ Sent to providers upon credentialing | 0.200 | | |
| | ☑ Re-distributed annually | 0.200 | | |
| | ☑ Re-distributed as updated | 0.200 | | |

*CRA § 2.17.4.1, .2 and .4 (E/W, Middle and TCS)*

P&P #GR 24.1.2: Member Handbook Development and Distribution addressed a process by which the Member Handbook would be developed and updated annually based on TennCare-provided templates. The policy also indicated that the Member Handbooks would be distributed to members within 30 days of receiving a notice of enrollment in the MCO, and the New Member Packet Monthly Log provided proof of this. The mailing log provided proof of the annual mailing as well. The TennCare Addendum to the Provider Agreement indicated that the health plan should either send a copy of the Member Handbook to the provider or include notification via the Provider Manual that it is accessible online. An active link to the Member Handbook was available.

| | | | | |
|---|---|---|---|---|
| **2 Complaint procedures** | | | 0.500 | 0.500 |
| The MCO has internal complaint procedures for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees, or court orders governing the appeals process. | ☑ Yes | 0.500 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.19.1.1 (E/W, Middle and TCS)*

P&P #GR 12.2: Member Complaint and Appeal Process-TennCare Only addressed the MCO's internal complaint procedure for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees, or court orders governing the appeals process.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Member Rights and Responsibilities** | | | | |
| **3 Communication of rights and responsibilities in Member Handbook** | | | 2.000 | 2.000 |
| The Member Handbook contains the following rights and responsibilities:<br>a. a right to file a complaint and a complaint form on which to do so;<br>b. the right to file an appeal;<br>c. a notice to the member that, in addition to the right to file an appeal of actions taken by the MCO, she/he has the right to request reassessment of eligibility-related decisions related directly to TennCare;<br>d. the member's responsibility to notify the MCO and TennCare each and every time the member moves to a new address;<br>e. the right to change MCOs;<br>f. the right to disenroll from TennCare;<br>g. the right to amend their data in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations;<br>h. the right to obtain information regarding the structure and operation of the MCO and physician incentive plans;<br>i. the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand; and<br>j. the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. | ☑ a. Right to file a complaint and form | 0.200 | | |
| | ☑ b. Right to file an appeal | 0.200 | | |
| | ☑ c. Right to request reassessment of eligibility-related decisions | 0.200 | | |
| | ☑ d. Responsibility to notify MCO and TennCare of address change | 0.200 | | |
| | ☑ e. Right to change MCOs | 0.200 | | |
| | ☑ f. Right to disenroll | 0.200 | | |
| | ☑ g. Right to amend their data | 0.200 | | |
| | ☑ h. Right to obtain information on structure/operation of MCO and physician incentive plans | 0.200 | | |
| | ☑ i. Right to receive information on available treatment options and alternatives | 0.200 | | |
| | ☑ j. Right to be free from restraint or seclusion | 0.200 | | |

*CRA § 2.17.4.5.11-.13, .17, .19-.21, .24-.27 and .29 (E/W and TCS);*
*CRA § 2.17.4.7.19, .23, .24, .28 -.32, .35 -.38 and .40 (Middle)*

The Member Handbook addressed each of the criteria mentioned in this element in its entirety.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Member Rights and Responsibilities** | | | | |
| **4 Member Handbook inclusions** | | | 2.600 | 2.600 |
| The Member Handbook is, at a minimum, in accordance with the following guidelines:<br>a. includes a description of services provided including benefit limits, exclusions and use on non-contract providers;<br>b. includes a description of TennCare cost share responsibilities for members including an explanation that providers and/or the MCO may utilize whatever legal actions that are available to collect these amounts;<br>c. indicates that members may not be billed for covered services except for the amounts of the specified TennCare cost share responsibilities and of their right to appeal in the event that they are billed;<br>d. includes procedures for obtaining required services, including procedures for obtaining referrals to network specialists and providers outside of the plan;<br>e. advises members that if they need a service that is not available within the plan, they will be referred to a provider outside of the plan and any co-payment requirements would be the same as if this provider were in the plan;<br>f. includes an explanation on how members will be notified of member specific information such as effective date of enrollment;<br>g. includes notice to the member that enrollment in the MCO's plan invalidates any prior authorization for services granted by another plan but not utilized prior to enrollment in the new MCO and notice of continuation of an active treatment plan or pregnancy;<br>h. includes information on how to access the PCP on a 24-hour basis as well as the 24-hour nurse line;<br>i. includes an explanation of emergency services and procedures on how to obtain them both in and out of the MCO's service area, including but not limited to: the use of 911, locations of emergency settings, and locations for services;<br>j. includes information about preventive services for adults and children, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for Medicaid-eligible members, listing of preventive services and notice that preventive services are at no cost and without cost share responsibilities;<br>k. includes written information concerning advance directives;<br>l. includes member services toll free telephone numbers, including the TennCare Hotline, the MCO's customer service line, and the MCO's | ☑ a. Description of service parameters | 0.200 | | |
| | ☑ b. Description of TennCare cost share responsibilities | 0.200 | | |
| | ☑ c. Billing for covered services and appeal of billed services | 0.200 | | |
| | ☑ d. Procedures for obtaining services and referrals in and out of plan | 0.200 | | |
| | ☑ e. Out-of-plan referrals co-pays | 0.200 | | |
| | ☑ f. Explanation of member notification | 0.200 | | |
| | ☑ g. Notice of continuation/discontinuation of previously authorized services | 0.200 | | |
| | ☑ h. Accessing PCP and nurse line 24/7 | 0.200 | | |
| | ☑ i. Obtaining emergency services | 0.200 | | |
| | ☑ j. Preventive services information | 0.200 | | |
| | ☑ k. Advance directives information | 0.200 | | |
| | ☑ l. Includes all required telephone numbers and notice that members may contact the MCO or TennCare with questions | 0.200 | | |
| | ☑ m. Information on appropriate prescription drug usage | 0.200 | | |

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
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## Member Rights and Responsibilities

24/7 Nurse Triage Line with a statement that the member may contact the plan or TennCare regarding questions about TennCare as well as the service/information that may be obtained from each line; and

m. information on appropriate prescription drug usage.

*CRA § 2.17.4.5.3, .4, .6 -.10, .15, .16, .22 and .28 (E/W and TCS);*
*CRA § 2.17.4.7.3, .5, .9-.11, .16, .17, .26, .27, .33 and .39 (Middle)*

The Member Handbook included all the mentioned guidelines in the element.

### 5 Notice of right to file a complaint

1.000 1.000

A notice of members' right to file complaints is included in quarterly newsletters sent by the MCO. The notice includes a contractor phone number for doing so and is written in English and Spanish.

| | | |
|---|---|---|
| ☑ | Notice in English and Spanish | 0.333 |
| ☑ | Required information in each quarterly newsletter | 0.333 |
| ☑ | Phone number for complaints | 0.334 |

*CRA § 2.17.5.3.3 (E/W and TCS); CRA § 2.17.5.3.5 (Middle)*

All quarterly newsletters sent by the MCO included a notice in English and Spanish of the members' right to file complaints and a phone number for doing so.

### 6 Notification of changes to written materials

1.000 0.500

The MCO provides written notice to members of any changes in policies or procedures described in written materials previously sent to members at least 30 days before the effective date of change.

| | | |
|---|---|---|
| ☑ | Written notice to members | 0.500 |
| ☐ | Members notified at least 30 days before effective date of change | 0.500 |

*CRA § 2.17.2.8 (E/W, Middle and TCS)*

P&P #GR 24.1.2 addressed that the MCO provides written notice to members of any changes in P&Ps 30 days before the effective date. The MCO had some changes to their policy regarding co-pay, effective 1/1/10, and the information was included as an insert to the Member Handbook. The MCO submitted the changes for approval to TennCare on 11/24/09 and received TennCare approval on 12/10/09. The MCO was unable to provide members with the written notice 30 days in advance.

AREA OF NONCOMPLIANCE: The MCO had updates to the policy regarding co-pay changes effective 1/1/10, but the members were not provided the written notice 30 days in advance.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Member Rights and Responsibilities** | | | | |
| **7 Translation services** | | | 1.000 | 1.000 |
| The MCO provides translation services for members as demonstrated by the following:<br>● Member Handbooks include information on how to obtain information in alternative formats or how to access interpretation services, as well as a statement that interpretation and translation services are free;<br>● Quarterly newsletters include the procedure on how to obtain information in alternative formats or how to access interpretation services, as well as a statement that interpretation and translation services are free;<br>● The MCO develops a written procedure for providing members language interpretation and translation services, including but not limited to members with hearing impairment and/or Limited English Proficiency (LEP);<br>● The MCO provides language help-lines with specific numbers for these members; and<br>● The MCO's Non-Discrimination Compliance Coordinator provides instruction for its staff, including but not limited to all providers and direct service subcontractors regarding the procedure. | ☑ Information listed in handbook | 0.200 | | |
| | ☑ Information in all quarterly newsletters | 0.200 | | |
| | ☑ Procedure for language interpretation and translation services | 0.200 | | |
| | ☑ Help-line numbers provided | 0.200 | | |
| | ☑ Instruction to staff, providers and subcontractors | 0.200 | | |

*CRA § 2.17.4.5.23 and 2.17.5.3.2 (E/W and TCS); CRA § 2.17.4.7.34 and 2.17.5.3.4 (Middle);*
*CRA § 2.18.1.3, 2.18.2.1-.2 and 2.28.2 (E/W, Middle and TCS)*

The Member Handbook, all quarterly newsletters and P&P #GR 24.1.2 included documentation on obtaining information in alternative formats and on how to access interpretation services for free. These documents also included that the translation services were not limited to members with hearing impairment and or LEP. The Member Handbook included language help-lines with specific numbers. The MCO provided Tackling TennCare Training to the staff that included the Non-Discrimination topic. The Providers could access this information on the MCO website under 'Welcome to AmeriChoice Tennessee's Provider University!' webpage.

# 2010 Annual Quality Survey - Quality Process Standards

CONFIDENTIAL

AmeriChoice-East

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Member Rights and Responsibilities** | | | | |
| **8 Translated vital documents** | | | 1.000 | 1.000 |
| All vital MCO documents and the Member Handbook are translated and available in Spanish. Within 90 days of notification from TennCare, all vital MCO documents are translated and available to each LEP group identified by TennCare that constitutes five percent of the TennCare population or 1,000 members, whichever is less. | ☑ All vital documents translated | 0.500 | | |
| | ☑ Vital documents translated within 90 days | 0.500 | | |

*CRA § 2.17.2.5 (E/W, Middle and TCS)*

P&P #GR 24.1.1: Members Materials Development and Requirements stated that all vital MCO documents must be translated and available in Spanish. The policy also indicated that all vital MCO documents must be translated and available to each LEP group identified by TennCare.

**Total Score: 9.600 out of 10.100 = 95.0 % Compliance**

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **1 New member calls** | | | 1.000 | 1.000 |
| The MCO conducts telephone calls to all new members under the age of 21 to inform them of TENNderCare services, including availability of assistance with appointment scheduling and transportation to appointments. (This is not applicable for East, West and Middle MCOs if the MCO's TENNderCare screening rate is above 90 percent, as determined in the most recent Centers for Medicare & Medicaid Services (CMS) 416 report.) | ☑ Yes or Not Applicable (CMS-416 screening rate above 90 percent) | 1.000 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.7.5.2.2.1 (E/W); CRA § 2.7.6.2.2.1 (Middle); CRA § 2.6.13.2.2.1 (TCS)*

Although the MCO was not required to conduct new member telephone calls based on the 2009 CMS-416 screening rate of 93.4 percent, telephone calls were made to new members throughout the year. This was verified in TENNderCare Welcome Calls reports provided on-site.

STRENGTH: The MCO chose to conduct new member calls on all new members despite having exceeded the required screening rate standard.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **2 Outreach contacts** | | | 0.750 | 0.750 |
| The MCO distributes six outreach contacts a year, which include:<br>● a Member Handbook sent within 30 days of enrollment (annually thereafter upon the member's anniversary date of enrollment, the MCO sends an updated handbook, a supplemental update to the handbook, or a reminder of EPSDT services);<br>● four quarterly newsletters;<br>● one reminder before screens are due with transportation and scheduling assistance offered; and<br>● at least one of the six outreach attempts identified above advises members who are blind, deaf, illiterate, or non-English speaking regarding how to request and/or access such assistance and/or information. | ☑ Member Handbook sent within 30 days of enrollment | 0.125 | | |
| | ☑ Quarterly newsletters | 0.125 | | |
| | ☑ Screening due reminders | 0.125 | | |
| | ☑ Annual reminder of EPSDT services | 0.125 | | |
| | ☑ Annually informed regarding availability of information in alternative formats | 0.250 | | |

*John B. Consent Decree (CD) ¶ 40 [39(b), (d), (e), (g) and (h)]; CRA § 2.7.5.2.2 and 2.7.5.2.2.2 (E/W); CRA § 2.7.6.2.2 and 2.7.6.2.2.2 (Middle); CRA § 2.6.13.2.2.2 (TCS)*

Mailing verifications showed that updated Member Handbooks were sent to all members in December 2009. The MCO provided a log verifying the mailing of new member packets, including Member Handbooks. Mailings occurred at multiple times of each month during 2009. Member Newsletters were sent in each quarter of 2009. Each newsletter was also produced and distributed in Spanish. All member newsletters informed members of how to access materials in other languages or formats and informed them of transportation assistance. The MCO sent anniversary reminders titled Keeping Your Child Healthy that reminded parents of the need to take their child for a check-up. Additionally, the MCO sent monthly reminder cards, also titled Keeping Your Child Healthy. The information in these cards reminded parents of the ages when their child should be seen for a check-up. Monthly mailing verifications were available on-site as evidence that anniversary reminders and monthly reminders were sent throughout 2009.

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| **3 Documenting outreach** | | | 0.500 | 0.500 |
| The MCO maintains a process, approved by TennCare, for follow-up that includes provisions for documenting all outreach attempts with a mechanism for maintaining records of efforts to reach members missing screenings when scheduled or who have failed to schedule regular check-ups. This includes a different method of outreach effort at least quarterly to accomplish a missed screening. | ☑ Yes | 0.500 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.7.5.2.4 (E/W); CRA § 2.7.6.2.4 (Middle); CRA § 2.6.13.2.4 (TCS); CD ¶ 40 [39(j)]*

AmeriChoice used its Universal Tracking Database (UTD)–a proprietary software–to track and monitor each child's TENNderCare status. The database identified members who were overdue for screenings and immunizations. The database was capable of generating immediate reports on each member's screening status. The MCO provided four different outreach methods for 2009. Each mailer was different, yet each reminded the parent/child to schedule a TENNderCare screening. One mailer also included the childhood and adolescent immunization schedules.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **4 Declined services** | | | 0.500 | 0.500 |
| The MCO requires providers to maintain a process for documenting services declined by a parent, guardian or mature competent child, specifying the service declined. | ☑ Yes | 0.500 | | |
| | ☐ No | 0.000 | | |

*CD ¶ 40 [39(i)]; CRA § 2.7.5.2.6 (E/W); CRA § 2.7.6.2.6 (Middle); CRA § 2.6.13.2.6 (TCS)*

P&P #HS QM PWE 1: TENNderCare/EPSDT stated that the MCO would "[r]equire providers to have a process for documenting declined services by a parent or guardian or mature competent child, specifying the particular service that was declined. This process must meet the requirements of the State Medicaid Manual." The MCO's EPSDT Medical Record Review Tool included a place for the reviewer to validate that the audited provider documented any refusal of EPSDT services by a parent/guardian or child. The TENNderCare Clinical Documentation Exit Summary Tool was used to discuss audit findings with providers/office managers. This tool included "Declination of Service by Parent" as a discussion point for the exit summary. Examples of medical record audits conducted in 2009 demonstrated that the MCO assessed the record for refusal of services, and the service (in this case an immunization) that was refused.

| | | | | |
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| **5 Re-notification if no services used** | | | 0.750 | 0.750 |
| The MCO maintains a process for determining if someone eligible for EPSDT has used no services within a year and follows up with two reasonable attempts to re-notify that member. (One attempt can be [an individual] referral to a Health Dept.) These two attempts are in addition to the required quarterly attempts outlined in Element #3. The attempts are different in format or message. | ☑ Maintains process | 0.250 | | |
| | ☑ Two additional re-notifications | 0.250 | | |
| | ☑ Attempts in different format or message | 0.250 | | |

*CD ¶ 40 [39(a)]; CRA § 2.7.5.2.5 (E/W); CRA § 2.7.6.2.5 (Middle); CRA § 2.6.13.2.5 (TCS)*

P&P # HS QM PWE 1 indicated that two attempts would be made to re-notify members who had not used services within one year. The P&P cited a referral to the Health Department and quarterly mailed reminders as the two methods used for notification. The MCO provided its postcard, "Did You Miss a Check-up?" as evidence of one outreach effort used for members who have not used services within a year. Instead of Health Department referrals, the MCO chose to conduct telephone calls to members who had not used services within a year. The policy has since been revised to reflect the use of telephonic outreach rather than Health Department referrals.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **6 Undeliverable mail** | | | 0.750 | 0.500 |
| The MCO documents two reasonable attempts to find a family when mail is returned as undeliverable. One of the two attempts is made within 90 days of receipt of mail returned as undeliverable. (For TennCare*Select,* the second attempt is made within 30 days.) At least one attempt is by phone. | ☑ Oral attempt | 0.250 | | |
| | ☑ Other attempt | 0.250 | | |
| | ☐ Attempt made within required time frame | 0.250 | | |

*CD ¶ 40 [39(a)]; CRA § 2.7.5.2.7 (E/W); CRA § 2.7.6.2.7 (Middle); CRA § 2.6.13.2.7 (TCS)*

The MCO submitted its TENNderCare/EPSDT Returned Mail Flow Chart to outline the process used to find families whose mail was returned as undeliverable. The flow chart indicated that all mail was sent by first class United States Postal Service to ensure that an attempt to re-send the mail occurred automatically. This was to occur within 30 days. If the mail was then returned, it was entered into the MCO's Returned Mail Tracking Log. A TENNderCare/EPSDT Coordinator would then search both AmeriChoice and public databases for member telephone numbers, which were used to generate a call list. This list was then used for the TeleVox Campaign, an automated telephonic outreach to these members, which was to occur within 90 days of receipt of returned mail. The MCO revised its member mailing process during 2009. During the on-site interview, the Manager of EPSDT and Preventive Health indicated that as the process was updated with the vendor, the second telephonic attempt fell outside of the 90 day requirement. The manager also stated that the process was now fully implemented to ensure both attempts would occur within the required time frames.

AREA OF NONCOMPLIANCE: The MCO should ensure that, when mail is returned as undeliverable, both attempts to find a family occur within the required time frames.

| | | | | |
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| **7 Accurate provider lists** | | | 0.500 | 0.500 |
| The MCO makes available to families accurate lists of names and phone numbers of contract providers who are currently accepting TennCare. | ☑ Yes | 0.500 | | |
| | ☐ No | 0.000 | | |

*CD ¶ 40 [39(f)]; CRA § 2.7.5.2.8 (E/W); CRA § 2.7.6.2.8 (Middle); CRA § 2.6.13.2.8 (TCS)*

The Member Handbook informed members that network providers were identified in the Provider Directory, which was distributed with the Member Handbook to all new members, and available online (at www.uhcrivervalley.com) or by calling the MCO at 1-800-690-1606. The MCO's website was accessed, and a link to the Provider Directory was found. New member packet mailing logs verified that Member Handbooks and Provider Directories were distributed to new members several times each month throughout 2009.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **8 Targeted activities** | | | 0.500 | 0.500 |
| The MCO has established criteria for determining when to target specific informing activities to pregnant women, families with newborns, adolescents, first-time eligible members, those not using the program for over two years and illiterate, blind, deaf and LEP members. Pregnant women are informed about the availability of EPSDT for their children prior to the delivery date (provided the MCO is informed of the pregnancy) and are offered EPSDT services for the child when it is born. The MCO treats a woman's request for EPSDT services during pregnancy as a request for EPSDT services for the child at birth. | ☑ Has criteria to target activities to pregnant women, families with newborns, adolescents, first-time eligible members, those not using the program for over two years, and illiterate, blind, deaf and LEP members | 0.250 | | |
| | ☑ Offers services for children when born | 0.250 | | |

*CD ¶ 40 [39(l) and (n)]; CRA § 2.7.5.2.9 (E/W); CRA § 2.7.6.2.9 (Middle); CRA § 2.6.13.2.9 (TCS)*

P&P #HS HFS 2: Perinatal Care Coordination discussed the methods used to target pregnant women and families with newborns. The P&P indicated that outreach would begin the day eligibility was determined and included appointment scheduling assistance and arranging transportation. It also indicated that the Healthy First Steps (HFS) CM would educate members regarding TENNderCare services for the newborn and other children in the household and would assist the member in selecting a PCP for the baby either before or after birth. Newsletters targeted at adolescents were sent in each quarter of 2009. All adolescent newsletters contained language assistance information and instructed members on how to obtain materials in alternate formats. The teen newsletters were also translated and distributed in Spanish upon request. All new members received welcome telephone calls informing them of TENNderCare services. The call scripts provided members the opportunity to hear the message in Spanish. Members who had not used services within two years were included in quarterly TENNderCare reminder mailings.

SUGGESTION: To further enhance its outreach efforts, the MCO should consider revising its TENNderCare/EPSDT policy (#HS QM PWE 1) to more specifically address outreach to members who have not used services in more than two years. Telephone scripts used with these members could remind them that they have not used services in a two-year time period.

| | | | | |
|---|---|---|---|---|
| **9 Outreach to illiterate, blind, deaf and LEP** | | | 0.500 | 0.500 |
| The MCO customizes methods to inform individuals who are illiterate, blind, deaf or LEP about the availability of EPSDT services. | ☑ Customized methods | 0.250 | | |
| | ☑ Items distributed to identified members | 0.250 | | |

*CD ¶ 40 [39(d)]; CRA § 2.7.5.2.2.2 (E/W); CRA § 2.7.6.2.2.2 (Middle); CRA § 2.6.13.2.2.2 (TCS)*

During new member telephone calls, members were given the option to hear the message in Spanish. All member newsletters, including teen newsletters, were printed in English and Spanish. Both contained instructions for members needing information in alternate formats. The Member Handbook informed members that materials were also available in Braille or compact disk (CD). DM staff supplied examples of requests and mailed information in other languages or formats.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **10 Community contacts approved** | | | 2.000 | 0.500 |
| All of the MCO's community health education and outreach activities are approved by TennCare prior to implementation. The MCO maintains documentation of this approval. | ☐ First quarter | 0.500 | | |
| | ☐ Second quarter | 0.500 | | |
| | ☐ Third quarter | 0.500 | | |
| | ☑ Fourth quarter | 0.500 | | |

*CRA § 2.7.3.2, 2.16.2 and 2.17.1.1 (E/W); CRA § 2.7.4.2 and 2.17.1.1 (Middle); CRA § 2.16.2 and 2.17.1.1 (TCS)*

Three community outreach events were chosen from each quarter of 2009. Only those chosen for the fourth quarter were documented accurately with the required TennCare approval obtained for all events. Events for which approval was not available for the remaining three quarters were either documented incorrectly in the quarterly EPSDT reports by the MCO, or the MCO was unable to demonstrate that approval had been obtained.

AREA OF NONCOMPLIANCE: The MCO should ensure that all community events involving member outreach/interaction receive appropriate approval from TennCare. The MCO should also ensure that events are documented accurately in quarterly EPSDT reports.

| | | | | |
|---|---|---|---|---|
| **11 Prenatal appointment assistance** | | | 2.000 | 2.000 |
| The MCO has policies and procedures to facilitate and take reasonable steps to assist pregnant members in accessing prenatal care and does the following:<br>● The MCO provides information on covered services to adolescent prenatal members who enter TennCare through presumptive eligibility;<br>● On the day eligibility is determined, the MCO offers assistance in making a timely first prenatal appointment after the diagnostic visit; and<br>● For a woman past her first trimester, this appointment occurs within 15 days of eligibility determination. | ☑ Policies and procedures | 0.500 | | |
| | ☑ Provides information on covered services | 0.500 | | |
| | ☑ On the day eligibility is determined, offers appointment assistance | 0.500 | | |
| | ☑ For a woman past her first trimester, appointment occurs within 15 days | 0.500 | | |

*CD ¶ 40 [39(m)]; CRA § 2.7.4.2.1 (E/W); CRA § 2.7.5.2.1 (Middle); CRA § 2.6.12 (TCS)*

P&P #HS HFS 2 outlined the processes used by the MCO to conduct outreach and coordinate services for pregnant members. It applied to all members - those who became enrolled in the MCO through presumptive eligibility and those enrolled at the time they became pregnant. The P&P stated that the HFS CM would assist or arrange for prenatal care to members on the date of their enrollment in the MCO. Assistance included arranging transportation and appointment scheduling. The P&P specified that if the woman was in her second or third trimester the appointment should be within 15 days. The P&P also stated that providers should be educated that failure to schedule an appointment for these members within 15 days would be considered a material breach of contract. Provider Manuals included this requirement in its Medical Appointment Scheduling Guidelines. The HFS Health Coach demonstrated the process used when contacting pregnant members. The assessment included offering appointment scheduling assistance - which was done within 15 days if the member was in her second or third trimester.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **12 Referrals from one level of screening to another** | | | 1.250 | 1.250 |
| The MCO has a policy and procedure to ensure that providers make and document appropriate referrals from one level of screening or diagnosis to another, more sophisticated level of diagnosis as needed to determine the child's physical health, behavioral health and developmental needs, as to medically necessary services. This is done regardless of whether the required services are covered by the MCO. | ☑ Policy and procedure | 0.500 | | |
| | ☑ Provider compliance | 0.750 | | |

*CD ¶ 53; CRA § 2.7.5.1.5.2 (E/W); CRA § 2.7.6.1.5.2 (Middle); CRA § 2.6.13.1.5.2 (TCS)*

P&P# HS QM stated that providers were required to refer members as appropriate and that all medically necessary services would be made available to the member regardless of whether the services were covered by the MCO. The MCO's EPSDT Medical Record Review Tool included a place for the reviewer to indicate if referrals had been made, and the TENNderCare Clinical Documentation Exit Summary Tool used by reviewers to discuss audit results with providers/office staff included a discussion point for referrals.

| | | | | |
|---|---|---|---|---|
| **13 Notify MCO if unable to make referral** | | | 1.000 | 1.000 |
| Procedures ensure a process for directing providers to notify the MCO in the event a screening reveals the need for other healthcare and the provider is unable to make an appropriate referral, including policies and procedures for the MCO to secure an appropriate referral and contact the member to offer scheduling assistance and transportation. | ☑ Yes | 1.000 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.7.5.1.6 (E/W); CRA § 2.7.6.1.6 (Middle); CRA § 2.6.13.1.6 (TCS)*

The Provider Manual informed providers that coordination of services for children should be done in accordance with TENNderCare requirements and that all referrals must be documented in the member's chart. The MCO included its toll-free telephone number for CM and instructed providers to call if assistance was needed with appointments or transportation. P&P #HS QM PWE 1 supported these instructions by stating that "Upon notification from a provider of the inability to make an appropriate referral, a care manager arranges a referral and offers scheduling assistance and transportation." The CM Manager indicated that this process was in place and documented in CareOne by CM staff.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **14 Medically necessary services** | | | 1.000 | 1.000 |
| The MCO has procedures in place to provide all medically necessary EPSDT services as required by law, including policies and procedures for educating providers about the necessity of documenting all components of a screen with accurate coding. | ☑ EPSDT services | 0.500 | | |
| | ☑ Educating providers | 0.500 | | |

*CD ¶ 54; CRA § 2.6.3.5 (E/W and Middle); CRA § 2.6.3.1 (TCS)*

P&P HS QM PWE 1 indicated that all medically necessary EPSDT services would be provided to TENNderCare-eligible members. The P&P also indicated that provider records would be monitored for appropriate coding and completion of EPSDT screenings. Providers were educated about documenting and coding all components of a TENNderCare screening in the Provider Manual. Instructions included details of the components of and correct billing codes for screening. Codes for preventive medicine visits, developmental, hearing and vision screenings were listed.

| | | | | |
|---|---|---|---|---|
| **15 Rehabilitation and maintenance services** | | | 0.500 | 0.500 |
| Rehabilitation services include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts for maximum reduction of physical or mental disability and restoration of a recipient to the best possible functional level. (These services may be, and where medically necessary to do so are, delivered in conjunction with the services listed in ¶ 54 of the John B. CD.) Covered services include maintenance services that prevent or mitigate the worsening of conditions or prevent the development of additional health problems. | ☑ Rehabilitation services provided as described | 0.250 | | |
| | ☑ Covered services include maintenance as described | 0.250 | | |

*CD ¶ 63 and 64*

P&P HS QM PWE 1 stated that "AmeriChoice provides all necessary healthcare, diagnostic services, treatment, and other measures to correct or ameliorate, or prevent from worsening; defects, physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan." The Provider Manual included similar statements indicating that all medically necessary services would be furnished for TENNderCare-eligible members.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **16 Medical necessity** | | | 2.000 | 2.000 |
| The MCO has a procedure that ensures consistent decisions are rendered concerning issues of medical necessity, which are compliant with federal and state laws. Only the definition of "medical necessity" as defined in the TennCare/MCO contract is used, or is no more restrictive than the definition in the contract. | ☑ Procedure in place | 0.500 | | |
| | ☑ Definition of medical necessity same as contract or no more restrictive | 0.500 | | |
| | ☑ Evidence of consistent decisions (e.g., Inter-Rater Reliability [IRR] testing) | 0.500 | | |
| | ☑ Appropriate follow-up to results of consistent decision process, as applicable | 0.500 | | |

*CD ¶ 55 and 56; CRA § 2.6.3.1 and .5 (E/W, Middle and TCS)*

The 2009 Sox Audit Summary indicated that UM cases were audited monthly to ensure compliance with MCO policies and procedures, clinical guidelines, CRA, the Centers for Medicare and Medicaid Services and the National Committee for Quality Assurance standards. P&P #HS UM 1: Medical Necessity Review indicated that the MCO used the definition of medical necessity as defined by the CRA. UM medical directors were audited annually. All medical directors scored above the required 90 percent compliance established by the MCO. UM staff scores were also expected to be at 90 percent or above. Staff who scored lower than the requirement were identified for additional training. The MCO provided examples of staff who received additional group and one on one training.

| | | | | |
|---|---|---|---|---|
| **17 Limitations/Capitations/Delays** | | | 0.750 | 0.750 |
| The MCO demonstrates that it does not impose benefit limitations, duration/scope limitations or monetary capitations upon EPSDT services. Services are provided based upon each child's individual needs. Utilization controls do not unreasonably delay the initial or continued receipt of services. | ☑ No limits/capitations | 0.250 | | |
| | ☑ Services based on individual needs | 0.250 | | |
| | ☑ UM controls do not delay services | 0.250 | | |

*CD ¶ 55(a) and 57; CRA § 2.6.3.2 and .4-.5 (E/W and Middle); CRA § 2.6.3.1 and .4-.5 (TCS)*

P&P #HS QM PWE 1 included multiple statements that indicated all medically necessary EPSDT services were covered for members. UM decisions were based on the individual needs of the child. Medically necessary services were to be provided regardless of whether they were covered by the plan. UM denials did not indicate any delays of services as a result of UM controls.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **18 Qualified UM personnel** | | | 3.000 | 3.000 |
| The MCO has a process in place that guarantees only qualified personnel with education, training or experience in child and adolescent health are employed to make utilization review and prior authorization decisions for members 20 and under. | ☑ Process in place | 0.500 | | |
| | ☑ Staff #1 trained/educated | 0.250 | | |
| | ☑ Staff #2 trained/educated | 0.250 | | |
| | ☑ Staff #3 trained/educated | 0.250 | | |
| Personnel making utilization review and prior authorization decisions for members 20 and under are trained or experienced as described above. | ☑ Staff #4 trained/educated | 0.250 | | |
| | ☑ Staff #5 trained/educated | 0.250 | | |
| | ☑ Staff #6 trained/educated | 0.250 | | |
| | ☑ Staff #7 trained/educated | 0.250 | | |
| | ☑ Staff #8 trained/educated | 0.250 | | |
| | ☑ Staff #9 trained/educated | 0.250 | | |
| | ☑ Staff #10 trained/educated | 0.250 | | |

*CD ¶ 58*

The QI Program Description indicated that only appropriately trained staff were responsible for UM decisions. This included registered nurses, licensed behavioral health clinicians (i.e., clinical social workers, professional counselors or senior psychological examiners) and physicians. P&P #HS UM 1 indicated that only a medical director made decisions on cases not meeting medical necessity criteria. Ten UM staff were selected for review. Licenses were verified and found to be current for all 10 staff. Resumes and education background were also reviewed. All staff received appropriate training and possessed sufficient experience to make UM decisions for members 20 and under.

| | | | | |
|---|---|---|---|---|
| **19 Services without prior authorization** | | | 1.000 | 1.000 |
| The MCO ensures that all medically necessary covered services (including interperiodic screens and continuation of services) are provided, whether the condition existed prior to any screening and regardless of whether or not the need for such services was identified by a provider whose services had received prior authorization from the MCO or by a network provider. | ☑ Yes | 1.000 | | |
| | ☐ No | 0.000 | | |

*CD ¶ 41(m), 42(c), 55(d) and 59; CRA § 2.7.5.1.7 (E/W); 2.7.6.1.7 (Middle); 2.6.13.1.7 (TCS)*

P&P #HS QM PWE 1 indicated that all medically necessary services were provided for members under the age of 21 regardless of whether or not the condition existed prior to a screening or the need for services was identified by a provider who received prior authorization from the MCO. Services were also provided regardless of the network status of the provider. P&P #HS UM 10: PriorAuth and Referral Exceptions indicated that prior authorization was not required for any EPSDT services.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **20 Specialist list** | | | 0.750 | 0.750 |
| The MCO demonstrates that it provides PCPs participating in EPSDT with an up-to-date list of specialists to whom referrals may be made for screens, lab tests, further diagnostic services and corrective treatment. The list is supplemented quarterly to indicate additions and deletions. The MCO also maintains an updated electronic, web-accessible version of the referral provider listing. | ☑ Yes | 0.750 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.14.3.5.1 (E/W, Middle and TCS); CD ¶ 62*

Mailing verifications showed that referral listings were mailed to PCPs in each quarter of 2009. The Provider Manual contained instructions for either contacting the MCO (toll-free telephone number included) or accessing the website for information on how to make referrals. Online provider directories were updated nightly via information received from Facets, the MCO's claims and network information system.

| | | | | |
|---|---|---|---|---|
| **21 MCO CM** | | | 0.750 | 0.750 |
| MCO CM services are provided consistent with federal law by providing assistance "in gaining access to needed medical, social, educational and other services." The MCO ensures that the CM provided "centers on the process of collecting information on health needs of the child, making and following up on referrals as needed, activating the examination/diagnosis/ treatment 'loop.'" Notification of the time members are due to receive a screening service is also a focus of the program. | ☑ Consistent with federal law | 0.250 | | |
| | ☑ Focused on information collection, making and following up on referrals | 0.250 | | |
| | ☑ Notification due for screening | 0.250 | | |

*CD ¶ 66 and 68; CRA § 2.7.5.4.8(19) (E/W); CRA § 2.7.6.4.8(19) (Middle); CRA § 2.6.13.4.8(19) (TCS)*

P&P HS QM PWE 1 indicated extensive CM involvement in multiple aspects of TENNderCare services provided by the MCO. CM staff assisted providers with referrals, made contact with pregnant members and assisted with appointment scheduling. The CM Manager indicated that initial assessments were conducted on all CM referrals and included assessments of medical and behavioral health needs and subsequent referrals as appropriate. CM staff followed up on referrals with members as soon as two weeks after the referral was made, but no later than 30 days. The CM system included specific assessments for pediatric and adolescent referrals. CM staff were able to access the MCO's UTD to determine a member's screening status. Staff were also kept aware of screenings that were due through follow up of the member's plan of care. These were flagged for follow up at least every 30 days. All initial CM assessments included an inquiry of the presence of children in the home, number of children and their EPSDT status, including the date of the most recent screening.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **22 Medically necessary CM services** | | | 1.000 | 1.000 |
| Mental health CM services, for children whose behavioral health needs require these services, are provided to all TennCare children for whom they are medically necessary. | ☑ Yes | 1.000 | | |
| | ☐ No | 0.000 | | |

*CD ¶ 69*

All CM cases were screened for behavioral health needs during the initial assessment. If the screening revealed the presence of behavioral health needs, a full behavioral assessment was performed in addition to the initial assessment. At this time the CM staff would assist the member with locating appropriate community resources or a behavioral health provider. If CM staff identified the presence of a behavioral health crisis during the assessment, appropriate MCO staff were contacted. P&P #HS QM PWE 1 indicated that CM staff were available to assist PCPs with behavioral health referrals when needed.

| | | | | |
|---|---|---|---|---|
| **23 CM central function** | | | 1.500 | 1.500 |
| EPSDT CM activities are a central function of the MCO, as evidenced by CM activities being integrated throughout the operations of the MCO. CM activities are individualized based on needs of the child and are not used only as a tool for prior authorizations. | ☑ Integrated throughout MCO | 0.750 | | |
| | ☑ Activities individualized | 0.750 | | |

*CD ¶ 70*

During interviews with the CM Manager and HFS Health Coach, it was evident that the MCO's CM activities crossed over to multiple areas within the organization. CM staff worked with members to develop a plan of care, which they followed up on at least every 30 days, and assisted the members in obtaining referrals for appropriate services. Such activities were conducted based on the needs of the member as identified through the initial CM assessment. They were not used as prior authorization tools. Medical and behavioral CM staff worked with one another to determine the most appropriate area of primary focus for the child. If the child was placed in behavioral CM, staff in that area consulted with medical CM staff as appropriate. The MCO provided an example of a case where the member's needs for additional therapy services were coordinated between medical and behavioral staff, and included input from the member's mother.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **24 Family involvement and accessible services** | | | 1.500 | 1.500 |
| Parents and family members are involved, to the greatest extent possible, in the determination of behavioral health services to be delivered to a particular child. The MCO provides a comprehensive and appropriate scope of geographically accessible child and adolescent behavioral health services in a range of treatment settings. | ☑ Parent/Family involvement | 0.375 | | |
| | ☑ Comprehensive/Appropriate scope | 0.375 | | |
| | ☑ Geographically accessible | 0.375 | | |
| | ☑ Range of treatment settings | 0.375 | | |

*CD ¶ 71(i and ii)*

The Manager of CM (Behavioral Health) provided examples of member cases which showed family member involvement in determining appropriate treatment of a child. CM notes indicated extensive efforts by the CM to work with families on obtaining the appropriate level of care. The CM also worked with facilities to assist each member's family in accessing the inpatient treatment required for the members. The MCO is contracted with all inpatient mental health facilities that provide services to children and adolescents in each region of the state. Services that were offered to families included inpatient options and therapeutic foster care. Family members were also offered assistance in coping with the children's behavioral health conditions.

| | | | | |
|---|---|---|---|---|
| **25 Follow-up after inpatient or residential treatment** | | | 2.000 | 2.000 |
| The MCO ensures through coordination efforts with its contracted facilities that psychiatric hospital and residential treatment facility discharges do not occur without a discharge plan in which the member, his/her family, or other caregivers, clinicians and social worker(s) have participated. This discharge plan includes an outpatient visit scheduled before discharge, which ensures access to proper provider/medication follow-up. Also, an appropriate placement or housing site is secured prior to discharge. | ☑ Discharge plan completed | 0.500 | | |
| | ☑ Required persons participated | 0.500 | | |
| | ☑ Outpatient appointment scheduled | 0.500 | | |
| | ☑ Appropriate placement or housing secured | 0.500 | | |

*CD ¶ 71(iii); CRA § 2.9.6.3.2 (E/W and TCS); CRA § 2.9.9.3.2 (Middle)*

The CM Manager (Behavioral Health) provided an example of discharge planning conducted as a member was prepared for discharge from a residential treatment facility. The case notes indicated that the MCO CM, facility CM and family were involved in determining the course of care to be provided upon discharge. The MCO CM also coordinated with the facility CM to ensure member had appropriate access to a provider upon discharge for medication follow-up. The MCO CM also worked with the member's family to ensure a safe home environment for the member and member's family.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **26 Screening components including follow-up** | | | 0.500 | 0.500 |
| The MCO has procedures in place for ensuring that all TENNderCare screens contain all required components, including follow-up components if all components of a screen cannot be completed in a single visit or whenever concerns or questions remain after the screening process. | ☑ Yes<br>☐ No | 0.500<br>0.000 | | |

*CD ¶ 41(a)-(l) and (n.v); CRA § 2.7.5.1.4 (E/W); CRA § 2.7.6.1.4 (Middle); CRA § 2.6.13.1.4 (TCS)*

The MCO used its Provider Manual to instruct providers that all parts of a TENNderCare screening should be documented in the medical record, and that in the event any part of a screening was not completed, a follow-up appointment should be scheduled. The MCO assessed provider compliance with this requirement during EPSDT medical record reviews. The TENNderCare Clinical Documentation Exit Summary Tool was used by MCO staff to discuss record review findings with providers/office staff. Providers were also given a handout at the time of the medical record review that included the excerpt from the Provider Manual with the TENNderCare documentation requirements.

| | | | | |
|---|---|---|---|---|
| **27 Interperiodic screen** | | | 1.000 | 1.000 |
| The MCO demonstrates that any encounter with a health professional practicing within the scope of his/her practice is an interperiodic screen and that any person who suspects a problem may refer a child for an interperiodic screen. An interperiodic screen does not have to include any screening elements required for a periodic screen. | ☑ Any encounter is interperiodic screen<br>☑ No required screening elements | 0.500<br>0.500 | | |

*CD ¶ 42(a) and (b)*

The MCO's provider manual indicated that interperiodic screenings were available whenever anyone (e.g., parent, guardian or teacher) identifies the need for a screening. The Member Handbook also contained language informing parents/guardians that if someone else, like a teacher, was concerned about the child's health, a screening could be obtained. P&P HS QM PWE 1 defined interperiodic screenings as "any encounter with any provider practicing within the scope of his/her license that does not include the screening elements required for a periodic TENNderCare exam. Anyone such as an educator, parent, or health professional who suspects a problem may refer a child for an interperiodic screening."

| | | | | |
|---|---|---|---|---|
| **28 Prior authorization prohibited** | | | 0.500 | 0.500 |
| The MCO does not impose prior authorization requirements on interperiodic screens conducted by the PCP. | ☑ Yes<br>☐ No | 0.500<br>0.000 | | |

*CD ¶ 42(c); CRA § 2.7.5.1.7 (E/W); CRA § 2.7.6.1.7 (Middle); CRA § 2.6.13.1.7 (TCS)*

P&P HS QM PWE 1 stated that the MCO did not require prior authorization for interperiodic screenings. The MCO's Physician, Health Care Professional, Facility and Ancillary Administrative Guide informed providers that "Interperiodic screens are available whenever a person like a teacher or parent notices a change that might require a screening."

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **29 Screening standards met** | | | 1.500 | 1.500 |
| The MCO demonstrates that EPSDT screening standards are met or that all children who have not received complete screenings have been subject to outreach efforts reasonably calculated to ensure participation. In the event that screening rates do not meet compliance standards, the MCO may demonstrate compliance by showing that such failure to achieve standards was due to factors beyond the MCO's control. | ☑ Yes | 1.500 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.7.5.1.1 (E/W); CRA § 2.7.6.1.1 (Middle); CRA § 2.6.13.1.1 (TCS); CD ¶ 51*

The screening rate for 2009 was 93.4 percent. The MCO continued to conduct multiple forms of outreach for all TENNderCare-eligible members throughout 2009. This included numerous community events throughout the year.

| | | | | |
|---|---|---|---|---|
| **30 Transportation** | | | 2.000 | 2.000 |
| The MCO has protocols and procedures for ensuring access to non-emergency transportation services in accordance with state and federal laws. The MCO does not place blanket restrictions/requirements because of age or lack of parental accompaniment. Transportation assistance includes related travel expenses, meals, lodging, and cost of an attendant to accompany the child if necessary. The MCO has protocols/procedures for making referrals to TennCare transportation providers. | ☑ Protocols and procedures | 0.500 | | |
| | ☑ No blanket restrictions | 0.500 | | |
| | ☑ Assistance is inclusive of identified components | 0.500 | | |
| | ☑ Protocols for transportation referral | 0.500 | | |

*CD ¶ 74-77; CRA § 2.7.5.4.6 (E/W); CRA § 2.7.6.4.6 (Middle); CRA § 2.16.13.4.6 (TCS)*

P&P #GR NEMT A.4: Approving NEMT Services outlined the MCO's procedures for providing members access to transportation services as well as referring members to transportation providers. P&P #HS QM PWE 1 stated that "AmeriChoice provides TENNderCare transportation assistance, for a child to include related travel expenses, cost of meals, and lodging in route to and from care, and the cost of an attendant to accompany child if necessary." This same P&P also indicated that blanket restrictions were not used when determining a child's needs for transportation services.

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| CRITERIA | | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | | |
| **31 Program coordination** | | | | 1.000 | 1.000 |
| The MCO coordinates TENNderCare outreach, screening, and treatment services with other children's health and education services and programs. | ☑ Yes | | 1.000 | | |
| | ☐ No | | 0.000 | | |

*CD ¶ 78; CRA § 2.7.5.1.3 (E/W); CRA § 2.7.6.1.3 (Middle); CRA § 2.6.13.1.3 (TCS)*

P&P #HS QM PWE 3: Health Education and Outreach Programs and Activities described the MCO's activities and efforts to coordinate TENNderCare services with other agencies and its efforts to engage members through outreach activities. Such activities were to include, but not be limited to the following: health fairs, baby showers, faith-based activities, school-based screenings and parent-teacher organizations.

STRENGTH: As part of the Emergency Department (ED) Diversion program, the MCO identified children with more than five ED visits in a seven- month period to determine if they had a medical home. During this process, several members were identified whose "troublesome patterns of service utilization" ultimately resulted in referrals and coordination with Department of Children Services.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **32 Individual education plans (IEPs)** | | | 1.000 | 1.000 |
| The MCO has a process to facilitate coordination of EPSDT services when TennCare-enrolled children have been identified as needing to receive medically related services in an educational setting, as listed in their IEPs. Annually, TennCare sends a letter to all School Directors and Special Education Directors requesting the IEPs on behalf of the MCOs. If the MCO becomes aware that a member has an IEP (for example, through the internal CM process), then the MCO is obligated to request a copy of the IEP from the school.<br><br>After receipt of the IEP, the MCO:<br>● either accepts the IEP as indication of a medical problem and treats the IEP as a request for service to which the MCO responds within 14 days or assists in making an appointment to have the child appropriately evaluated within the time frames specified in the TennCare Waiver Terms and Conditions for access to care;<br>● sends a copy of the IEP and related information to the PCP; and<br>● notifies the designated school contact of the ultimate disposition of the request.<br><br>Coordination by the MCO is calculated to reduce gaps and overlaps in services. | ☑ Requests IEPs | 0.200 | | |
| | ☑ Accepts problem or has tested | 0.200 | | |
| | ☑ Shares with PCP | 0.200 | | |
| | ☑ Notifies school contact of disposition of request | 0.200 | | |
| | ☑ Coordination calculated to reduce gaps and overlaps | 0.200 | | |

*CD ¶ 81; TENNderCARE Connection Policy; CRA § 2.9.11.5.1, 2.9.11.5.2 and 2.9.11.5.2.1-.3 (E/W); CRA § 2.9.14.8.1, 2.9.14.8.2 and 2.9.14.8.2.1-.3 (Middle); CRA § 2.9.12.6.1, 2.9.12.6.2 and 2.9.12.6.2.1-.3 (TCS)*

P&P #HS CM 11: Coordinating Services For a child With an Individualized Education Program (IEP) described the MCO's process for ensuring that members with IEPs receive the necessary services. All components listed above were identified in the P&P. Attachment B of the P&P, Individualized Education Program/IEP Workflow Process, also contained all components listed above. The CM Manager described the process in place by the MCO which mirrored that outlined in its P&P. She also provided an example of an IEP from the IEP Tracking Database. The database included a field that identified when the IEP was sent to the member's PCP. This process was effective in reducing gaps and overlaps in care.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **33 Tracking system** | | | 2.000 | 2.000 |
| Tracking system data is used to take action to improve the EPSDT services. The tracking system information has been utilized to contact providers regarding the need to set appointments for the individual member. The tracking system information has been used to contact parents/ guardians/members regarding the need to make an appointment and receive EPSDT services. (For more detailed information refer to EPSDT Information System Tracking Review Tool). | ☑ Contact providers | 1.000 | | |
| | ☑ Contact parent/guardian/member | 1.000 | | |

*CD ¶ 94; CRA § 2.7.5.1.8 and 2.7.5.2.4 (E/W); CRA § 2.7.6.1.8 and 2.7.6.2.4 (Middle); CRA § 2.6.13.1.8 and 2.6.13.2.4 (TCS)*

The MCO's tracking system was reviewed during Performance Activity file review. Members who were noncompliant with TENNderCare screenings were referred to providers for outreach and appointment scheduling, and were subject to all appropriate outreach efforts by the MCO. The MCO used its online provider portal to supply PCPs with current lists of members not up-to-date on TENNderCare screenings. Providers were instructed to use this list to identify members who needed to be contacted for appointment scheduling. Provider newsletters and training conducted by the Provider Relations department informed PCPs of the list and how to access it. Hard copy lists were also made available upon request.

SUGGESTION: To further ensure that PCPs use the online list of TENNderCare members who are not up-to-date on their screenings, the MCO could include more specific instructions in newsletters and training materials that direct providers to the health plan website.

| | | | | |
|---|---|---|---|---|
| **34 EPSDT language in contracts** | | | 1.750 | 1.750 |
| All contracts with appropriate providers contain language requiring the EPSDT elements:<br>● comprehensive health history<br>● comprehensive physical exam<br>● laboratory testing<br>● vision and hearing testing<br>● dental screening<br>● health education<br>● immunizations | ☑ Comprehensive health history | 0.250 | | |
| | ☑ Comprehensive physical exam | 0.250 | | |
| | ☑ Laboratory testing | 0.250 | | |
| | ☑ Vision and hearing testing | 0.250 | | |
| | ☑ Dental screening | 0.250 | | |
| | ☑ Health education | 0.250 | | |
| | ☑ Immunizations | 0.250 | | |

*CRA § 2.12.7.48 (E/W and TCS); CRA § 2.12.9.56 (Middle)*

Provider contracts informed providers that all requirements in the provider manual must be followed. Medical Records Standards for TENNderCARE (EPSDT) Examinations in the provider manual were specific to the required exam components.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **35 EPSDT contract review** | | | 0.500 | 0.500 |
| Review of contracts ensures that there are no provisions which would encourage violations of EPSDT mandate. | ☑ Yes (no provisions) | 0.500 | | |
| | ☐ No | 0.000 | | |

*CD ¶ 102*

Provider agreements were reviewed, and no provisions were found that would encourage violations of the John B. CD.

**Total Score: 37.750 out of 39.500 = 95.6 % Compliance**

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Grier Revised Consent Decree** | | | | |
| **1 Appeals unit** | | | 0.750 | 0.750 |
| The MCO has sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting members. | ☑ Yes<br>☐ No | 0.750<br>0.000 | | |
| *Grier Revised CD; CRA § 2.19.2.3 (E/W and TCS); CRA § 2.19.3.3 (Middle)* | | | | |
| The Appeals Organization Chart indicated that the MCO had sufficient staff (one Manager, one nurse and nine Clinical Appeals Reviewers) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting members. | | | | |
| **2 Grier/Appeals procedures** | | | 0.500 | 0.500 |
| The MCO has internal appeal procedures for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees, or court orders governing the appeals process. | ☑ Yes<br>☐ No | 0.500<br>0.000 | | |
| *CRA § 2.19.1 (E/W, Middle and TCS)* | | | | |
| P&P #GR 12.2: Member Complaint and Appeal Process-(TennCare Only) describes the MCO's internal appeal procedure for members in accordance with the TennCare rules and regulations, the TennCare waiver, consent decrees or court orders governing the appeals process. | | | | |

**Total Score: 1.250 out of 1.250 = 100 % Compliance**

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Non-Discrimination Compliance** | | | | |
| **1 Non-Discrimination Compliance Plan** | | | 0.250 | 0.250 |
| There is documentation of the MCO's annual submission of a Non-Discrimination Compliance Plan to TennCare, no later than 90 days after the end of the calendar year. | ☑ Yes | 0.250 | | |
| | ☐ No | 0.000 | | |
| *CRA § 2.30.20.5 (E/W and TCS); CRA § 2.30.21.5 (Middle)* | | | | |
| An e-mail from MCO to TennCare indicated the submission of Non-Discrimination Compliance for 2008 on 03/31/09. | | | | |
| **2 Assurance of Non-Discrimination** | | | 0.250 | 0.250 |
| There is documentation of the MCO's annual submission of its Assurance of Non-Discrimination Certification, which has been signed and dated by the MCO's Chief Executive Officer (CEO) or his/her authorized agent. The annual date of the Assurance coordinates with the annual date of the Non-Discrimination Compliance Plan as documented in Element #1 above. (The certification is the MCO's assurance of compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981, the Church Amendments, Public Health Service Act Sec. 245 and the Weldon Amendments.) | ☑ Documented submission of signed and dated Assurance | 0.125 | | |
| | ☑ Date of Assurance coordinates with Non-Discrimination Compliance Plan | 0.125 | | |
| *CRA § 2.30.20.5 (E/W and TCS); CRA § 2.30.21.5 (Middle)* | | | | |
| An e-mail from MCO to TennCare indicated the submission of Annual Non-Discrimination Title VI Compliance & Assurance Plans for 2008 on 3/31/09.The MCO's Assurance of Non-Discrimination certification was signed and dated by the MCO's CEO on 3/31/09.The annual date of the Assurance coordinates with the annual date of the Non-Discrimination Compliance Plan as documented in Element #1 above. | | | | |

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Non-Discrimination Compliance** | | | | |
| **3 Display of non-discrimination posters** | | | 0.250 | 0.000 |
| Posters informing MCO employees of their rights and obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 are displayed in conspicuous places, such as breakrooms, lunchrooms, human resource offices and near elevators. | ☐ Yes<br>☑ No | 0.250<br>0.000 | | |

*CRA § 4.32.3 (E/W and Middle); CRA § 5.21 (TCS)*

Posters located in the breakroom did not have information on the Omnibus Budget Reconciliation Act of 1981.

AREA OF NONCOMPLIANCE: The MCO should include the information on the posters located in their breakrooms informing their employees regarding the Omnibus Budget Reconciliation Act of 1981. The MCO should continue to include the current information like employees rights and obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990 and the Age Discrimination Act of 1975.

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|---|---|---|---|---|
| **Non-Discrimination Compliance** | | | | |
| **4 Non-discrimination written materials** | | | 0.500 | 0.500 |
| All vital MCO documents and member materials are made available to members in compliance with the LEP requirements of Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act of 1990. | ☑ Documents are translated as described | 0.250 | | |
| | ☑ Written materials made available in alternate formats at no cost | 0.250 | | |

There is evidence that they are being provided as noted below:

- All vital MCO documents and member materials are translated and available in Spanish. Within 90 calendar days of notification from TennCare, all vital MCO documents are translated and available to each LEP group identified by TennCare that constitutes five percent of the TennCare population or 1,000 members, whichever is less;
- All written materials are made available in alternative formats for persons with special needs, or appropriate interpretation/translation services are provided by the health plan at no cost to the member; and
- The MCO can show proof of its capability to provide vital documents to members with impaired sensory skills (visually impaired) who require communication assistance in alternative formats.

*CRA § 1 and 2.17.2.5-.7 (E/W and Middle); CRA § 1.3 and 2.17.2.5-.7 (TCS)*

P&P #GR 24.1.1 stated that all vital MCO documents and member materials are being translated into Spanish. Also, if any LEP group is identified the MCO would translate the documents and make them available to the members within 90 days of notification from TennCare. There were no LEP groups identified in 2009, and hence no vital documents were needed to be translated. The policy also stated that all written materials are made available in an alternative format at no cost to persons with special needs. The Manager of TennCare Compliance mentioned that all vital documents would be available to members with impaired sensory skills in alternative formats such as live interpretation service.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Non-Discrimination Compliance** | | | | |
| **5 Written policy and procedure** | | | 1.000 | 1.000 |
| The MCO has a written policy and procedure on file for the provision of language interpretation and translation services for any member with LEP. The policy and procedure also addresses the provision of language assistance for members who require communication assistance in alternative formats (e.g., members who are visually impaired, deaf and/or deaf/blind). It has been approved by TennCare.<br><br>The MCO shows that it:<br>● instructs its staff, including but not limited to all providers and direct service subcontractors, regarding the policy and procedure; and<br>● has available language/communication help-lines with specific numbers that are made known to its members and subcontractors for the provision of member translation services and communication assistance in alternative formats.<br><br>*CRA § 2.18.1.3, 2.28.2-.3 and 2.30.20.4 (E/W and TCS);*<br>*CRA § 2.18.1.3, 2.28.2-.3 and 2.30.21.4 (Middle)* | ☑ Language interpretation and translation services addressed; | 0.200 | | |
| | ☑ Communication assistance in alternative formats addressed; | 0.200 | | |
| | ☑ Staff, providers and direct service subcontractors instructed; | 0.200 | | |
| | ☑ Proof of available help-lines demonstrated; and | 0.200 | | |
| | ☑ Phone numbers made known to members and subcontractors. | 0.200 | | |

P&P #GR 24.1.1 addressed the provision of language interpretation and translation services for any member with LEP, and the provision of language assistance to members who require communication in alternative format. The inclusion of visually impaired or blind members could have been more explicit. An email from TennCare to the MCO provided the proof of approval of the policy. The Tackling TennCare Training PowerPoint presentation instructed the staff regarding the policy and procedures. The Member Handbook and the Physician, Health Care Professional, Facility and Ancillary Administrative Guide, as well as the MCO's website facilitated the providers and direct service subcontractors with information on policy and procedure. The Member Handbook and the Physician Health Care Professional, Facility and Ancillary Administrative Guide included the language/communication help-lines with specific numbers that were made available to members and subcontractors for the provision of member translation services and communication assistance in alternative formats.

SUGGESTION: The health plan's policy and procedure regarding language and interpretation services could more clearly state that assistance is available to visually impaired or blind members.

# 2010 Annual Quality Survey - Quality Process Standards

CONFIDENTIAL

AmeriChoice-East

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Non-Discrimination Compliance** | | | | |
| **6 Complaint resolution and reporting** | | | 1.000 | 1.000 |
| The MCO has on file a written policy and procedure, approved by TennCare, for monitoring, investigating and resolving discrimination complaints. The MCO has written documentation that all discrimination complaints are investigated and resolved. The MCO submits a quarterly *Alleged Discrimination Report* to TennCare. The report lists all complaints of alleged discrimination filed against the MCO by employees, members, providers and subcontractors. | ☑ Policy and procedure | 0.200 | | |
| | ☑ Approved by TennCare | 0.200 | | |
| | ☑ Complaints documented, investigated and resolved, and are reported quarterly | 0.300 | | |
| | ☑ Quarterly report submitted with required information | 0.300 | | |

*CRA § 2.28.7 and 2.30.20.3 (E/W and TCS); CRA § 2.28.7 and 2.30.21.3 (Middle)*

P&P #AD CL 4: Non-discrimination Complaint Resolution addressed the process for monitoring, investigating and resolving discrimination complaints. The Desk Audit Tool provided the proof of approval of the policy. The Quarterly Non-Discrimination Compliance Report for all four quarters indicated that all discrimination complaints were investigated and resolved. An email from TennCare to the MCO indicated that the quarterly Alleged Discrimination Reports were received by TennCare. The report list included all complaints of alleged discrimination filed by employees, members, providers and subcontractors.

| | | | | |
|---|---|---|---|---|
| **7 Member Handbook notification and Complaint Form** | | | 0.500 | 0.500 |
| The MCO has included a notice of the right to file a discrimination complaint and a copy of a Discrimination Complaint Form in its English and Spanish Member Handbooks. | ☑ Notice of right placed in Member Handbooks | 0.250 | | |
| | ☑ Copy of form placed in English and Spanish Member Handbooks | 0.250 | | |

*CRA § 2.17.4.5.11 (E/W and TCS); CRA § 2.17.4.7.19 (Middle)*

The MCO included a notice of the right to file a discrimination complaint and a copy of a Discrimination Complaint Form in its English and Spanish Member Handbook.

# 2010 Annual Quality Survey - Quality Process Standards

CONFIDENTIAL

AmeriChoice-East

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Non-Discrimination Compliance** | | | | |
| **8 Quarterly newsletter notification** | | | 0.500 | 0.500 |
| Each quarterly newsletter sent by the MCO to members includes a notice of the right to file a complaint and a contractor phone number for doing so, as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981. The notice is in English and Spanish. | ☑ Notice of right and a phone number for making complaint | 0.250 | | |
| | ☑ Notice is in English and Spanish | 0.250 | | |

*CRA § 2.17.5.3.3 (E/W and TCS); CRA § 2.17.5.3.5 (Middle)*

Each quarterly newsletter sent by the MCO to members include a notice of the right to file a complaint and a contractor phone number for doing so. The notice was in English and Spanish.

| | | | | |
|---|---|---|---|---|
| **9 Subcontractor compliance education** | | | 0.250 | 0.250 |
| The MCO can document that its subcontractors have been made aware of their obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981. | ☑ Yes | 0.250 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.26.5 (E/W and TCS); CRA § 2.26.7 (Middle)*

Physician, Health Care Professional, Facility and Ancillary Administrative Guide provided by the MCO to its subcontractors made them aware of their obligations under the necessary federal laws.

**Total Score: 4.250 out of 4.500 = 94.4 % Compliance**

# APPENDIX B | *Performance Activity Review Tool Instructions*

*for **AmeriChoice-East***

This section contains the instructions for the Annual Quality Survey (AQS) Performance Activity (PA) Review Tools for Managed Care Organizations (MCOs), 2010 Edition.

# *MCC Utilization Management (UM) Denials* (age 20 and younger only)—File Review Tool Instructions

***Authority:*** *Contractor Risk Agreement (CRA) between TennCare and Dental Benefits Manager (DBM)—§A.8.3.2.1; CRA between TennCare and East, Middle and West Managed Care Organizations (MCOs)—§ 2.6, 2.7, 2.13 and 2.14; CRA between TennCare and TennCareSelect—§ 2.6 and 2.9; and 42 Code of Federal Regulations (CFR) § 438.210 and .214, and § 431.211 and .213.*

## Time Standard

Review the MCC's policy and procedure regarding UM denials and note the maximum hours/days allowable for: 1) a decision to be made and 2) the member and provider to be notified of the decision to deny/reduce requested service. Then, compare the MCC's standards to the 21 days allowed by the CRA and to the CFR time frames listed below. **The time standard used for this review is the shortest of the three (MCC, CRA and CFR).** Record this number in the tool database and indicate whether this standard is based on calendar or business days.

The time frames the federal government has listed in 42 CFR § 438.210 and .214, and § 431.211 and .213 are as follows:

- *Standard authorization decisions* "may not exceed **14 calendar days** following receipt of the request for service, with a possible extension of up to 14 additional calendar days" if certain conditions apply.
- *Expedited authorization decisions* must be provided "as expeditiously as the…[member's] health condition requires and no later than 3 working days after receipt of the request for service." The MCC "may extend the 3 working days time period by up to 14 calendar days if the…[member] requests an extension, or if the MCC justifies a need for additional information and how the extension is in the…[member's] interest."
- *Timing of notice*. The health plan must mail the notice "…**at least 10 days before** the date of action, except … The agency [MCC] may mail a notice not later than the date of action if":
  - **a.** the plan has factual information confirming the death of a…[member];
  - **b.** the plan receives written notice from…[member] that she/he – "1) …no longer wishes services; or 2) gives information that requires termination or reduction of services and indicates that [she/he] understands that this must be the result of supplying that information;
  - **c.** the…[member] has been admitted to an institution where she/he is ineligible under the plan for further services;
  - **d.** the …[member's] whereabouts are unknown;
  - **e.** the plan establishes the fact that the …[member] has been accepted for Medicaid services elsewhere;
  - **f.** a change in the level of medical care is prescribed by the…[member's] physician;
  - **g.** the notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or

h. the date of action will occur in less than 10 days, in accordance with § 483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of § 483.12(a)(5)(i)."

## Tool Components

Record the name of the MCC and the date of the review in the spaces provided.

Review the previously selected UM denial files for members under the age of 21 to complete **columns 2 – 15** on the *MCC UM Denials – File Review Tool* until there is a denominator of 10 files, all of which are denials. If a file is not applicable (i.e., anything other than a denial, or member is 21 years or older), it may be necessary to review additional files from the oversample to reach a denominator of 10 denials.

- **Column 1–File #:** This column is pre-populated with 1 through 10 to identify the number of files required for review.
- **Column 2–Case ID:** The Case ID represents the order of the file taken from the file review list (comprised of those files randomly abstracted from the MCC's data). The Case ID and the File # may not always match. For example, the first file examined (File # 1) may be the third file from the file review list (Case ID 3). This occurs when a file from the review list does not contain the required data for proper analysis. Because the Case ID is based on the file review list, QSource and the MCC are able to determine which file was reviewed should that be needed at a later date.
- **Column 3–Request Rcvd. Date:** Enter the month, day and year (MM/DD/YY) the request for the service or procedure was received by the MCC.
- **Column 4–Decision Made Date:** Enter the month, day and year (MM/DD/YY) the decision to deny was made.
- **Column 5–Wait (days) on Decision:** Enter the number of days it took the MCC to make the decision. Calculate by subtracting **column 3** from **column 4**.
- **Column 6–Decision Time Std.:** Enter the most stringent number of days after comparing MCC, CRA and CFR standards (e.g., if the MCC allows 10 days for a decision while the CRA allows 21 and the CFR allows 14, enter 10 days as the standard).
- Column 7 – Met Decision Time Std.: If column 5 is ≤ column 6, mark the "Y" cell. If column 5 is > column 6, mark the "N" cell.
- **Column 8–Decision Review Criteria Apropos to Condition:** Mark the "Y" cell in each row if a condition-appropriate review criterion was used to make the decision and to take action either to deny or reduce the amount, duration, or scope of the requested service; otherwise, mark the "N" cell.
- **Column 9–Consulted Requesting Provider as Apropos:** Mark the "Y" cell if the requesting provider was consulted prior to making the denial decision. Mark the "N" cell if not consulted, but there is evidence that she/he should have been. Otherwise, mark the "NA" cell.
- **Column 10–Final Denial by Qualified Med. Prof.:** A licensed physician or Doctor of Dental Surgery (DDS) must make all final denial and reduction of service decisions regarding inpatient hospital services. All other decisions to deny or reduce a service should be made

by a qualified clinical professional. Mark the "Y" cell if an appropriate professional made the decision; otherwise mark the "N" cell.

- **Column 11–Decision Not Arbitrary = Yes:** MCCs may not arbitrarily deny or reduce the amount, duration, or scope of a requested service solely because of the type of illness, diagnosis, or condition of the member. Mark the "Y" cell if the decision was NOT arbitrary; otherwise mark the "N" cell.
- **Column 12–Initial Notification Date:** Enter the month, day and year (MM/DD/YY) the MCC notified the member and provider about the decision to deny.
- **Column 13–Wait (days) to be Initially Notified:** Enter the number of business days it took the MCC to make the notification. Calculate by subtracting **column 3 from 12**.
- **Column 14–Initial Notification Time Std.:** Enter the most stringent number of days used to notify members and providers about a denial/reduction in service decision after comparing the MCC, CRA and CFR time standards.
- **Column 15–Met Initial Notification Time Std.:** If **column 13** is ≤ **column 14** mark the "Y" cell; otherwise mark the "N" cell.

## Scoring Directions

- **Applicable Answers, column 9:** Enter the number of cells in this column (i.e., all of those with "Ys" and "Ns"). All other columns for **Applicable Answers** are pre-populated with the applicable points for the number of files reviewed.
- **Compliant Answers, columns 7–11 and 15:** Enter the total number of **Compliant Answers** for each column (i.e., the number of "Y" cells).
- **Total Compliant:** Enter the sum of the numbers from **Compliant Answers**, **columns 7–11** and **15**.
- **Total Applicable:** Enter the sum of the numbers from **Applicable Answers**, **columns 7–11** and **15**.
- **Percent Compliant:** Divide the **Total Compliant** by the **Total Applicable** and enter that number as a percentage (e.g., 1/4 = 0.25 = 25 percent).

# *EPSDT Information System Tracking*—File Review Tool Instructions

***Authority:*** *John B. Consent Decree (EPSDT) ¶ 94; Contractor Risk Agreement (CRA) between TennCare and East, West and Middle Managed Care Organizations (MCOs)—§ 2.7.5.1; and CRA between TennCare and TennCareSelect—§ 2.6.13.*

## Tool Components

Record the name of the MCO and the date of the review in the spaces provided.

Review the previously selected EPSDT files to complete **columns 2–9** on the *EPSDT Information System Tracking–Review Tool* until there is a denominator of 10 files, all of which are EPSDT. If a file is not applicable (i.e., anything other than an EPSDT file), it may be necessary to review additional files from the oversample in order to reach a denominator of 10 EPSDT files.

- **Column 1–File #:** This column is pre-populated with 1 through 10 to identify the number of files required for review.
- **Column 2–Case ID:** The Case ID represents the order of the file taken from the file review list (comprised of those files randomly abstracted from the MCC's data). The Case ID and the File # may not always match. For example, the first file examined (File # 1) may be the third file from the file review list (Case ID 3). This occurs when a file from the review list does not contain the required data for proper analysis. Because the Case ID is based on the file review list, QSource and the MCC are able to determine which file was reviewed should that be needed at a later date.
- **Column 3–Medical Record (MR) or Information System (IS):** There are two rows per file for **columns 3–7.** The **MR** row is used to document information found in the member's medical record; the **IS** row is used to document information found in the health plan's IS tracking program.
- **Column 4–Receipt of Screening:** Mark the "Y" cell in the **MR** row if the member's receipt is documented in the medical record; otherwise, mark the "N" cell. Mark the "Y" cell in the **IS** row if the member's receipt is documented in the health plan's IS tracking program; otherwise, mark the "N" cell.
- **Column 5–Diagnosis Documented:** Mark the "Y" cell in the appropriate row if the diagnosis for this encounter is documented; otherwise, mark the "N" cell. Complete this process in the **MR** and **IS** rows for each file.
- **Column 6–Treatment, Immunization, Lab Work Documented:** Mark the "Y" cell in the appropriate row if any treatment, immunization or laboratory work was *done, given to* or *prescribed* for the member. Mark the "N" cell if none was *done, given* or *prescribed* but there is evidence that treatment, immunization, or laboratory work was indicated; otherwise, mark the "NA" cell.
- **Column 7–Ability to Determine Screening Status:** Mark the "Y" cell in the appropriate row if the member's current screening status is documented; otherwise, mark the "N" cell. Complete this process in the **MR** and **IS** rows for each file.

- **Column 8–Actions Taken to Improve Member's Screenings by Contacting Provider:** Mark the "Y" cell if the PCP was contacted regarding the need to set appointments for the member as a direct result of the information in the MCO's tracking system; otherwise, mark "N" cell. Mark the "NA" cell if contacting the PCP was not indicated because the medical record and tracking system showed evidence that the member was up to date.
- **Column 9–Actions Taken to Improve Member's Screenings by Contacting Parent/ Guardian/Member:** Mark the "Y" cell if the parent/guardian/member was contacted regarding the need to make an appointment and receive EPSDT services as a direct result of the information in the MCO's tracking system; otherwise, mark the "N" cell. Mark the "NA" cell if contacting the parent/guardian/member was not indicated because the medical record and tracking system showed evidence that the member was up to date.

## Scoring Directions

- **Applicable Answers, columns 6, 8 and 9:** Enter the applicable number of cells for each column (i.e., all of those with "Ys" and "Ns"). All other columns for **Applicable Answers** are pre-populated with the applicable points for the number of files reviewed.
- **Compliant Answers, columns 4–9:** For **columns 4–7** enter the total number of rows where the "Ys" or "Ns" are the same for each member. For **columns 8** and **9** enter the total number of rows that are marked "Y."
- **Total Compliant:** Enter the sum of the numbers from **Compliant Answers**, **columns 4–9**.
- **Total Applicable:** Enter the sum of the numbers from **Applicable Answers**, **columns 4–9**.
- **Percent Compliant:** Divide the **Total Compliant** by the **Total Applicable** and enter that number as a percentage (e.g., 1/4 = 0.25 = 25 percent).

# *MCC Appeals (Grier)* —File Review Tool Instructions

***Authority:*** *Grier v. Wadley Revised Consent Decree (Grier Revised CD) § C.7 and C.16.b; Tennessee Code Annotated (TCA) § 4-5-202, 4-5-301, et seq., 71-5-105 and 71-5-109; Executive Order No. 23 of 1999 (Amendment filed February 1, 2001, and made effective April 17, 2001); 42 Code of Federal Regulations (CFR) § 438.406 and .408; Contractor Risk Agreement (CRA) between TennCare and East, Middle, West and TennCare*Select *Managed Care Organizations (MCOs)—§ 2.19; and CRA between TennCare and Dental Benefits Manager (DBM)—§ A.17.*

## Tool Components

Record the name of the Managed Care Contractor (MCC) and the date of the review in the spaces provided.

**MCC decision time standards:** Review the MCC's policy and procedure regarding *Grier Revised CD* (appeal) handling. Record in the tool database the maximum number of hours/days allowable (most stringent) for appeal decisions. The *Grier Revised CD* maximum lengths of time for decisions are five days if expedited and 14 days if routine.

**MCC notification time standards:** From the policy, record in the tool database the number of days the MCC has determined to be the maximum amount of time allowable to notify the member of the decision, with regard to the concurrent-routine TennCare and CFR regulations. Indicate whether this standard is based on calendar or business days.

**For concurrent-routine:** The *Grier Revised CD* states that notice must be given **10 days** prior to action taking effect. **Two days** notice is allowed ***only*** if the member's provider initiates a reduction, termination, or suspension in the following instances:

- Any behavioral health service for a severely and persistently mentally ill adult member or severely emotionally disturbed child member;
- Any inpatient psychiatric or residential service;
- Any service being provided to treat a member's chronic condition across a continuum of services when the next appropriate level of medical services is not immediately available; or
- Home health services.

The Rules of the Tennessee Department of Finance and Administration, Bureau of TennCare, Chapters 1200-13-13 and 1200-13-14 state that in the "instances of Managed Care Contractor-initiated reduction, termination, or suspension of inpatient hospital treatment, the notice must be…at least 2 business days in advance of the proposed action. Where applicable and not in conflict with this rule, the exceptions set out at 42 CFR 431.211-.214 permit or require reduction of the time frames within which advance notice must be given."

Review the previously selected appeal files completing **columns 2–18** on the *MCC Appeals (Grier) – File Review Tool*. If a file is not applicable (i.e., anything other than an appeal), it may be necessary to review additional files from the oversample to reach a denominator of 10 appeals.

- **Column 1–File #:** This column is pre-populated with 1 through 10 to identify the number of files required for review.
- **Column 2–Case ID:** The Case ID represents the order of the file taken from the file review list (comprised of those fi**les** randomly abstracted from the MCC's data). The Case ID and the File # may not always match. For example, the first file examined (File # 1) may be the third file from the file review list (Case ID 3). This occurs when a file from the review list does not contain the required data for proper analysis. Because the Case ID is based on the file review list, QSource and the MCC are able to determine which file was reviewed should that be needed at a later date.
- **Column 3–E/R and C/N:** Indicate the type of file under review by writing an "E" (expedited) or "R" (routine) **AND** "C" (concurrent) or "N" (non-concurrent).
- **Column 4–Appeal Rcvd. Date:** Enter the month, day and year (MM/DD/YY) on which the appeal request was received by the MCC from the TennCare Solutions Unit.
- **Column 5–Authorization Request with Named Provider:** Mark the "Y" cell if the practitioner/provider is listed by name. If the appeal is from a practitioner/provider, or if the member wants the practitioner/provider to be able to provide a service and the practitioner/provider's name is not listed, mark the "N" cell. If no practitioner/provider was involved in the case (e.g., member appeals on behalf of him/herself), mark the "NA" cell.
- **Column 6–Reviewed by Same Practitioner Type as Requester:** If the appealed denial is being upheld, the file is to be reviewed by a qualified professional, which is a practitioner with experience in the condition for which the request was made. Mark the "NA" cell if the denial is being overturned. Mark the "Y" cell if a qualified professional reviewed the file. Mark the "N" cell if not reviewed by a qualified professional.
- **Column 7–Appeal Investigation Documented:** Mark the "Y" cell if the appeal was appropriately investigated; otherwise, mark the "N" cell. A proper investigation includes the following steps:
  - Documentation of the substance of the appeal and the MCC's actions, including any aspects of medical care involved;
  - Investigation of the appeal, including a description of the medical assistance requested;
  - The MCC considered any additional information provided by the member and/or practitioner/provider and determined if additional information was available that was not considered when it made the first decision; and
  - The MCC gathered information to help understand the member's report of the situation and collected information from involved MCC departments, as well as the practitioner/provider's office, if applicable.
- **Column 8–Decision Made Date:** Enter the month, day and year (MM/DD/YY) the appeal decision was sent to the member and/or the practitioner/provider. This can be delivered by mail, phone, fax, or other method as appropriate.
- **Column 9–Wait (days) on Decision:** Enter the number of days it took the MCC to make the decision. The date of receipt is day zero. Exclude state holidays and weekends if the standard is business days.

- **Column 10–Decision Time Std.:** Enter the most stringent number of days after comparing the MCC and *Grier Revised CD* standards (e.g., for an Expedited file, if the MCC allows 3 days for a decision and the *Grier Revised CD* allows 5 days, enter 3 days as the standard).
- **Column 11–Met Decision Time Std.:** If **column 9** is ≤ **column 10**, mark the "Y" cell; otherwise mark the "N" cell.
- **Column 12–Member Notified Date:** Enter the month, day and year (MM/DD/YY) on which the MCO notified the member of the resolution.
- **Column 13–Wait (days) to be Notified:** Enter the number of days it took the MCC to contact the member. The date of decision is day zero.
- **Column 14–Notification time standard (most stringent):** Enter the number of hours/days listed for the type of file after comparing the MCO and *Grier Revised CD* standards.
- **Column 15–Met Notification Time Std.:** If **column 13** is ≤ **column 14**, mark the "Y" cell; otherwise mark the "N" cell.
- **Column 16–Used State Letter Template and 6th Grade Level:** Mark the "Y" cell if the letter sent to the member met these requirements. The letter must include a statement of reasons for the decision (such as state rule or health plan provision). If the letter was not the appropriate template from the Bureau of TennCare, mark the "N" cell.
- **Column 17–Instructions on contesting:** For cases where the denial was upheld, mark the "Y" cell if the letter contains instructions on how to contest decisions at the MCO level **and** if those instructions include all three of the following components:
  - Information about the opportunity to contest the decision;
  - Instructions on how to contest the decision, including the right to an expedited process concerning urgent care; and
  - An explanation of the circumstances under which on-going medical services will be continued if a hearing is requested.

  Mark the "N" cell if the denial was upheld but not all components were included. Mark the "NA" cell if the denial was overturned by the MCC based on this appeal.
- **Column 18–For Delayed Decision, Notification <21 days:** Mark the "Y" cell if it took more than 14 days to make a decision but the MCC notified the member of the delay by day 21 and made the services available. Mark the "N" cell if it took more than 14 days **AND** the member was **NOT** notified by day 21 **OR** if the member was notified of the delay, but the services were not offered. Mark "NA" cell if notification of the decision occurred prior to day 14.

## Scoring Directions

- **Applicable Answers, columns 5, 6, 17 and 18:** Enter the applicable number of cells in each column (i.e., all of those with "Ys" and "Ns"). All other columns for **Applicable Answers** are pre-populated with the applicable points for the number of files reviewed.
- **Compliant Answers, columns 5–7, 11, and 15–18:** Enter the total number of compliant answers for each column (i.e., the number of "Y" cells marked in each).

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- **Total Compliant:** Enter the sum of the numbers from **Compliant Answers**, **columns 5–7**, **11**, and **15–18**.
- **Total Applicable:** Enter the sum of the numbers from **Applicable Answers**, **columns 5–7**, **11**, and **15–18**.
- **Percent Compliant:** Divide the **Total Compliant** by the **Total Applicable,** and enter that number as a percentage (e.g., 1/4 = 0.25 = 25 percent).

# APPENDIX C | *Performance Activity Review Tools*

*for **AmeriChoice-East***

This section contains the completed Annual Quality Survey (AQS) Performance Activity (PA) Review Tools for Managed Care Organizations (MCOs), 2010 Edition.

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## MCC UM Denials – File Review Tool

MCC: AmeriChoice-East | Time Standard Calculation: Calendar Days | Date: 4/20/10

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | | 8 | | 9 | | | 10 | | 11 | | 12 | 13 | 14 | 15 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| File # | Case ID* | Request Rcvd. Date | Decision Made Date | Wait (days) on Deci-sion | Deci-sion Time Std. | Met Decision Time Std. | | Decision Review Criteria Apropos to Condition | | Consulted Requesting Provider as Apropos | | | Final Denial by Qualified Med. Prof. | | Decision Not Arbitrary = Yes | | Initial Notifica-tion Date | Wait (days) to be Initially Notified | Initial Notifica-tion Time Std. | Met Initial Notification Time Std. | |
| | | | | | | Y | N | Y | N | Y | N | NA | Y | N | Y | N | | | | Y | N |
| 1 | 1 | 08/27/09 | 08/28/09 | 1 | 14 | X | | X | | | | X | X | | X | | 08/28/09 | 1 | 14 | X | |
| 2 | 12 | 09/22/09 | 09/23/09 | 1 | 14 | X | | X | | | | X | X | | X | | 09/28/09 | 6 | 14 | X | |
| 3 | 3 | 10/19/09 | 10/22/09 | 3 | 14 | X | | X | | | | X | X | | X | | 11/02/09 | 14 | 14 | X | |
| 4 | 4 | 12/01/09 | 12/10/09 | 9 | 14 | X | | X | | | | X | X | | X | | 12/10/09 | 9 | 14 | X | |
| 5 | 5 | 09/02/09 | 09/04/09 | 2 | 14 | X | | X | | | | X | X | | X | | 09/04/09 | 2 | 14 | X | |
| 6 | 6 | 01/20/09 | 02/02/09 | 13 | 14 | X | | X | | | | X | X | | X | | 02/02/09 | 13 | 14 | X | |
| 7 | 8 | 12/18/09 | 12/28/09 | 10 | 14 | X | | X | | | | X | X | | X | | 12/30/09 | 12 | 14 | X | |
| 8 | 9 | 10/08/09 | 10/12/09 | 4 | 14 | X | | X | | | | X | X | | X | | 10/12/09 | 4 | 14 | X | |
| 9 | 10 | 11/19/09 | 11/30/09 | 11 | 14 | X | | X | | | | X | X | | X | | 12/01/09 | 12 | 14 | X | |
| 10 | 11 | 12/09/09 | 12/17/09 | 8 | 14 | X | | X | | | | X | X | | X | | 12/21/09 | 12 | 14 | X | |
| Applicable Answers | | | | | | 10 | | 10 | | 0 | | | 10 | | 10 | | | | | 10 | |
| Compliant Answers | | | | | | 10 | | 10 | | 0 | | | 10 | | 10 | | | | | 10 | |

*Case IDs have been altered to protect patient information.*

| | |
|---|---|
| Total Compliant | 50 |
| Total Applicable | 50 |
| Percent Compliant | 100% |

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## EPSDT Information System Tracking – Review Tool

MCO: AmeriChoice-East | Time Standard Calculation: NA | Date: 4/20/10

| 1 | 2 | 3 | 4 | | 5 | | 6 | | | 7 | | 8 | | | 9 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| File # | Case ID* | Medical Record (MR) / Information System (IS) | Receipt of Screening | | Diagnosis Documented | | Treatment, Immunization, Lab Work Documented | | | Ability to Determine Screening Status | | Actions Taken to Improve Member's Screenings by Contacting Provider | | | Actions Taken to Improve Member's Screenings by Contacting Parent/Guardian/Member | | |
| | | | Y | N | Y | N | Y | N | NA | Y | N | Y | N | NA | Y | N | N/A |
| 1 | 1 | MR | | X | X | | X | | | X | | | | X | | | X |
| | | IS | | X | X | | X | | | X | | | | | | | |
| 2 | 2 | MR | | X | X | | X | | | X | | X | | | X | | |
| | | IS | | X | X | | X | | | X | | | | | | | |
| 3 | 3 | MR | X | | X | | X | | | X | | | | X | | | X |
| | | IS | X | | X | | X | | | X | | | | | | | |
| 4 | 4 | MR | X | | X | | X | | | X | | | | X | | | X |
| | | IS | X | | X | | X | | | X | | | | | | | |
| 5 | 5 | MR | | X | X | | X | | | X | | X | | | X | | |
| | | IS | | X | X | | X | | | X | | | | | | | |
| 6 | 6 | MR | | X | X | | X | | | X | | | | X | X | | |
| | | IS | | X | X | | X | | | X | | | | | | | |
| 7 | 7 | MR | | X | X | | X | | | X | | | | X | X | | |
| | | IS | | X | X | | X | | | X | | | | | | | |
| 8 | 8 | MR | | X | X | | X | | | X | | X | | | X | | |
| | | IS | | X | X | | X | | | X | | | | | | | |
| 9 | 9 | MR | X | | X | | | | X | X | | | | X | X | | |
| | | IS | X | | X | | | | X | X | | | | | | | |
| 10 | 10 | MR | | X | X | | | | X | X | | X | | | X | | |
| | | IS | | X | X | | | | X | X | | | | | | | |
| Applicable Answers | | | 10 | | 10 | | 8 | | | 10 | | 4 | | | 7 | | |
| Compliant Answers | | | 10 | | 10 | | 8 | | | 10 | | 4 | | | 7 | | |

| | |
|---|---|
| Total Compliant | 49 |
| Total Applicable | 49 |
| **Percent Compliant** | **100%** |

**Case IDs have been altered to protect patient information.*

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## MCC Appeals (*Grier*) – File Review Tool

**MCC: AmeriChoice-East** | **Time Standard Calculation: Calendar Days** | **Date: 4/20/10**

| 1 | 2 | 3 | 4 | 5 | | | 6 | | | 7 | | 8 | 9 | 10 | 11 | | 12 | 13 | 14 | 15 | | 16 | | 17 | | | 18 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| File # | Case ID* | E/R and C/N** | Appeal Rcvd. Date | Authorization Request with Named Provider | | | Reviewed by Same Practitioner Type as Requester | | | Appeal Investigation Documented | | Decision Made Date | Wait (days) on Decision | Decision Time Std. | Met Decision Time Std. | | Member Notified Date | Wait (days) to be Notified | Notification Time Std. | Met Notification Time Std. | | Used State Letter Template & 6th Grade Level | | Contesting Instructions in Letter | | | For Delayed Decision, Notification <21 days | | |
| | | | | Y | N | NA | Y | N | NA | Y | N | | | | Y | N | | | | Y | N | Y | N | Y | N | NA | Y | N | NA |
| 1 | 1 | RN | 04/09/09 | X | | | X | | | X | | 04/21/09 | 12 | 14 | X | | 04/23/09 | 14 | 14 | X | | X | | X | | | | | X |
| 2 | 3 | EN | 06/17/09 | | | X | | | X | X | | 06/24/09 | 7† | 5 | X | | 06/25/09 | 8† | 5 | X | | X | | | | X | | | X |
| 3 | 4 | RN | 01/21/09 | | | X | | | X | X | | 01/26/09 | 5 | 14 | X | | 01/30/09 | 9 | 14 | X | | X | | X | | | | | X |
| 4 | 5 | RN | 12/21/09 | X | | | | | X | X | | 12/28/09 | 7 | 14 | X | | 12/28/09 | 7 | 14 | X | | X | | X | | | | | X |
| 5 | 6 | RN | 09/16/09 | X | | | X | | | X | | 09/24/09 | 8 | 14 | X | | 09/25/09 | 9 | 14 | X | | X | | X | | | | | X |
| 6 | 7 | RN | 11/24/09 | X | | | X | | | X | | 12/07/09 | 13 | 14 | X | | 12/08/09 | 14 | 14 | X | | X | | | | X | | | X |
| 7 | 8 | RN | 07/01/09 | | | X | | | X | X | | 07/10/09 | 9 | 14 | X | | 07/10/09 | 9 | 14 | X | | X | | X | | | | | X |
| 8 | 9 | EC | 07/10/09 | X | | | X | | | X | | 07/16/09 | 6† | 5 | X | | 07/17/09 | 7† | 5 | X | | X | | | | X | | | X |
| 9 | 10 | RN | 09/01/09 | X | | | | | X | X | | 09/11/09 | 10 | 14 | X | | 09/15/09 | 14 | 14 | X | | X | | | | X | | | X |
| 10 | 11 | RN | 11/02/09 | X | | | X | | | X | | 11/12/09 | 10 | 14 | X | | 11/16/09 | 14 | 14 | X | | X | | | | X | | | X |
| **Applicable Answers** | | | | 7 | | | 5 | | | 10 | | | | | 10 | | | | | 10 | | 10 | | 5 | | | 0 | | |
| **Compliant Answers** | | | | 7 | | | 5 | | | 10 | | | | | 10 | | | | | 10 | | 10 | | 5 | | | 0 | | |

| | |
|---|---|
| **Total Compliant:** | **57** |
| **Total Applicable:** | **57** |
| **Percent Compliant:** | **100%** |

**Case IDs have been altered to protect patient information.*

***Expedited or routine and concurrent or non-concurrent.*

*†Extension approved by TennCare.*

# APPENDIX D | *Response to AQS Findings*

*for **AmeriChoice-East***

**AmeriChoice-East** had the opportunity to respond to the draft of this report. No comments were received.

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| AmeriChoice-East's Responses to QP Standard Areas of Noncompliance and Suggestions | | | |
|---|---|---|---|
| Report Finding | Health Plan Comment | QSource Response | Additional Comments |
| | None | | |

| AmeriChoice-East's Responses to PA Areas of Noncompliance and Suggestions | | | |
|---|---|---|---|
| Report Finding | Health Plan Comment | QSource Response | Additional Comments |
| | None | | |

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AmeriChoice **East** 2010 AQS Plan Of Correction

| 2010 Annual Quality Survey<br>Corrective Action Plan | | | |
|---|---|---|---|
| **Areas of Noncompliance** | **Action Steps/Progress** | **Intended Completion Date** | **Responsible Person/Titles** |
| **Notification of changes to written materials**<br>The MCO had updates to the policy regarding co-pay changes effective 1/1/2010, but the members were not provided the written 30 days in advance. | As benefit changes are identified, Americhoice will contact the state and request template changes at least 90 days prior to the effective date of the change. If the state does not intend to provide a template for the member communication, AmeriChoice will develop the communication and submit for approval no later than 60 days prior to the effective date of the change. AmeriChoice will communicate with the approved language no later than 30 days prior to the effective date of the change. If AmeriChoice is given less than 60 days notice, then AmeriChoice will request that the state clarify contract expectations around member notification for that benefit change event. The Health Plan will update the member communication policy to reflect the notification requirements around benefit change communications. | September 1, 2010 | Compliance Officer and<br>Vice President of Marketing Outreach and Communication |
| **Undeliverable Mail (EPSDT)**<br>The MCO should ensure that, when mail is returned as undeliverable, both attempts to find family occur within the required time frames. | In 2010, the Health Plan initiated a new process for EPSDT returned mail by adding a bar code to all EPSDT mail so that when mail is returned, it is scanned electronically and a list generated for automated calls. The 1st attempt process did not change and continues to meet the 30 day timeframe. The bar code scanning process was completed and the first 2010 monthly "Returned Mail Call Campaign" was conducted March 12, 2010. Returned Mail Call Campaigns continue monthly to meet the 90 day 2nd attempt timeline. | Completed | Manager, Prevention and Wellness Education<br>TENNderCare/EPSDT |

| | | | |
|---|---|---|---|
| **Community contacts approved (EPSDT)**<br>The MCO should ensure that all community events involving member outreach/interaction receive appropriate approval from TennCare. The MCO should also ensure that events are documented accurately in quarterly EPSDT reports. | AMC will strengthen quality controls around EPSDT community outreach to ensure a) prior approval of 100% of events and b) 100% reporting compliance for all completed EPSDT community outreach events.<br><br>Step 1: Revise tracking mechanism to include all events for approval.<br><br>Step 2: Update Policy & Procedure to reflect new database process and quality controls<br><br>Step 3: Update Policy & Procedure to reflect quarterly report process including increased quality controls<br><br>Step 4: Implement new P&Ps | Step 1: July 1, 2010<br><br>Step 2: July 15, 2010<br><br>Step 3: July 15, 2010<br><br>Step 4: August 1, 2010 | Vice President of Marketing Outreach and Communication |
| **Display of non-discrimination posters**<br>The MCO should include the information on the posters located in their break rooms informing their employees regarding the Omnibus Budget Reconciliation Act of 1981. The MCO should continue to include the current information like employees' rights and obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990 and the Age Discrimination Act of 1975. | Order new posters which include required non-discrimination language and display in the employee break rooms. | Completed | Compliance Officer |

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# State of Tennessee
# Department of Finance and Administration
# Bureau of TennCare

# UnitedHealthcare Plan of the River Valley, Inc. (AmeriChoice-West)

## 2010 Annual Quality Survey

## June 2010

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# Updates to AQS Terminology

Beginning with the 2010 AQS, the following terms have been changed at TennCare's request:

- **enrollee** is referred to as **member**
- **area of opportunity** is referred to as **area of noncompliance**
- **Plan of Correction (POC)** is referred to as **Corrective Action Plan (CAP)**

This new wording is used in all instances throughout this report, including references to items from the 2009 AQS.

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# Acronyms, Abbreviations and Initialisms

ANA ..... Annual Network Adequacy
..... also known as Annual Provider Network Adequacy and Benefit Delivery Review
AQS ..... Annual Quality Survey
BBA ..... *Balanced Budget Act of 1997*
C/N ..... Concurrent or Non-Concurrent (*Grier*)
CAP ..... Corrective Action Plan
CD ..... Consent Decree
CEO ..... Chief Executive Officer
CFR ..... *Code of Federal Regulations*
CM ..... Case Management
CMS ..... Centers for Medicare & Medicaid Services
CRA ..... Contractor Risk Agreement
d.b.a. ..... doing business as
DBM/DBMC ..... Dental Benefits Manager/DBM Contract
DDS ..... Doctor of Dental Surgery
E/R ..... Expedited or Routine (*Grier* file review)
ED ..... Emergency Department
EPSDT ..... Early and Periodic Screening, Diagnosis, and Treatment (federal standard)
..... also used in reference to the *John B. Consent Decree* (state mandate)
..... and to TENNderCare (Tennessee's EPSDT program)
EQR/EQRO ..... External Quality Review/External Quality Review Organization
*Grier* ..... *Grier Revised Consent Decree* (state mandate)
..... also used in reference to member appeals
HIPAA ..... *Health Insurance Portability and Accountability Act*
IEP ..... Individual Education Plan
IRR ..... Inter-Rater Reliability
IS ..... Information System
ISO ..... International Organization for Standardization
LEP ..... Limited English Proficiency
MCC/MCO ..... Managed Care Contractor/Managed Care Organization
MR/MRR ..... Medical Record/MR Review
NA ..... Not Applicable
NCQA ..... National Committee for Quality Assurance
OCCP ..... Office of Contract Compliance and Performance
ORR ..... On Request Report
P&P ..... Policy and Procedure
PA ..... Performance Activity
PAS ..... Provider Affairs Subcommittee
PCP ..... Primary Care Physician/Provider
PEP ..... Provider Evaluation of Performance

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PHI ..... Protected Health Information
PIHP ..... Prepaid Inpatient Health Plan
POC ..... Plan of Correction
Q ..... Quarter
QI ..... Quality Improvement
QM/QMP ..... Quality Management/Quality Management Program
QOC ..... Quality of Care
QP ..... Quality Process
SEC ..... Sentinel Event Committee
TCA ..... Tennessee Code Annotated
TDMHDD ..... Tennessee Department of Mental Health and Developmental Disabilities
TennCare ..... Tennessee Department of Finance and Administration, Bureau of TennCare
UM ..... Utilization Management
UTD ..... Universal Tracking Database

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# Executive Summary

*for **AmeriChoice-West***

## *Introduction*

As the External Quality Review Organization (EQRO) for the Tennessee Department of Finance and Administration, Bureau of TennCare (TennCare), QSource is required by the *Balanced Budget Act of 1997* (BBA) to assess each TennCare health plan's "…strengths and weaknesses with respect to the quality, timeliness, and access to healthcare services furnished to Medicaid recipients" (42 *Code of Federal Regulations* [CFR] 438.364[a][2]). One requirement of the External Quality Review (EQR) contract with TennCare is to conduct an Annual Quality Survey (AQS) of each Managed Care Organization (MCO), and the Dental Benefits Manager (DBM), collectively referred to as the state's Managed Care Contractors (MCCs). This is the fifth year that QSource has performed the AQS. The purpose of the AQS is to determine the extent to which each TennCare MCC is in compliance with:

- its Contractor Risk Agreement (CRA) with the State of Tennessee, Bureau of TennCare;
- 42 CFR Parts 417.106, 430, 433, 434 and 438; and
- other quality standards established by the state of Tennessee.

In addition, QSource's review of MCCs incorporates two state mandates that address services and due process for managed care Medicaid members: *John B. Consent Decree* (supports the federal Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] standard of care for children age 20 and younger) and the *Grier Revised Consent Decree* (governs contested denials).

QSource also follows the Centers for Medicare & Medicaid Services (CMS) *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs), Final Protocol, Version 1.0*, February 11, 2003. In compliance with these protocols, this *UnitedHealthcare Plan of the River Valley, Inc. (**AmeriChoice-West**) 2010 Annual Quality Survey* (herein referred to as the *2010 AQS Report)* includes the Executive Summary and the following sections:

- Methodology
- Evaluation of Plan Process
- Evaluation of Plan Results
- Summary and Recommendations
- Appendices

## *Methodology*

The general scope of AQS assessment activity was previously defined by 10 state-specific MCO quality process (QP) standards and five performance activities (PAs). All MCOs under contractual obligation with TennCare have now achieved accreditation from the National Committee for Quality Assurance (NCQA). This accreditation reduced the number of QP

standards and PAs requiring EQRO assessment, preventing duplication of activities as prescribed by federal guidelines. **Table 1-1** lists all QP standards assessed for the 2010 AQS.

| Table 1-1. 2010 AQS QP Standards for AmeriChoice-West |
|---|
| Quality Improvement (QI) Program |
| Network: Contracting, Availability, Access and Documentation |
| QI Activities |
| Clinical Criteria for Utilization Management (UM) Decisions |
| Member Rights and Responsibilities |
| *John B. Consent Decree* (EPSDT) |
| *Grier Revised Consent Decree* |
| Non-Discrimination Compliance |

Two QP standards/PAs—**Credentialing/Recredentialing** and **Benefit Delivery Review**—were assessed as part of the 2010 Annual Provider Network Adequacy and Benefit Delivery Review (ANA); results were detailed in **AmeriChoice-West**'s *2010 ANA Report* and, as such, do not appear here.

The PAs for the **AmeriChoice-West** 2010 AQS appear in **Table 1-2**. Because all MCOs are now NCQA accredited, complaint review is no longer required. Additionally, the *Newberry Dispute Resolution* that mandated a review specific to home health denials has expired. UM denials pertain to members age 20 years and younger only.

| Table 1-2. 2010 AQS PAs for AmeriChoice-West |
|---|
| **MCO Activity by Standard** |
| Clinical Criteria for UM Decisions: Denial File Review (age 20 and younger only) |
| *John B. Consent Decree* (EPSDT): Information System Tracking Review |
| *Grier Revised Consent Decree*: Appeal File Review |

Detailed lists of all 2010 MCO evaluation elements are presented in **Tables 2-2** and **2-3** of the Methodology section.

## *Evaluation of Plan Process*

Plan performance values/star ratings for the 2010 AQS are indicated in **Table 1-3**.

| Table 1-3. AQS Rating Scale Key | | |
|---|---|---|
| **Plan Performance** | **Level of Compliance** | **Star Rating** |
| 90—100% | Total Compliance | ☆☆☆☆☆ |
| 80—89% | Substantial Compliance | ☆☆☆☆ |
| 65—79% | Partial Compliance | ☆☆☆ |
| 55—64% | Minimal Compliance | ☆☆ |
| 0—54% | Noncompliance | ☆ |

# *Evaluation of Plan Results*

## Scores and Ratings

**Table 1-4** summarizes **AmeriChoice-West**'s specific compliance percentage for each QP standard assessed for the 2010 AQS review. The health plan's star ratings from the 2010 AQS are also included by QP standard. A single score for *all* QP standards, as well as multi-year trending, is no longer calculable due to the reduction of standards and elements following NCQA accreditation.

**Table 1-4. 2010 QP Standard Scores and Ratings for AmeriChoice-West**

| MCO Standard | Percent Compliant | Star Rating |
|---|---|---|
| Quality Improvement (QI) Program | 100% | ☆☆☆☆☆ |
| Network: Contracting, Availability, Access and Documentation | 100% | ☆☆☆☆☆ |
| QI Activities | 100% | ☆☆☆☆☆ |
| Clinical Criteria for Utilization Management (UM) Decisions | 100% | ☆☆☆☆☆ |
| Member Rights and Responsibilities | 95.0% | ☆☆☆☆☆ |
| *John B. Consent Decree* (EPSDT) | 94.3% | ☆☆☆☆☆ |
| *Grier Revised Consent Decree* | 100% | ☆☆☆☆☆ |
| Non-Discrimination Compliance | 94.4% | ☆☆☆☆☆ |

**Table 1-5** summarizes **AmeriChoice-West**'s specific compliance percentage for each PA assessed for the 2010 AQS review. The health plan's star ratings from the 2010 AQS are also included by PA. As with QP standards, neither an overall PA score nor trending can be calculated due to NCQA accreditation, which eliminated complaint file review, and the expiration of the *Newberry Dispute Resolution*, which required the review of home health denials. UM denials pertain to members age 20 years and younger only.

**Table 1-5. 2010 PA Scores and Ratings for AmeriChoice-West**

| MCO Activity by Standard | Percent Compliant | Star Rating |
|---|---|---|
| Clinical Criteria for UM Decisions: Denial File Review (age 20 and younger only) | 100% | ☆☆☆☆☆ |
| *John B. Consent Decree* (EPSDT): Information System Tracking Review | 100% | ☆☆☆☆☆ |
| *Grier Revised Consent Decree*: Appeal File Review | 100% | ☆☆☆☆☆ |

## Corrective Action Plan Process

TennCare requires the MCO to submit a Corrective Action Plan (CAP) for *any* QP standard element or PA that has been identified as an area of noncompliance (i.e., less than 100 percent compliance), regardless of overall performance on the corresponding QP standard or PA. At the direction of TennCare, CAPs will also be required for deficiencies noted in the unscored elements of the QI Activities standard. CAPs are considered On Request Reports (ORRs),

meaning that TennCare may request them at its discretion and not solely based on the MCO's performance outcomes. All CAPs must be designed to improve performance in areas of noncompliance.

**AmeriChoice-West** did not achieve full compliance on:

- Member Rights and Responsibilities, Element #6: Notification of changes to written materials.
- *John B. Consent Decree* (EPSDT):
  - Element #6: Undeliverable mail
  - Element #10: Community contacts approved
- Non-Discrimination Compliance, Element #3: Display of non-discrimination posters

A CAP will be required for each of these items. Within 14 days of the posting notification of its final AQS report, the **AmeriChoice-West** must electronically submit all required CAPs to **OCCP.Reports@tn.gov** with copies to **Judy.M.Womack@tn.gov**, **Pauline.S.McIntyre@tn.gov** and **aqs-cap@qsource.org**. CAPs will not be considered submitted if they are not received by all four parties within the required time frame.

## *Summary and Recommendations*

The health plan achieved 100 percent compliance on five of eight QP standards, and on all PAs. Where full compliance was not met, the MCO's performance ranged from 94.3 to 95.6 percent. The following section summarizes the areas of noncompliance, strengths and suggestions that QSource identified during the 2010 AQS. These are discussed in greater detail in the full-length **Summary and Recommendations** of this report, as are the health plan's medical-behavioral health integration efforts.

### Integration of Medical-Behavioral Services

**AmeriChoice-West**'s policies and procedures (P&Ps) helped ensure the coordination of medical and behavioral health activities. The roles and responsibilities of primary care providers (PCPs) and mental health/substance abuse treatment providers were well defined. Collaboration was promoted via the health plan's P&Ps, processes, Provider Manual, website and provider newsletters. Screening tools were utilized to identify the need for case management (CM) and to assess the behavioral health needs of those already in CM. **AmeriChoice-West** used multiple tools to evaluate provider performance in these areas, and evidence produced on-site demonstrated collaboration, the monitoring of implementation and outcomes, and follow-up for members at least every 30 days.

There were distinct P&Ps for adverse occurrences, which were reported, reviewed, investigated and addressed through corrective action by the Provider Affairs Subcommittee (PAS). QSource verified these actions in staff interviews and document review. **AmeriChoice-West**

demonstrated compliance with tracking and trending, reporting requirements and the availability of MCO adverse occurrence documentation to TennCare.

The health plan's coordination efforts for children were also evident. Family involvement, accessible services, and follow-up after inpatient or residential treatment were just a few of the actions noted for TENNderCare members.

## Areas of Noncompliance

Areas of noncompliance were identified where **AmeriChoice-West** achieved less than 100 percent compliance. This includes the unscored elements in the QI Activities QP standard. Areas of noncompliance reflect what the health plan *should do* and may be accompanied by recommended policy, procedure or process changes from QSource. **AmeriChoice-West**'s areas of noncompliance centered primarily on member communication, outreach approval/ documentation and display of non-discrimination posters. Upon changing the policies regarding co-pay rates, the MCO failed to notify members 30 days in advance, as is required by TennCare. Also, the MCO did not ensure that undeliverable mail was followed up on with attempts to locate family members within required time frames. The MCO should make sure to secure approval for and accurately document community outreach activities with TennCare prior to the events; they should also ensure that events are documented accurately in quarterly EPSDT reports. The MCO is also required to display non-discrimination posters that contain all of the federally required statutes regarding employee rights and obligations. The posters located in the MCO's breakroom did not have information on the *Omnibus Budget Reconciliation Act of 1981*.

All areas of noncompliance addressed during the 2009 AQS report were successfully resolved.

## Strengths

Strengths indicate that the MCO demonstrated particular proficiency on a given QP standard element or PA and can be identified independent of 100 percent compliance. QSource documented strengths under the *John B. Consent Decree* during the 2010 AQS. The MCO chose to conduct new member calls on all new members despite having exceeded the required screening rate standard.

Another strength in the same area was attributed to program coordination. As part of the Emergency Department (ED) Diversion program, the MCO identified children with more than five ED visits in a seven- month period to determine if they had a medical home. During this process, several members were identified whose "troublesome patterns of service utilization" ultimately resulted in referrals and coordination with the Department of Children Services.

## Suggestions

During the 2010 AQS, QSource made suggestions that are encouraged for **AmeriChoice-West** but not required. These are detailed in the full-length Summary and Recommendations section of this report.

# Methodology

*for **AmeriChoice-West***

## *Purpose of the Evaluation*

The Tennessee Department of Finance and Administration, Bureau of TennCare (TennCare) contracts with QSource to perform Annual Quality Survey (AQS) evaluations, which provide meaningful information that TennCare and **AmeriChoice-West** can use for:

1. measuring the quality of both the healthcare and services that it provides to its members;
2. evaluating its application of the *John B. Consent Decree* and the *Grier Revised Consent Decree* state mandates;
3. evaluating its policies, tracking processes and rates of compliance with the activities of TENNderCare, TennCare's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program;
4. identifying variations in healthcare services across Tennessee; and
5. implementing proactive measures for more effective/efficient service delivery.

To complete these components for the 2010 AQS, QSource assembled a team of experienced health plan surveyors to collect and analyze data; complete a review of contractual, clinical and administrative outcomes; and prepare a report for TennCare and **AmeriChoice-West**.

## *Results Evaluated*

This *2010 AQS Report* documents the evaluation of **AmeriChoice-West**'s compliance with its *Contractor Risk Agreement (CRA) between the State of Tennessee, doing business as (d.b.a.) TennCare and UnitedHealthcare Plan of the River Valley, Inc. (AmeriChoice-West)–East/West CRA–May 19, 2008–With Amendment 1 (September 1, 2009),* and the quality process (QP) standards and performance activities (PAs) derived from it. The *2010 AQS Report* also documents compliance with:

- QP standards derived from the *John B. Consent Decree* (EPSDT), *Grier Revised Consent Decree,* and for non-discrimination;
- PAs derived from the *John B. Consent Decree* (EPSDT) and *Grier Revised Consent Decree*; and an additional PA regarding UM Denials File Review;
- 42 *Code of Federal Regulations* (CFR) Parts 417.106, 430, 433, 434 and 438; and
- other quality standards established by the state of Tennessee.

## *Quality Assessment Activities*

For each Managed Care Contractor (MCC), the AQS includes a pre-assessment documentation review, an on-site visit and post-on-site analyses. QSource developed the AQS tools to be used on-site and forwarded them to **AmeriChoice-West**. The pre-assessment phase gave both

QSource and the health plan an opportunity to ask questions before the on-site visit. QSource surveyors conducted **AmeriChoice-West**'s on-site visit **April 20–22, 2010**. **Table 2-1** details the assessment activities QSource performed for the AQS.

| Table 2-1. 2010 AQS Activities Performed |
|---|
| **Step 1: Establish survey schedule.** |
| ♦ Before the on-site visit, QSource submitted the survey schedule to TennCare for approval. |
| **Step 2: Prepare data collection survey tools and submit them to TennCare for review/approval.** |
| ♦ QSource developed evidence-based oversight/monitoring tools in consultation with TennCare representatives to ensure CRA-specific criteria were met and all data sought were collected.<br>♦ Approved tools completed for **AmeriChoice-West** are in **Appendices A** and **C.** |
| **Step 3: Submit survey tools to the MCC.** |
| ♦ QSource forwarded the survey tools to the health plan, giving it the opportunity to gather the required data and facilitate process streamlining for the on-site visit. |
| **Step 4: Prepare/Submit the Pre-Assessment Documentation List to the MCC.** |
| ♦ QSource sent a letter to TennCare MCCs requesting that specific desk review documents be submitted to QSource. The Pre-Assessment Documentation List was accompanied by instructions on how to organize and prepare the documents for the surveyors. |
| **Step 5: Respond to MCC questions/information requests prior to on-site review.** |
| ♦ QSource remained in contact via telephone and e-mail to respond to questions and to provide additional information as needed to key **AmeriChoice-West** personnel and TennCare representatives, particularly concerning clarification of the **Pre-Assessment Documentation List** and the on-site assessment process. |
| **Step 6: Receive pre-assessment documentation and gather information before the on-site visit.** |
| ♦ QSource used the survey tools to examine and document all information received before the on-site visit to offer surveyors insight into **AmeriChoice-West**'s structure, member population, providers, services, operations, resources and delegated functions to enable initial compiling of data.<br>♦ From the PA data submitted by the health plan, QSource abstracted a random sample of files, including an oversample, for desk review.<br>♦ During the desk review process, the surveyors:<br>(1) took notes to assist in the completion of the survey tools and guide determination about compliance with the regulatory provisions;<br>(2) identified those areas and issues requiring further clarification or follow-up during the on-site interviews; and<br>(3) clarified which requested information was not found in the pre-assessment documentation. |
| **Step 7: Develop an on-site agenda.** |
| ♦ QSource surveyors developed a general agenda to assist the **AmeriChoice-West** staff in participation planning, documentation gathering and addressing logistical issues (such as arranging locations for surveyors to conduct document reviews and interviews). |
| **Step 8: Discuss the on-site agenda with the MCC.** |
| ♦ Through setting the tone and expectations in an on-site agenda and discussing it with **AmeriChoice-West** in preparation for the on-site assessment, QSource helped ensure that all participants understood the time frames involved so that the process was more efficient and effective. |

| Table 2-1. 2010 AQS Activities Performed |
|---|
| **Step 9: Conduct the on-site visit.** |
| ♦ During the on-site document assessment, **AmeriChoice-West** staff was available to answer questions or assist the QSource review team in locating specific documents or information sources.<br>♦ QSource coordinated interviews/discussions with staff to maximize results while minimizing disruption to plan operations, as document review alone is generally insufficient to determine compliance since content and actual performance of the procedures outlined in the documents can typically be determined only by interaction and interviews with plan staff.<br>♦ The review team interacted with staff to determine the degree of compliance with contract requirements, to explore any issues not fully addressed in the documents reviewed and to increase overall understanding of **AmeriChoice-West**'s performance. |
| **Step 10: Review information and documentation using the survey tools.** |
| ♦ Throughout the documentation review and on-site assessment processes, QSource reviewers used the survey tools to obtain information and to document findings regarding **AmeriChoice-West**'s compliance with set standards through a review of policies/procedures, committee minutes, quality studies, reports, medical record/file review and other related health plan documentation.<br>♦ Surveyors took notes during staff interviews and document review to obtain the required data. (These notations were included in the completed survey tools in this report as **Appendices A** and **C** to serve as a comprehensive record of the assessment activity.) |
| **Step 11: Summarize findings at the completion of the survey.** |
| ♦ As a final step for completing the on-site survey, QSource met with **AmeriChoice-West** to summarize initial findings and recommendations. |
| **Step 12: Calculate the individual ratings for the MCC's performance.** |
| ♦ For comparing performance and determining **AmeriChoice-West**'s compliance with QP standards and program requirements, QSource incorporated nationally recognized guidelines from:<br>(1) *Standards and Guidelines for the Accreditation of Health Plans* from the National Committee for Quality Assurance (NCQA);<br>(2) protocols of the Centers for Medicare & Medicaid Services (CMS); and<br>(3) state and federal regulations.<br>♦ QSource analyzed every element in the survey tools using weighted point values to determine **AmeriChoice-West**'s performance on each standard. |
| **Step 13: Prepare a report of findings and recommendations.** |
| ♦ After completing data analyses, QSource prepared this report of the review findings and recommendations. A draft AQS report was due 30 days after the survey was completed, with the final AQS report due 60 days after completion of the survey. Both reports were forwarded to TennCare for approval within these deadlines. |
| **Step 14: Provide post-survey support to the MCC.** |
| ♦ QSource provided **AmeriChoice-West** with technical assistance as needed to foster performance improvement. |

## *Standards and Measures Reviewed*

As part of the 2010 AQS, QSource's surveyors evaluated the elements of the QP standards and PAs identified in **Tables 2-2** and **2-3**. *Please note that the element titles in these tables do not necessarily reflect*

*the entirety of the content reviewed for each QP standard or PA identified. Also, recall that Credentialing/Recredentialing and Benefits Delivery Review were included in* ***AmeriChoice-West****'s* 2010 Annual Network Adequacy (ANA) Report *and, as such, are not included in this* 2010 AQS Report.

| Table 2-2. QP Standard Elements for AmeriChoice-West | |
|---|---|
| **Quality Improvement (QI) Program** | |
| 1) Member safety and quality | |
| **Network: Contracting, Availability, Access and Documentation** | |
| 1) Specialist termination | 2) Notice of provider termination |
| **QI Activities** | |
| 1) Coordination between physical and behavioral health<br>2) Adverse occurrences policies and procedures<br>3) Adverse occurrences definition<br>4) Adverse occurrences to be reported | 5) Adverse occurrences and quality of care issues<br>6) Adverse occurrence tracking and trending<br>7) Adverse occurrence reporting requirements<br>8) Availability of adverse occurrence documents |
| **Clinical Criteria for Utilization Management (UM) Decisions** | |
| 1) Availability of criteria | 2) Transition to other care |
| **Member Rights and Responsibilities** | |
| 1) Member Handbook development and distribution<br>2) Complaint procedures<br>3) Communication of rights and responsibilities in Member Handbook | 4) Member Handbook inclusions<br>5) Notice of right to file a complaint<br>6) Notification of changes to written materials<br>7) Translation services<br>8) Translated vital documents |
| ***John B. Consent Decree* (EPSDT)** | |
| 1) New member calls<br>2) Outreach contacts<br>3) Documenting outreach<br>4) Declined services<br>5) Re-notification if no services used<br>6) Undeliverable mail<br>7) Accurate provider lists<br>8) Targeted activities<br>9) Outreach to illiterate, blind, deaf and LEP<br>10) Community contacts approved<br>11) Prenatal appointment assistance<br>12) Referrals from one level of screening to another<br>13) Notify MCO if unable to make referral<br>14) Medically necessary services<br>15) Rehabilitation and maintenance services<br>16) Medical necessity<br>17) Limitations/Capitations/Delays<br>18) Qualified UM personnel | 19) Services without prior authorization<br>20) Specialist list<br>21) MCO CM<br>22) Medically necessary CM services<br>23) CM central function<br>24) Family involvement and accessible services<br>25) Follow-up after inpatient or residential treatment<br>26) Screening components including follow-up<br>27) Interperiodic screen<br>28) Prior authorization prohibited<br>29) Screening standards met<br>30) Transportation<br>31) Program coordination<br>32) IEPs<br>33) Tracking system<br>34) EPSDT language in contracts<br>35) EPSDT contract review |
| ***Grier Revised Consent Decree*** | |
| 1) Appeals unit | 2) *Grier*/Appeals procedures |

| Table 2-2. QP Standard Elements for AmeriChoice-West | |
|---|---|
| **Non-Discrimination Compliance** | |
| 1) Non-Discrimination Compliance Plan<br>2) Assurance of Non-Discrimination<br>3) Display of non-discrimination posters<br>4) Non-discrimination written materials<br>5) Written policy and procedure | 6) Complaint resolution and reporting<br>7) Member Handbook notification and Complaint Form<br>8) Quarterly newsletter notification<br>9) Subcontractor compliance education |

| Table 2-3. PAs by Standard for AmeriChoice-West |
|---|
| **MCO Activity by Standard** |
| Clinical Criteria for UM Decisions: Denial File Review (age 20 and younger only) |
| *John B. Consent Decree* (EPSDT): Information System Tracking Review |
| *Grier Revised Consent Decree*: Appeal File Review |

## *Conducting the Survey*

QSource worked closely with TennCare and with the health plan throughout the survey process, ensuring a supportive and coordinated approach in carrying out survey activities. All tools were approved by TennCare prior to conducting the survey.

Before the on-site visit, QSource contacted **AmeriChoice-West** to exchange information, to set dates for the visit, and to discuss other activities needed to complete the evaluation methodically and accurately. Dates for the contract term, the reporting period under review and QSource's on-site visit to **AmeriChoice-West** are detailed in **Table 2-4**.

| Table 2-4. Principal Dates for the AmeriChoice-West 2010 AQS | |
|---|---|
| **Key Stages** | **Time Span** |
| Contract Term | May 19, 2008 – Present |
| Reporting Period Under Review | January 1—December 31, 2009 |
| Dates of Review | April 20—22, 2010 |

## *Producing and Delivering the Survey Report*

In compliance with CMS protocol, this report includes:

- a detailed assessment of **AmeriChoice-West**'s strengths regarding the quality, timeliness and accessibility of its healthcare services;
- specific areas of noncompliance to help the health plan improve performance; and
- QSource's assessment to ensure the health plan's continued improvement on standards with less than 100 percent compliance.

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**AmeriChoice-West** had the opportunity to respond to the draft of this report. No comments were received, as indicated in **Appendix D**.

## *MCO Scores*

The total point value assigned to the QP standards section was 63.6 points (51.5 percent), and the total point value assigned to the PA section was 60 points (48.5 percent). The processes used for calculating QP standards and PA scores are detailed below.

### QP Standards–Element Scores

Using specific criteria, each QP standard score was calculated by adding its individual evaluation element scores (see **Table 2-2**). For example, *John B. Consent Decree* (EPSDT) has a total value of 39.50 points, which represents the sum of its 35 evaluation element scores (ranging from 0.500 to 3.000 each). The scored QP standard review tool for **AmeriChoice-West** is located in **Appendix A**.

### PA Scores

Each PA evaluation is unique and, as such, has its own distinct review tool. Each of the PAs was assigned a 20-point value. The scored PA tools for **AmeriChoice-West** are in **Appendix C**. Any tool component considered not applicable (NA) was excluded from scoring.

### Rating Determination

A rating of one to five stars was assigned for every QP standard and PA based on the percentage of total points earned for each. **Table 2-5** provides a summary.

**Table 2-5. AQS Rating Scale Key**

| Plan Performance | Compliance Rating | Star Rating |
|---|---|---|
| 90—100% | Total Compliance | ☆☆☆☆☆ |
| 80—89% | Substantial Compliance | ☆☆☆☆ |
| 65—79% | Partial Compliance | ☆☆☆ |
| 55—64% | Minimal Compliance | ☆☆ |
| 0—54% | Noncompliance | ☆ |

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# Evaluation of Plan Process

*for **AmeriChoice-West***

Using Centers for Medicare & Medicaid Services (CMS) protocol for External Quality Review Organizations (EQROs), QSource reviewed documentation from **AmeriChoice-West** and conducted on-site interviews to identify the health plan's progress toward quality standard goals set in 2009. This protocol, and QSource's 2010 survey tools, helped to determine the Managed Care Organization's (MCO's) compliance with contractual standards specified in the Contractor Risk Agreement (CRA); 42 *Code of Federal Regulations (*CFR*)* Parts 417.106, 430, 433, 434 and 438; and other quality standards established by the state of Tennessee.

QSource has met the federal qualifications for EQROs set forth in 42 CFR § 433.354. In brief, these include demonstrated experience and knowledge of Medicaid as well as managed care policies, processes, and data systems. The organization is a 501(c)(3) not-for-profit whose survey staff includes registered nurses, master's level public health and healthcare administration professionals, and those experienced in research design and statistical analysis. QSource holds a 9001:2008 quality management certification from the International Organization for Standardization (ISO) and is certified by the state of Tennessee as a utilization review agent. QSource has met all standards of independence required of EQROs in their contracts with governmental and/or other agencies.

## *Pre-Assessment Review*

To expedite the 2010 Annual Quality Survey (AQS), QSource sent a written request for documentation to each Managed Care Contractor (MCC) of the Tennessee Department of Finance and Administration, Bureau of TennCare (TennCare), prior to the scheduled on-site survey. The request included a Pre-Assessment Documentation List of items pertaining to the quality process (QP) standards and performance activities (PAs) to be evaluated.

Pre-assessment documentation review facilitates a more efficient on-site survey and helps surveyors conduct better MCC staff interviews in the time allotted. **AmeriChoice-West** was compliant in providing the requested pre-assessment information in a timely manner.

The documentation QSource requested and reviewed consisted of the following:

1. Member Handbooks in English and Spanish
2. Provider Manual
3. 2009 Quality Improvement (QI) Program Description
4. QI Program Evaluation of 2008 activities
5. TENNderCare Program Description
6. All provider and member newsletters
7. 2009 quarterly and annual EPSDT reports
8. 2009 Utilization Management (UM) Program Description

9. UM Program Evaluation of 2008 activities
10. All provider and member satisfaction surveys
11. Information and documentation related to 2009 AQS Corrective Action Plan (CAP) activities and interventions
12. Policies that define the MCC's time standards for handling all denials and appeals
13. Completed table of time standards used for the resolution of UM denials and appeals

In addition to these pre-assessment documents, QSource asked that **AmeriChoice-West** have available on-site all curricula vitae/resumes for UM staff involved in medical necessity decision-making, as well as:

- 15 UM denial files (EPSDT-eligible members only)
- 15 EPSDT files
- 15 appeal (*Grier*) files

# *On-Site Review*

## Survey Participants

The MCC representative interview is integral to the AQS. Interview participants supplement, clarify and confirm what is learned during the pre-assessment review; they supply further evidence that what the MCC documents and what it practices are congruent. **Table 3-1** lists the on-site surveyors and the **AmeriChoice-West** staff members they contacted during the survey.

**Table 3-1. Participants in the AmeriChoice-West 2010 AQS**

| Name | Credentials | Title |
|---|---|---|
| **QSource On-Site Surveyors** | | |
| Ginger Botts | RN, BSN | QI Clinical Specialist |
| Michelle North | RN, BSN | QI Clinical Specialist |
| Swapna Jamode | MHA | Health Analyst |
| **AmeriChoice-West Staff Facilitating the Evaluation** | | |
| Amanda Hamblen | | Manager, DM |
| Beth Fortenberry | RN, BSN | Associate Director, Clinical Medical Operations |
| Charles Nails | BSW | Quality Specialist |
| Christa Thomas | RN | Manager, Case Management (CM); Private Duty Nurse |
| David O. Hollis | MD, FACP | Chief Medical Officer |
| Elliot Sparks | MSW, LMSW | Manager, Behavioral Health CM |
| Hayley Clothier | BA | Quality Manager |
| Jerry Sullivan | PsyD | Executive Director, Behavioral Health |
| Judith Black | RN | Director, Special Projects |
| Kim Seay | BS | Senior Director, Quality Management |

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| Table 3-1. Participants in the AmeriChoice-West 2010 AQS | | |
|---|---|---|
| **Name** | **Credentials** | **Title** |
| Lisa Ellis | RN,BSN, MSA | Southeast Regional Director, Integrated Care Coordinator, Teen-Medicaid |
| Sandy Sanderson | RN | Manager, Care Management |
| Sara (Dusti) Williams | RN, BSN | Manager, EPSDT & Preventive Health |
| Sarah Marcel | MBA | Manager, TennCare Compliance |
| Stephanie McNeal | RN | Associate Director, Appeals/Clinical Letter Compliance |
| Tristin Blade | | Health Coach II, Healthy First Steps (HFS) |

## On-Site Documentation

Once on-site, QSource surveyors examined additional documents (detailed in **Table 3-2**) that were not included in the pre-assessment review.

**Table 3-2. On-Site Documentation for the AmeriChoice-West 2010 AQS**

1) 2009 QI Work Plan
2) Adverse Incident Work Guide
3) Adverse Occurrence Investigation Files and Tracking Log
4) Appeals Organization Chart
5) Availability of Behavioral Health Practitioners and Providers - 2009 Annual Analysis
6) Behavioral Health Inter-Rater Reliability (IRR) Vignettes
7) Completed Medical Record Audit Tool
8) Desk Audit Tool
9) Emails Regarding:
   - QM Health Programs to be Posted to Web in 2009 (email chain from 12/2/08 – 12/4/08)
   - TennCare Approval of Policies and Procedures (P&P)
10) Final Version of P&P #HS UM 10: Prior Authorization and/or Referral Exceptions
11) IEP Tracking Database Screenshots
12) Member Care Management Notes (3/1/09-12/31/09)
13) Member Notes For CM – Collaboration of Physical & Behavioral Health
14) New Member Packet Monthly Log
15) Postal Confirmation Forms on Annual Member Packets Mailing
16) Regional Sample of CM Case Notes for Member's Home Health Care Providers that would Term with MCO
17) Sarbanes-Oxley UM Audit Process Summary
18) UM Quality Audit Examples; Redesign Workshop PowerPoint; and Staff List, Licenses and Resumes

## *Overview of Findings*

During the review, QSource surveyors used the tools in **Appendices A** and **C** – along with personal observations, interviews with key health plan staff and on-site file/document reviews – to facilitate analyses and compilation of findings. The results include:

- quality process (QP) standard evaluation results (**Table 4-1**)
- performance activity (PA) evaluation results (**Table 4-2**)
- QP standard strengths and opportunities (**Table 4-3**)
- PA strengths and opportunities (**Table 4-4**)

**AmeriChoice-West**'s individual element and PA file compliance scores can also be found in **Appendices A** and **C**.

### Scores and Ratings

**Table 4-1** summarizes **AmeriChoice-West**'s specific compliance percentage for each QP standard assessed for the 2010 Annual Quality Survey (AQS). The Managed Care Organization's (MCO's) star ratings from the 2010 AQS are also included by QP standard. A single score for all QP standards, as well as multi-year trending, is no longer calculable due to the reduction of standards and elements following National Committee for Quality Assurance (NCQA) accreditation.

As shown, **AmeriChoice-West** achieved 100 percent compliance on five of eight QP standards. On the remaining standards, performance ranged from 94.3 to 95.6 percent.

**Table 4-1. 2010 QP Standard Scores and Ratings for AmeriChoice-West**

| MCO Standard | Percent Compliant | Star Rating |
|---|---|---|
| Quality Improvement (QI) Program | 100% | ☆☆☆☆☆ |
| Network: Contracting, Availability, Access and Documentation | 100% | ☆☆☆☆☆ |
| QI Activities | 100% | ☆☆☆☆☆ |
| Clinical Criteria for Utilization Management (UM) Decisions | 100% | ☆☆☆☆☆ |
| Member Rights and Responsibilities | 95.0% | ☆☆☆☆☆ |
| *John B. Consent Decree* (EPSDT) | 94.3% | ☆☆☆☆☆ |
| *Grier Revised Consent Decree* | 100% | ☆☆☆☆☆ |
| Non-Discrimination Compliance | 94.4% | ☆☆☆☆☆ |

**Table 4-2** summarizes **AmeriChoice-West**'s specific compliance percentage for each PA evaluated for the 2010 AQS review. Star ratings for the 2010 AQS are also included. As with QP

standards, neither an overall PA score nor trending can be calculated due to NCQA accreditation, which eliminated complaint file review, and the expiration of the Newberry Dispute Resolution, which required the review of home health denials. UM denials pertain to members age 20 years and younger only.

**AmeriChoice-West** achieved 100 percent compliance on all PAs.

| Table 4-2. 2010 PA Scores and Ratings for AmeriChoice-West | | |
|---|---|---|
| **MCO Activity by Standard** | **Percent Compliant** | **Star Rating** |
| Clinical Criteria for UM Decisions: Denial File Review (age 20 and younger only) | 100% | ☆☆☆☆☆ |
| *John B. Consent Decree* (EPSDT): Information System Tracking Review | 100% | ☆☆☆☆☆ |
| *Grier Revised Consent Decree*: Appeal File Review | 100% | ☆☆☆☆☆ |

## Strengths and Areas of Noncompliance

The AQS aids QSource and the Tennessee Department of Finance and Administration, Bureau of TennCare (TennCare) in the identification of strengths and areas of noncompliance to benefit **AmeriChoice-West**. **Strengths** indicate that the health plan demonstrated particular proficiency on a given QP standard element or PA, and can be identified independent of 100 percent compliance. The lack of an identified strength should not be interpreted as a shortcoming on the part of **AmeriChoice-West**.

**Areas of noncompliance** were identified where **AmeriChoice-West** achieved less than 100 percent compliance. They reflect what the health plan *should do* and may be accompanied by recommended policy, procedure or process changes from QSource. A score of 100 percent on a standard indicates that **AmeriChoice-West** fully met the criteria and, therefore, is in full compliance. **Tables 4-3** and **4-4** detail **AmeriChoice-West**'s strengths and areas of noncompliance for the 2010 AQS. No areas of noncompliance items repeated from the 2009 survey.

| Table 4-3. 2010 QP Standard Strengths and Areas of Noncompliance for AmeriChoice-West | |
|---|---|
| **Strengths** | **Areas of Noncompliance** |
| **Quality Improvement (QI) Program** | |
| **AmeriChoice-West** was in full compliance with this standard. | |
| **Network: Contracting, Availability, Access and Documentation** | |
| **AmeriChoice-West** was in full compliance with this standard. | |
| **QI Activities** | |
| **AmeriChoice-West** was in full compliance with this standard. | |

| Table 4-3. 2010 QP Standard Strengths and Areas of Noncompliance for AmeriChoice-West | |
|---|---|
| **Strengths** | **Areas of Noncompliance** |
| **Clinical Criteria for Utilization Management (UM) Decisions** | |
| **AmeriChoice-West** was in full compliance with this standard. | |
| **Member Rights and Responsibilities** | |
| | **Element #6: Notification of changes to written materials.** The MCO had updates to the policy regarding co-pay changes effective 01/01/2010, but the members were not provided the written notice 30 days in advance. |
| ***John B. Consent Decree* (EPSDT)** | |
| **Element #1: New member calls.** The MCO chose to conduct new member calls on all new members despite having exceeded the required screening rate standard.<br><br>**Element #31. Program Coordination.** As part of the Emergency Department (ED) Diversion program, the MCO identified children with more than five ED visits in a seven- month period to determine if they had a medical home. During this process, several members were identified whose "troublesome patterns of service utilization" ultimately resulted in referrals and coordination with Department of Children Services. | **Element #6: Undeliverable mail.** The MCO should ensure that, when mail is returned as undeliverable, both attempts to find family occur within the required time frames.<br><br>**Element #10: Community contacts approved.** The MCO should ensure that all community events involving member outreach/interaction receive appropriate approval from TennCare. The MCO should also ensure that events are documented accurately in quarterly EPSDT reports. |
| ***Grier Revised Consent Decree*** | |
| **AmeriChoice-West** was in full compliance with this standard. | |
| **Non-Discrimination Compliance** | |
| | **Element # 3: Display of non-discrimination posters.** The MCO should include the information on the posters located in their breakrooms informing their employees regarding the Omnibus Budget Reconciliation Act of 1981. The MCO should continue to include the current information like employees' rights and obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990 and the Age Discrimination Act of 1975. |

| Table 4-4. 2010 PA Strengths and Areas of Noncompliance for AmeriChoice-West | |
|---|---|
| **Strengths** | **Areas of Noncompliance** |
| **Clinical Criteria for UM Decisions: Denial File Review (age 20 and younger only)** | |
| **AmeriChoice-West** was in full compliance with this PA. | |
| ***John B. Consent Decree* (EPSDT): Information System Tracking Review** | |
| **AmeriChoice-West** was in full compliance with this PA. | |
| ***Grier Revised Consent Decree*: Appeal File Review** | |
| **AmeriChoice-West** was in full compliance with this PA. | |

## *Corrective Action Plan Process*

CAPs are designed to improve performance in areas of noncompliance. TennCare requires that the MCO submit a CAP for *any* QP standard element or PA that has been identified as an area of noncompliance (i.e., less than 100 percent compliance), regardless of overall performance on the corresponding QP standard or PA. At the direction of TennCare, CAPs will also be required for deficiencies noted in the unscored elements of the QI Activities standard. The AQS represents an opportunity for health plans to receive technical assistance – from TennCare or QSource – while developing a CAP for areas that require improvement. CAPs are considered On Request Reports (ORRs), meaning that TennCare may request them at its discretion and not solely based on the MCO's performance outcomes.

Within 14 days of the posting notification of its final AQS report, **AmeriChoice-West** must electronically submit all required CAPs to the following:

- TennCare Office of Contract Compliance and Performance (OCCP): **OCCP.Reports@tn.gov**
- TennCare Division of Quality Oversight:
  - Director: **Judy.M.Womack@tn.gov**
  - Assistant Director: **Pauline.S.McIntyre@tn.gov**
- QSource: **aqs-cap@qsource.org**

CAPs will not be considered as submitted if they are not received by all four parties within the required time frame. Following CAP evaluation, TennCare will send the health plan either a letter of approval or a denial with a request for additional clarifying information.

**AmeriChoice-West** did not achieve full compliance on:

- Member Rights and Responsibilities, Element #6: Notification of changes to written materials.

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- *John B. Consent Decree* (EPSDT):
  - Element #6: Undeliverable mail
  - Element #10: Community contacts approved
- Non-Discrimination Compliance, Element #3: Display of non-discrimination posters

A CAP will be required for each of these items. Each CAP must address and meet the intent of the identified area of noncompliance, show progress made in meeting the CAP, include an intended completion date, and the titles of those responsible for its completion.

## *Quality Improvements since the Previous AQS*

Each year, the AQS summarizes the quality improvements made by each MCC since the previous year's survey. As detailed in **Table 4-5**, this summary includes areas of noncompliance that were identified by QSource in 2009 and **AmeriChoice-West**'s planned action as described in its CAP(s). With its CAPs, the MCO satisfied all areas of noncompliance identified during the 2009 AQS. For more detailed results, see **AmeriChoice-West**'s *2009 AQS Report*.

| Table 4-5. QP Standard Improvements since the 2009 AQS | | |
|---|---|---|
| **2009 Area of Noncompliance** | **AmeriChoice-West's Planned Action** | **Action Accomplished** |
| ***John B. Consent Decree* (EPSDT)** | | |
| **Element #27: Individual education plans (IEPs).** After receipt of the IEP, the MCO should send a copy of it and any related information (e.g., action taken by the MCO in response to receipt of the IEP, action the MCO expects the provider to take) to the primary care provider/physician (PCP). | A tracking log is maintained on a common drive so that all IEPs are documented and tracked in one central location.<br><br>One of the tracking elements includes documentation of the date the copy of the IEP was sent to the PCP. Quality audits are conducted in the Medical CM [Care Management] Dept. on a monthly basis.<br><br>As part of the monthly Quality audit - the region manager will review the assigned CM CareOne notes for all new IEPs for that month to be certain that the notification/IEP was sent to the member's PCP. | Quality audits occurred monthly until October 2009, at which time the corporate standard transitioned to quarterly audits. The CM Manager showed online examples at her desk of audit results from 2009. The audits included an evaluation of CareOne documentation by CMs, in which documentation regarding IEPs was included. The IEP Tracking Database contained all pertinent dates related to the IEP process, including the date of PCP contact for member evaluation and the date the IEP was sent to the PCP. This satisfies the CAP for 2009. |
| **Comment:** None. | | |

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# Summary and Recommendations

*for **AmeriChoice-West***

Overall, **AmeriChoice-West** demonstrated a commitment to quality and TennCare contractual compliance. The health plan achieved 100 percent compliance on five of eight quality process (QP) standards, and on all performance activities (PAs). Where full compliance was not met, the Managed Care Organization's (MCO's) performance ranged from 94.3 to 95.6 percent. This section includes a comparison with the previous year's compliance results and a detailed discussion of areas of noncompliance, strengths and suggestions identified during the 2010 Annual Quality Survey (AQS).

## *Integration of Medical-Behavioral Services*

**AmeriChoice-West**'s policies and procedures (P&Ps) helped ensure the coordination of medical and behavioral health activities. The roles and responsibilities of primary care providers (PCPs) and mental health/substance abuse treatment providers were well defined. Collaboration was promoted via the health plan's P&Ps, processes, Provider Manual, website and provider newsletters. Screening tools were utilized to identify the need for case management (CM) and to assess the behavioral health needs of those already in CM. **AmeriChoice-West** used multiple tools to evaluate provider performance in these areas, and evidence produced on-site demonstrated collaboration, the monitoring of implementation and outcomes, and follow-up for members at least every 30 days.

There were distinct P&Ps for adverse occurrences, which were reported, investigated and addressed through corrective action by the Provider Affairs Subcommittee (PAS). QSource verified these actions in staff interviews and document review. **AmeriChoice-West** demonstrated compliance with tracking and trending, reporting requirements and the availability of MCO adverse occurrence documentation to TennCare.

The health plan's coordination efforts for children were also evident. Family involvement, accessible services, and follow-up after inpatient or residential treatment were just a few of the actions noted for TENNderCare members.

## *Areas of Noncompliance*

Areas of noncompliance were identified where **AmeriChoice-West** achieved less than 100 percent compliance. This includes the unscored elements in the QI Activities QP standard. Areas of noncompliance reflect what the health plan *should do* and may be accompanied by recommended policy, procedure or process changes from QSource. **AmeriChoice-West's** areas of noncompliance centered primarily on member communication, outreach approval/ documentation and display of non-discrimination posters. Upon changing the policies regarding co-pay rates, the MCO failed to notify members 30 days in advance, as is required by TennCare. Also, the MCO did not ensure that undeliverable mail was followed up on with

attempts to locate family members within required time frames. The MCO should make sure to receive appropriate approval for all community outreach activities with TennCare prior to the events; they should also ensure that events are documented accurately in quarterly reports of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) efforts. The MCO is also required to display non-discrimination posters that contain all of the federally required statutes regarding employee rights and obligations. The posters located in the MCO's breakroom did not have information on the *Omnibus Budget Reconciliation Act of 1981*.

All areas of noncompliance addressed during the 2009 AQS report were successfully resolved.

## Strengths

Strengths indicate that the MCO demonstrated particular proficiency on a given QP standard element or PA and can be identified independent of 100 percent compliance. QSource documented strengths under the *John B. Consent Decree* during the 2010 AQS. The MCO chose to conduct new member calls on all new members despite having exceeded the required screening rate standard.

Another strength in the same area was attributed to program coordination. As part of the Emergency Department (ED) Diversion program, the MCO identified children with more than five ED visits in a seven- month period to determine if they had a medical home. During this process, several members were identified whose "troublesome patterns of service utilization" ultimately resulted in referrals and coordination with the Department of Children Services.

## Suggestions

During the 2010 AQS, QSource made suggestions that are encouraged for **AmeriChoice-West** but not required. The MCO should consider including a statement in the quarterly member newsletter indicating the availability and location of safety and quality performance information. To further enhance its outreach efforts, the MCO should consider revising its TENNderCare/EPSDT policy (#HS QM PWE 1) to more specifically address outreach to members who have not used services in more than two years. Telephone scripts used with these members could remind them that they have not used services in a two-year time period.

To further ensure that PCPs use the online list of TENNderCare members who are not up-to-date on their screenings, the MCO could include more specific instructions in newsletters and training materials that direct providers to the health plan website.

Additionally, to aid non-discrimination compliance, the health plan's policy and procedure regarding language and interpretation services could more clearly state that assistance is available to visually impaired or blind members.

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# APPENDIX A | *Quality Process Standard Survey Tool*

*for **AmeriChoice-West***

This section contains the completed Annual Quality Survey (AQS) Quality Process (QP) Standard Survey Tool for Managed Care Organizations (MCOs), 2010 Edition.

Each evaluation element is referenced with the relevant paragraphs/sections of the Contractor Risk Agreement (CRA) and/or other applicable state or federal rules or laws.

# 2010 Annual Quality Survey - Quality Process Standards

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AmeriChoice-West

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Quality Improvement (QI) Program** | | | | |
| **1 Member safety and quality** | | | 0.750 | 0.750 |
| The MCO has a written plan for collecting and providing information on member safety that includes actions taken to:<br>● document provider efforts to improve member safety; and<br>● make performance data available for members and practitioners. | ☑ Plan for collecting<br>☑ Plan for distributing | 0.375<br>0.375 | | |

*CRA § 2.15.1.3 (E/W, Middle and TCS)*

The health plan's 2009 QI Program reported supporting the prevention and elimination of healthcare errors through a commitment to the practice of evidence-based medicine using a variety of mechanisms, including but not limited to measurement tools and reporting metrics focused on patient safety, evidence-based claims and prescription reports to identify adverse events, quality of care (QOC) referrals, and databases that identify, track and address safety concerns. The QI Program also stated that patient safety goals are developed and integrated into the QI Work Plan annually. The 2009 Work Plan was reviewed on-site and evidenced that the Managed Care Organization (MCO) is addressing member safety through activities such as on-site office assessments of primary care provider (PCP) initial credentialing, pharmacy audits (e.g., audits of quarterly prescribing pattern, narcotic drug utilization review program and polypharmacy program), and preventive/ambulatory screening of all age members throughout the year. Also, the Provider Manual addressed many areas of patient safety, including preventive initiatives, hospital safety and medication safety. The website (uhcrivervalley.com) was accessed by reviewers and found to contain a link that directed the member to The Joint Commission website to compare hospital and provider quality. Also, the 2nd quarter (Q2) member newsletter, Health Talk, featured an article titled "We Make Sure You Get Great Care and Service." At the end of the article, members were referred to the health plan's website for additional information on their quality management, utilization management, MCO structure, etc.

SUGGESTION: The MCO could include a statement in the quarterly member newsletter informing members that information on safety and quality performance is available on the website or by making a request to Customer Service.

**Total Score: 0.750 out of 0.750 = 100 % Compliance**

# 2010 Annual Quality Survey - Quality Process Standards

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Network: Contracting, Availability, Access and Documentation** | | | | |
| **1 Specialist termination** | | | 0.250 | 0.250 |
| Contracts with specialists and specialty group practices require timely notification (no less than 30 days prior when possible) to MCO members affected by the termination of a specialist or the entire specialty group. | ☑ Yes<br>☐ No | 0.250<br>0.000 | | |

*CRA § 2.11.8.1.4 (E/W and TCS); CRA § 2.11.9.1.4 (Middle)*

The section on Term and Termination in the Tennessee Program Network Practitioner Provider Agreement Between UnitedHealthcare Plan of the River Valley, Inc., and [Contracting Practitioner] as well as the Tennessee Program Network Practitioner Group Provider Agreement Between UnitedHealthcare Plan of the River Valley, Inc. and [Contracting Practitioner Group] stated that the contracting practitioner and contracting practitioner group shall provide 60 days written notification of termination of the agreement to MCO Members.

| | | | | |
|---|---|---|---|---|
| **2 Notice of provider termination** | | | 0.250 | 0.250 |
| If a Primary Care Physician (PCP) ceases participation in the MCO, the MCO immediately provides written notice--no less than 30 days prior to the effective date of the termination and no more than 15 days after receipt or issuance of the termination notice--to each member who has chosen the provider as his/her Primary Care Provider (PCP). | ☑ Yes<br>☐ No | 0.250<br>0.000 | | |

*Notice template provided by TennCare;*
*CRA § 2.11.8.1.2 (E/W and TCS); CRA § 2.11.9.1.2 (Middle)*

Policy and Procedure (P&P) #GR AC 2: Member Notification of Physician Change or Termination addressed that if a PCP or non-PCP provider no longer provides services for health plan members, the health plan will notify members at least 30 calendar days prior to the effective termination date. It also included that, in those instances when the practitioner leaves the network without prior notice of termination, the members who had chosen the provider as his/her PCP will be notified no more than 15 calendar days after termination.

**Total Score: 0.500 out of 0.500 = 100 % Compliance**

# 2010 Annual Quality Survey - Quality Process Standards

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AmeriChoice West

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **QI Activities** | | | | |
| **1 Coordination between physical and behavioral health** | | | 5.500 | 5.500 |
| The MCO has policies and procedures and ensures coordination between physical and behavioral health services by including key elements to the right: | ☑ Screening for behavioral health needs | 0.500 | | |
| | ☑ Referral to physical and behavioral health providers | 0.500 | | |
| | ☑ Exchange of information | 0.500 | | |
| | ☑ Confidentiality | 0.500 | | |
| | ☑ Assessment | 0.500 | | |
| | ☑ Treatment plan development | 0.500 | | |
| | ☑ Collaboration | 0.500 | | |
| | ☑ Case Management (CM) and Disease Management (DM) | 0.500 | | |
| | ☑ Provider training | 0.500 | | |
| | ☑ Monitoring implementation and outcomes | 0.500 | | |
| | ☑ Encourages PCPs and other providers to use state-approved behavioral health screening tool | 0.500 | | |

*CRA § 2.9.5.1 and 2.9.5.3.2 (E/W and TCS);*
*CRA § 2.9.8.1 and 2.9.8.3.2 (Middle)*

P&P #HS GEN 7: Coordination of Physical and Behavioral Health Services described in detail the roles and responsibilities for both PCPs and specialty care providers (e.g., mental health providers and substance abuse providers). These roles were clearly outlined in the Provider Manual as well. PCPs were responsible for assessing members' mental health and substance abuse problems using screening tools such as the Behavioral Health Toolkit (available on the provider website). P&P #HS GEN 7 Attachments A (Provider Evaluation of Performance [PEP] Plan), B (audit tool) and C (medical record review tool) were used to evaluate the provider's performance. CM processes were discussed with the Manager of Care Management in detail regarding coordination of physical and behavioral health. The process was reported to include behavioral health screening for all members, using the screening tool to determine if there is a behavioral component present. In addition to the behavioral screening tool, it was reported that a health risk assessment was performed. When a behavioral problem is identified with the screening, it was noted that the member is offered participation in the internal behavioral health CM program. It was further reported that when the internal program is declined, the member is offered outside assistance opportunities (e.g. community counseling, outreach assessment, behavioral providers.) The Manager of Care Management reported that, once the assessment is completed, the screening tool auto-populates an easily customized plan of care for the member. She also provided a case to validate collaboration between DM and Behavioral Health; there was evidence of collaboration and monitoring of implementation and outcomes as well. There was a follow-up at least every 30 days, or more frequently as the situation required. Newsletters for both members and providers addressed coordination of behavioral healthcare. The MCO website was also accessed, and it provided detailed information on coordination of physical and behavioral services. The PEP Plan provided evidence that the MCO reviewed provider records to ensure that behavioral health and substance abuse screening was performed and that coordination of care occurred. P&P #HS GEN 7 also cited the following tools and resources to inform clinicians and facilities of the requirement to communicate, coordinate and collaborate healthcare delivery with other active healthcare providers: Provider Manual, provider newsletters, provider trainings and the health plan website.

# 2010 Annual Quality Survey - Quality Process Standards

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AmeriChoice-West

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **QI Activities** | | | | |
| **2 Adverse occurrences policies and procedures** | | | 0.000 | 0.000 |
| The MCO has policies and procedures in place for reporting, investigating and managing adverse occurrences (also known as sentinel events and critical incidents) related to the provision of behavioral services. | ☑ Yes<br>☐ No | 0.000<br>0.000 | | |

P&P #HS QM 10: Addressing Potential Quality of Care/Quality of Service stated that "all potential…QOC…complaints and referrals will be handled in a professional and timely manner in accordance with applicable legal and governing bodies requirements. The information will be maintained in a manner consistent with preserving peer review privilege when it applies, protecting Protected Health Information from improper use and disclosure as required by federal law." The policy further stated that behavioral health issues would be referred to appropriate behavioral health resources in the health plan or in a United Behavioral Health Regional Center. P&P #BH: Peer Review of Behavioral Health Adverse Occurrences defined an adverse event and outlined the scope, purpose and process for this occurrence. The Provider Affairs Subcommittee (PAS) minutes were reviewed and documented on-site, they showed the PAS reported and investigated QOC/Quality of Services for each quarter of 2009 with their determination/severity level and any corrective action that was required.

| | | | | |
|---|---|---|---|---|
| **3 Adverse occurrences definition** | | | 0.000 | 0.000 |
| The MCO identifies what constitutes an adverse occurrence, sentinel event or critical incident that requires reporting and review. | ☑ Yes<br>☐ No | 0.000<br>0.000 | | |

P&P: BH Peer Review of Behavioral Health Adverse Occurrence defined an adverse occurrence as "an unexpected occurrence involving death or serious physical injury or the risk thereof that occurs during the course of a member receiving behavioral health treatment. For the purpose of this policy occurrences are defined as any of the following or the risk thereof: Completed suicides on either an outpatient or inpatient basis; homicides attributed to members; assault, including an alleged assault, of a patient while in treatment at an inpatient, partial hospitalization or residential mental health or substance abuse facility; death or serious injury of a patient while in treatment at an inpatient, partial hospitalization, or residential mental health or substance abuse facility." The Adverse Occurrence Provider Letter reviewed on-site defined adverse occurrence for the provider, cited examples to be reported, and outlined the steps to be taken when reporting an adverse occurrence. The report form was included with the letter as well as a reference to its location on the website. The quarterly Adverse Occurrence Reports for all three regions were also reviewed in a grid format. The report was broken down into the number of occurrences for that quarter, a summary of the findings and any intervention required.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **QI Activities** | | | | |
| **4 Adverse occurrences to be reported** | | | 0.000 | 0.000 |
| The MCO collects reports on adverse occurrences, including but not limited to the events listed at right: | ☑ Unexpected death of a member | 0.000 | | |
| | ☑ Suicide or attempted suicide | 0.000 | | |
| | ☑ Suspected physical, sexual or mental abuse of a member while the member is undergoing treatment, or if it is alleged that the suspected abuse was done by a provider or employee of a provider | 0.000 | | |
| | ☑ Injury sustained by a member while in a behavioral health treatment facility | 0.000 | | |
| | ☑ Medication errors involving a member | 0.000 | | |

P&P: BH Peer Review of Behavioral Health Adverse Occurrences identified adverse occurrence events as: unexpected death of a member, incomplete or completed suicides in either an inpatient or outpatient setting, suspected physical, sexual, or mental abuse during the course of treatment of the member that was alleged to be due to the actions of a provider or employee of the provider; or injury sustained by a member while in a behavioral health treatment facility. The Adverse Occurrence Provider Letter cited treatment complications (adverse medication errors and reaction), accidents or injuries to the member, death and attempted suicide, as well as suspected physical, sexual, or mental abuse while undergoing treatment as examples of occurrences to be reported. The 2009 Adverse Occurrence Report documented all reported occurrences on a quarterly basis with a synopsis of the findings for each quarter.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **QI Activities** | | | | |
| **5 Adverse occurrences and quality of care issues** | | | 0.000 | 0.000 |
| The MCO shows evidence that it uses data related to adverse occurrences to identify and address potential and actual quality of care and/or health and safety issues through the following actions: | ☑ Identifying adverse occurrences; | 0.000 | | |
| | ☑ Tracking adverse occurrences; | 0.000 | | |
| | ☑ Reviewing adverse occurrences; and | 0.000 | | |
| | ☑ Analyzing adverse occurrences. | 0.000 | | |

P&P: BH Peer Review of Behavioral Health Adverse Occurrences stated that adverse occurrences must be reported by network providers to all appropriate agencies as required by licensure and state/federal laws within specified time frames required immediately following the event. The health plan noted that it required network providers to report adverse occurrences, that it peer reviews adverse occurrences and submits a quarterly report of all adverse occurrences in a format prescribed by the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD). Examples of adverse occurrences cited in the P&P included but were not limited to: treatment complications (including medication errors and adverse medication reactions); accidents or injuries to the member; morbidity; suicide attempts; death of the member; allegations of physical abuse or sexual abuse, neglect; mistreatment, and/or verbal abuse; abuse of isolation, mechanical restraint or physical holding restraint. The following documents were reviewed on-site: PAS minutes, Adverse Occurrence Report and Adverse Occurrence Tracking log. All documents validated that the adverse occurrences were being properly reported, reviewed, investigated, and sent to Medical Director review for determination and assignment of a severity level. It was noted when appropriate corrective actions were taken. In some situations/adverse occurrence cases were taken for peer review.

| | | | | |
|---|---|---|---|---|
| **6 Adverse occurrence tracking and trending** | | | 0.000 | 0.000 |
| The MCO regularly reviews the number and types of adverse occurrences (including, for example, the number and type of adverse occurrences across settings, providers, and provider types) and findings from investigations by both the MCO and agencies external to the MCO. It identifies trends, patterns and opportunities for improvement, and develops and implements strategies to reduce the occurrence of these incidents. | ☑ Regularly reviews the number and types of adverse occurrences | 0.000 | | |
| | ☑ Reviews findings from investigations by MCO and external agencies | 0.000 | | |
| | ☑ Identifies trends and patterns | 0.000 | | |
| | ☑ Identifies opportunities for improvement | 0.000 | | |
| | ☑ Develops and implements strategies to reduce occurrences | 0.000 | | |

P&P: BH Peer Review of Behavioral Health Adverse Occurrences stated that the health plan required network providers to report all adverse occurrences. The health plan was noted to have peer-reviewed adverse occurrences and submitted a quarterly report of all adverse occurrences in a format prescribed by TDMHDD. The PAS Sentinel Event Committee (SEC)…“will serve as the peer review committee for adverse occurrences and will review all such occurrences and make recommendations for improving patient care and safety." The scope, purpose and procedure were outlined in detail in this P&P. The following documents were reviewed on-site: PAS minutes, Adverse Occurrence Reports and tracking log; all documents supported that the MCO was reviewing adverse occurrences within standard time frames and reporting them on a quarterly basis. When adverse occurrences were confirmed, appropriate action was noted to be taken with the provider.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **QI Activities** | | | | |
| **7 Adverse occurrence reporting requirements** | | | 0.000 | 0.000 |
| The MCO requires staff and providers to report adverse occurrences in accordance with applicable requirements. The MCO requires its staff and providers to report, respond to and document adverse occurrences in a manner specified by the MCO. The MCO develops and implements an adverse occurrence reporting process, including the form to be used to report adverse occurrences and reporting time frames. | ☑ MCO requires staff and providers to report adverse occurrences | 0.000 | | |
| | ☑ MCO requires staff and providers to respond to and document adverse occurrences | 0.000 | | |
| | ☑ MCO has a reporting process and form in use | 0.000 | | |

P&P: BH Peer Review of Behavioral Health Adverse Occurrences stated: "Adverse Occurrence reports must be reported by network providers to all appropriate agencies as required by licensure and state/federal laws within the specified time frames required immediately following the event. Per the P&P, health plan Care Management staff are required to report all adverse occurrences to the Chief Medical Officer and Behavioral Health Medical Director who, within three business days, was required to begin administrative review of the case and complete a written summary on the proper form. The PAS and SEC were reported to serve as the peer review committee for adverse occurrences, providing review of all such occurrences and making recommendations for improving patient care and safety. The P&P noted that results of any reviews may be used to make recommendations to suspend, terminate, conduct a site audit, and/or alter the participation status of programs, providers, and/or practitioners. On-site review of the Adverse Occurrence Provider Letter documented that physicians were provided a copy of the form to be submitted when reporting an adverse occurrence. The letter also directed the provider to the MCO website to obtain the adverse report form. PAS minutes documented behavioral health adverse actions/sentinel events reported and related discussions at each committee meeting.

| | | | | |
|---|---|---|---|---|
| **8 Availability of adverse occurrence documents** | | | 0.000 | 0.000 |
| The MCO makes available for review to TennCare or its designated contractor all minutes, files, notes and committee actions related to the reporting and review of adverse occurrences. | ☑ Yes | 0.000 | | |
| | ☐ No | 0.000 | | |

PAS minutes, Adverse Occurrence Reports, and Investigation Files for adverse occurrences were provided for review on-site and evidenced that they were available for review by TennCare.

**Total Score: 5.500 out of 5.500 = 100 % Compliance**

# 2010 Annual Quality Survey - Quality Process Standards

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AmeriChoice-West

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Clinical Criteria for Utilization Management (UM) Decisions** | | | | |
| **1 Availability of criteria** | | | 1.000 | 1.000 |
| The MCO includes the following information in its provider manuals:<br>● medical necessity standards and clinical practice guidelines; and<br>● prior authorization, referral and other UM requirements and procedures. | ☑ Medical necessity standards and clinical practice guidelines included | 0.500 | | |
| | ☑ Prior authorization, referral and other UM requirements included | 0.500 | | |

*CRA § 2.18.5.1.7 and .10 (E/W and TCS); CRA § 2.18.5.3.8 and .16 (Middle)*

The MCO's Provider Manual stated medical necessity was determined using nationally recognized review criteria (e.g., Milliman), and appropriateness using internal criteria (e.g., Level of Care guidelines). All criteria were reported to be reviewed on an annual basis. The Provider Manual also stated that other criteria may be used when there is published peer-review literature that supports admission or continued stay criteria. Updates were noted to be provided to the MCO as they were developed by Milliman, on an annual or as-needed basis. In the July 2009 Network Bulletin, the MCO was reported to have "gone live" with the 13th Edition of Milliman Care Guidelines. The internal guidelines, however, were noted to be reviewed and revised annually with a review of the literature. The medical necessity criteria and clinical guidelines were noted and reviewed on the website (uhcrivervalley.com/10Provider) or may be requested from the Customer Service Department. Prior authorization, referral and other UM procedures were also found in the Provider Manual and on the website above.

| | | | | |
|---|---|---|---|---|
| **2 Transition to other care** | | | 0.500 | 0.500 |
| The MCO has policies and procedures and shows evidence it assists with either a member's transition to other care or to another provider when the current provider has terminated participation with the MCO. | ☑ Yes | 0.500 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.9.3.1 (E/W and TCS); CRA § 2.9.4.1 (Middle)*

P&P #HS GEN 3: Transitional Care for Members of Terminated Providers stated that there was a "defined process in place to provide for an orderly transfer of care to appropriate network providers, with attention to the individual needs of the member, timely information exchange between providers and maintaining the member confidentiality; while minimizing disruption in the care process." The P&P detailed the process that would take place in the event such a transition occurred. The policy stated the health plan "is responsible for the cost of continuation of medically necessary services the member is receiving. Continuation of such services is covered up to 90 calendar days or until the member may be transferred without disruption, whichever is less. No prior approval is necessary for the first 30 days, regardless as to whether such services are being provided by a contracted or non-contracted provider." The MCO provided a regional sample (one member case from each grand region documenting the transition from a terminated provider to the new in-network provider) that showed evidence of compliance with this element. The CM's clinical notes documented that continuous care was available or given from a provider who would cover the term at the end of the year until the transition to the new provider.

**Total Score: 1.500 out of 1.500 = 100 % Compliance**

# 2010 Annual Quality Survey - Quality Process Standards

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AmeriChoice-West

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Member Rights and Responsibilities** | | | | |
| **1 Member Handbook development and distribution** | | | 1.000 | 1.000 |
| The Member Handbook is:<br>● developed and updated annually based on TennCare-provided templates;<br>● distributed to members within 30 days of receiving notice of enrollment in the MCO;<br>● distributed to all contracted providers upon initial credentialing; and<br>● re-distributed to all members and providers annually and as updates occur. | ☑ Developed/Updated using TennCare templates | 0.200 | | |
| | ☑ Sent to members within 30 days of enrollment | 0.200 | | |
| | ☑ Sent to providers upon credentialing | 0.200 | | |
| | ☑ Re-distributed annually | 0.200 | | |
| | ☑ Re-distributed as updated | 0.200 | | |

*CRA § 2.17.4.1, .2 and .4 (E/W, Middle and TCS)*

P&P #GR 24.1.2: Member Handbook Development and Distribution addressed a process by which the Member Handbook would be developed and updated annually based on TennCare-provided templates. The policy also indicated that the Member Handbooks would be distributed to members within 30 days of receiving a notice of enrollment in the MCO, and the New Member Packet Monthly Log provided proof of this. The mailing log provided proof of the annual mailing as well. The TennCare Addendum to the Provider Agreement indicated that the health plan should either send a copy of the Member Handbook to the provider or include notification via the Provider Manual that it is accessible online. An active link to the Member Handbook was available.

| | | | | |
|---|---|---|---|---|
| **2 Complaint procedures** | | | 0.500 | 0.500 |
| The MCO has internal complaint procedures for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees, or court orders governing the appeals process. | ☑ Yes | 0.500 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.19.1.1 (E/W, Middle and TCS)*

P&P #GR 12.2: Member Complaint and Appeal Process-TennCare Only addressed the MCO's internal complaint procedure for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees, or court orders governing the appeals process.

# 2010 Annual Quality Survey - Quality Process Standards

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AmeriChoice-West

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Member Rights and Responsibilities** | | | | |
| **3 Communication of rights and responsibilities in Member Handbook** | | | 2.000 | 2.000 |
| The Member Handbook contains the following rights and responsibilities:<br>a. a right to file a complaint and a complaint form on which to do so;<br>b. the right to file an appeal;<br>c. a notice to the member that, in addition to the right to file an appeal of actions taken by the MCO, she/he has the right to request reassessment of eligibility-related decisions related directly to TennCare;<br>d. the member's responsibility to notify the MCO and TennCare each and every time the member moves to a new address;<br>e. the right to change MCOs;<br>f. the right to disenroll from TennCare;<br>g. the right to amend their data in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations;<br>h. the right to obtain information regarding the structure and operation of the MCO and physician incentive plans;<br>i. the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand; and<br>j. the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. | ☑ a. Right to file a complaint and form | 0.200 | | |
| | ☑ b. Right to file an appeal | 0.200 | | |
| | ☑ c. Right to request reassessment of eligibility-related decisions | 0.200 | | |
| | ☑ d. Responsibility to notify MCO and TennCare of address change | 0.200 | | |
| | ☑ e. Right to change MCOs | 0.200 | | |
| | ☑ f. Right to disenroll | 0.200 | | |
| | ☑ g. Right to amend their data | 0.200 | | |
| | ☑ h. Right to obtain information on structure/operation of MCO and physician incentive plans | 0.200 | | |
| | ☑ i. Right to receive information on available treatment options and alternatives | 0.200 | | |
| | ☑ j. Right to be free from restraint or seclusion | 0.200 | | |

*CRA § 2.17.4.5.11-.13, .17, .19-.21, .24-.27 and .29 (E/W and TCS);*
*CRA § 2.17.4.7.19, .23, .24, .28 -.32, .35 -.38 and .40 (Middle)*

The Member Handbook addressed each of the criteria mentioned in this element in its entirety.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Member Rights and Responsibilities** | | | | |
| **4 Member Handbook inclusions** | | | 2.600 | 2.600 |
| The Member Handbook is, at a minimum, in accordance with the following guidelines:<br>a. includes a description of services provided including benefit limits, exclusions and use on non-contract providers;<br>b. includes a description of TennCare cost share responsibilities for members including an explanation that providers and/or the MCO may utilize whatever legal actions that are available to collect these amounts;<br>c. indicates that members may not be billed for covered services except for the amounts of the specified TennCare cost share responsibilities and of their right to appeal in the event that they are billed;<br>d. includes procedures for obtaining required services, including procedures for obtaining referrals to network specialists and providers outside of the plan;<br>e. advises members that if they need a service that is not available within the plan, they will be referred to a provider outside of the plan and any co-payment requirements would be the same as if this provider were in the plan;<br>f. includes an explanation on how members will be notified of member specific information such as effective date of enrollment;<br>g. includes notice to the member that enrollment in the MCO's plan invalidates any prior authorization for services granted by another plan but not utilized prior to enrollment in the new MCO and notice of continuation of an active treatment plan or pregnancy;<br>h. includes information on how to access the PCP on a 24-hour basis as well as the 24-hour nurse line;<br>i. includes an explanation of emergency services and procedures on how to obtain them both in and out of the MCO's service area, including but not limited to: the use of 911, locations of emergency settings, and locations for services;<br>j. includes information about preventive services for adults and children, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for Medicaid-eligible members, listing of preventive services and notice that preventive services are at no cost and without cost share responsibilities;<br>k. includes written information concerning advance directives;<br>l. includes member services toll free telephone numbers, including the TennCare Hotline, the MCO's customer service line, and the MCO's | | | | |
| | ☑ a. Description of service parameters | 0.200 | | |
| | ☑ b. Description of TennCare cost share responsibilities | 0.200 | | |
| | ☑ c. Billing for covered services and appeal of billed services | 0.200 | | |
| | ☑ d. Procedures for obtaining services and referrals in and out of plan | 0.200 | | |
| | ☑ e. Out-of-plan referrals co-pays | 0.200 | | |
| | ☑ f. Explanation of member notification | 0.200 | | |
| | ☑ g. Notice of continuation/discontinuation of previously authorized services | 0.200 | | |
| | ☑ h. Accessing PCP and nurse line 24/7 | 0.200 | | |
| | ☑ i. Obtaining emergency services | 0.200 | | |
| | ☑ j. Preventive services information | 0.200 | | |
| | ☑ k. Advance directives information | 0.200 | | |
| | ☑ l. Includes all required telephone numbers and notice that members may contact the MCO or TennCare with questions | 0.200 | | |
| | ☑ m. Information on appropriate prescription drug usage | 0.200 | | |

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
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## Member Rights and Responsibilities

24/7 Nurse Triage Line with a statement that the member may contact the plan or TennCare regarding questions about TennCare as well as the service/information that may be obtained from each line; and

m. information on appropriate prescription drug usage.

*CRA § 2.17.4.5.3, .4, .6 -.10, .15, .16, .22 and .28 (E/W and TCS);*
*CRA § 2.17.4.7.3, .5, .9-.11, .16, .17, .26, .27, .33 and .39 (Middle)*

The Member Handbook included all the mentioned guidelines in the element.

### 5 Notice of right to file a complaint

1.000 1.000

A notice of members' right to file complaints is included in quarterly newsletters sent by the MCO. The notice includes a contractor phone number for doing so and is written in English and Spanish.

- ☑ Notice in English and Spanish — 0.333
- ☑ Required information in each quarterly newsletter — 0.333
- ☑ Phone number for complaints — 0.334

*CRA § 2.17.5.3.3 (E/W and TCS); CRA § 2.17.5.3.5 (Middle)*

All quarterly newsletters sent by the MCO included a notice in English and Spanish of the members' right to file complaints and a phone number for doing so.

### 6 Notification of changes to written materials

1.000 0.500

The MCO provides written notice to members of any changes in policies or procedures described in written materials previously sent to members at least 30 days before the effective date of change.

- ☑ Written notice to members — 0.500
- ☐ Members notified at least 30 days before effective date of change — 0.500

*CRA § 2.17.2.8 (E/W, Middle and TCS)*

P&P #GR 24.1.2 addressed that the MCO provides written notice to members of any changes in P&Ps 30 days before the effective date. The MCO had some changes to their policy regarding co-pay, effective 1/1/10, and the information was included as an insert to the Member Handbook. The MCO submitted the changes for approval to TennCare on 11/24/09 and received TennCare approval on 12/10/09. The MCO was unable to provide members with the written notice 30 days in advance.

AREA OF NONCOMPLIANCE: The MCO had updates to the policy regarding co-pay changes effective 1/1/10, but the members were not provided the written notice 30 days in advance.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Member Rights and Responsibilities** | | | | |
| **7 Translation services** | | | 1.000 | 1.000 |
| The MCO provides translation services for members as demonstrated by the following:<br>● Member Handbooks include information on how to obtain information in alternative formats or how to access interpretation services, as well as a statement that interpretation and translation services are free;<br>● Quarterly newsletters include the procedure on how to obtain information in alternative formats or how to access interpretation services, as well as a statement that interpretation and translation services are free;<br>● The MCO develops a written procedure for providing members language interpretation and translation services, including but not limited to members with hearing impairment and/or Limited English Proficiency (LEP);<br>● The MCO provides language help-lines with specific numbers for these members; and<br>● The MCO's Non-Discrimination Compliance Coordinator provides instruction for its staff, including but not limited to all providers and direct service subcontractors regarding the procedure. | ☑ Information listed in handbook | 0.200 | | |
| | ☑ Information in all quarterly newsletters | 0.200 | | |
| | ☑ Procedure for language interpretation and translation services | 0.200 | | |
| | ☑ Help-line numbers provided | 0.200 | | |
| | ☑ Instruction to staff, providers and subcontractors | 0.200 | | |

*CRA § 2.17.4.5.23 and 2.17.5.3.2 (E/W and TCS); CRA § 2.17.4.7.34 and 2.17.5.3.4 (Middle);*
*CRA § 2.18.1.3, 2.18.2.1-.2 and 2.28.2 (E/W, Middle and TCS)*

The Member Handbook, all quarterly newsletters and P&P #GR 24.1.2 included documentation on obtaining information in alternative formats and on how to access interpretation services for free. These documents also included that the translation services were not limited to members with hearing impairment and or LEP. The Member Handbook included language help-lines with specific numbers. The MCO provided Tackling TennCare Training to the staff that included the Non-Discrimination topic. The Providers could access this information on the MCO website under 'Welcome to AmeriChoice Tennessee's Provider University!' webpage.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Member Rights and Responsibilities** | | | | |
| **8 Translated vital documents** | | | 1.000 | 1.000 |
| All vital MCO documents and the Member Handbook are translated and available in Spanish. Within 90 days of notification from TennCare, all vital MCO documents are translated and available to each LEP group identified by TennCare that constitutes five percent of the TennCare population or 1,000 members, whichever is less. | ☑ All vital documents translated | 0.500 | | |
| | ☑ Vital documents translated within 90 days | 0.500 | | |

*CRA § 2.17.2.5 (E/W, Middle and TCS)*

P&P #GR 24.1.1: Members Materials Development and Requirements stated that all vital MCO documents must be translated and available in Spanish. The policy also indicated that all vital MCO documents must be translated and available to each LEP group identified by TennCare.

**Total Score: 9.600 out of 10.100 = 95.0 % Compliance**

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **1 New member calls** | | | 1.000 | 1.000 |
| The MCO conducts telephone calls to all new members under the age of 21 to inform them of TENNderCare services, including availability of assistance with appointment scheduling and transportation to appointments. (This is not applicable for East, West and Middle MCOs if the MCO's TENNderCare screening rate is above 90 percent, as determined in the most recent Centers for Medicare & Medicaid Services (CMS) 416 report.) | ☑ Yes or Not Applicable (CMS-416 screening rate above 90 percent) | 1.000 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.7.5.2.2.1 (E/W); CRA § 2.7.6.2.2.1 (Middle); CRA § 2.6.13.2.2.1 (TCS)*

Although the MCO was not required to conduct new member telephone calls based on the 2009 CMS-416 screening rate of 101.76 percent, telephone calls were made to new members throughout the year. This was verified in TENNderCare Welcome Calls reports provided on-site.

STRENGTH: The MCO chose to conduct new member calls on all new members despite having exceeded the required screening rate standard.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **2 Outreach contacts** | | | 0.750 | 0.750 |
| The MCO distributes six outreach contacts a year, which include:<br>● a Member Handbook sent within 30 days of enrollment (annually thereafter upon the member's anniversary date of enrollment, the MCO sends an updated handbook, a supplemental update to the handbook, or a reminder of EPSDT services);<br>● four quarterly newsletters;<br>● one reminder before screens are due with transportation and scheduling assistance offered; and<br>● at least one of the six outreach attempts identified above advises members who are blind, deaf, illiterate, or non-English speaking regarding how to request and/or access such assistance and/or information. | ☑ Member Handbook sent within 30 days of enrollment | 0.125 | | |
| | ☑ Quarterly newsletters | 0.125 | | |
| | ☑ Screening due reminders | 0.125 | | |
| | ☑ Annual reminder of EPSDT services | 0.125 | | |
| | ☑ Annually informed regarding availability of information in alternative formats | 0.250 | | |

*John B. Consent Decree (CD) ¶ 40 [39(b), (d), (e), (g) and (h)]; CRA § 2.7.5.2.2 and 2.7.5.2.2.2 (E/W); CRA § 2.7.6.2.2 and 2.7.6.2.2.2 (Middle); CRA § 2.6.13.2.2.2 (TCS)*

Mailing verifications showed that updated Member Handbooks were sent to all members in December 2009. The MCO provided a log verifying the mailing of new member packets, including Member Handbooks. Mailings occurred at multiple times of each month during 2009. Member Newsletters were sent in each quarter of 2009. Each newsletter was also produced and distributed in Spanish. All member newsletters informed members of how to access materials in other languages or formats and informed them of transportation assistance. The MCO sent anniversary reminders titled Keeping Your Child Healthy that reminded parents of the need to take their child for a check-up. Additionally, the MCO sent monthly reminder cards, also titled Keeping Your Child Healthy. The information in these cards reminded parents of the ages when their child should be seen for a check-up. Monthly mailing verifications were available on-site as evidence that anniversary reminders and monthly reminders were sent throughout 2009.

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| **3 Documenting outreach** | | | 0.500 | 0.500 |
| The MCO maintains a process, approved by TennCare, for follow-up that includes provisions for documenting all outreach attempts with a mechanism for maintaining records of efforts to reach members missing screenings when scheduled or who have failed to schedule regular check-ups. This includes a different method of outreach effort at least quarterly to accomplish a missed screening. | ☑ Yes | 0.500 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.7.5.2.4 (E/W); CRA § 2.7.6.2.4 (Middle); CRA § 2.6.13.2.4 (TCS); CD ¶ 40 [39(j)]*

AmeriChoice used its Universal Tracking Database (UTD)–a proprietary software–to track and monitor each child's TENNderCare status. The database identified members who were overdue for screenings and immunizations. The database was capable of generating immediate reports on each member's screening status. The MCO provided four different outreach methods for 2009. Each mailer was different, yet each reminded the parent/child to schedule a TENNderCare screening. One mailer also included the childhood and adolescent immunization schedules.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **4 Declined services** | | | 0.500 | 0.500 |
| The MCO requires providers to maintain a process for documenting services declined by a parent, guardian or mature competent child, specifying the service declined. | ☑ Yes | 0.500 | | |
| | ☐ No | 0.000 | | |

*CD ¶ 40 [39(i)]; CRA § 2.7.5.2.6 (E/W); CRA § 2.7.6.2.6 (Middle); CRA § 2.6.13.2.6 (TCS)*

P&P #HS QM PWE 1: TENNderCare/EPSDT stated that the MCO would "[r]equire providers to have a process for documenting declined services by a parent or guardian or mature competent child, specifying the particular service that was declined. This process must meet the requirements of the State Medicaid Manual." The MCO's EPSDT Medical Record Review Tool included a place for the reviewer to validate that the audited provider documented any refusal of EPSDT services by a parent/guardian or child. The TENNderCare Clinical Documentation Exit Summary Tool was used to discuss audit findings with providers/office managers. This tool included "Declination of Service by Parent" as a discussion point for the exit summary. Examples of medical record audits conducted in 2009 demonstrated that the MCO assessed the record for refusal of services, and the service (in this case an immunization) that was refused.

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| **5 Re-notification if no services used** | | | 0.750 | 0.750 |
| The MCO maintains a process for determining if someone eligible for EPSDT has used no services within a year and follows up with two reasonable attempts to re-notify that member. (One attempt can be [an individual] referral to a Health Dept.) These two attempts are in addition to the required quarterly attempts outlined in Element #3. The attempts are different in format or message. | ☑ Maintains process | 0.250 | | |
| | ☑ Two additional re-notifications | 0.250 | | |
| | ☑ Attempts in different format or message | 0.250 | | |

*CD ¶ 40 [39(a)]; CRA § 2.7.5.2.5 (E/W); CRA § 2.7.6.2.5 (Middle); CRA § 2.6.13.2.5 (TCS)*

P&P # HS QM PWE 1 indicated that two attempts would be made to re-notify members who had not used services within one year. The P&P cited a referral to the Health Department and quarterly mailed reminders as the two methods used for notification. The MCO provided its postcard, "Did You Miss a Check-up?" as evidence of one outreach effort used for members who have not used services within a year. Instead of Health Department referrals, the MCO chose to conduct telephone calls to members who had not used services within a year. The policy has since been revised to reflect the use of telephonic outreach rather than Health Department referrals.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **6 Undeliverable mail** | | | 0.750 | 0.500 |
| The MCO documents two reasonable attempts to find a family when mail is returned as undeliverable. One of the two attempts is made within 90 days of receipt of mail returned as undeliverable. (For TennCare*Select,* the second attempt is made within 30 days.) At least one attempt is by phone. | ☑ Oral attempt | 0.250 | | |
| | ☑ Other attempt | 0.250 | | |
| | ☐ Attempt made within required time frame | 0.250 | | |

*CD ¶ 40 [39(a)]; CRA § 2.7.5.2.7 (E/W); CRA § 2.7.6.2.7 (Middle); CRA § 2.6.13.2.7 (TCS)*

The MCO submitted its TENNderCare/EPSDT Returned Mail Flow Chart to outline the process used to find families whose mail was returned as undeliverable. The flow chart indicated that all mail was sent by first class United States Postal Service to ensure that an attempt to re-send the mail occurred automatically. This was to occur within 30 days. If the mail was then returned, it was entered into the MCO's Returned Mail Tracking Log. A TENNderCare/EPSDT Coordinator would then search both AmeriChoice and public databases for member telephone numbers, which were used to generate a call list. This list was then used for the TeleVox Campaign, an automated telephonic outreach to these members, which was to occur within 90 days of receipt of returned mail. The MCO revised its member mailing process during 2009. During the on-site interview, the Manager of EPSDT and Preventive Health indicated that as the process was updated with the vendor, the second telephonic attempt fell outside of the 90 day requirement. The manager also stated that the process was now fully implemented to ensure both attempts would occur within the required time frames.

AREA OF NONCOMPLIANCE: The MCO should ensure that, when mail is returned as undeliverable, both attempts to find a family occur within the required time frames.

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|---|---|---|---|---|
| **7 Accurate provider lists** | | | 0.500 | 0.500 |
| The MCO makes available to families accurate lists of names and phone numbers of contract providers who are currently accepting TennCare. | ☑ Yes | 0.500 | | |
| | ☐ No | 0.000 | | |

*CD ¶ 40 [39(f)]; CRA § 2.7.5.2.8 (E/W); CRA § 2.7.6.2.8 (Middle); CRA § 2.6.13.2.8 (TCS)*

The Member Handbook informed members that network providers were identified in the Provider Directory, which was distributed with the Member Handbook to all new members, and available online (at www.uhcrivervalley.com) or by calling the MCO at 1-800-690-1606. The MCO's website was accessed, and a link to the Provider Directory was found. New member packet mailing logs verified that Member Handbooks and Provider Directories were distributed to new members several times each month throughout 2009.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **8 Targeted activities** | | | 0.500 | 0.500 |
| The MCO has established criteria for determining when to target specific informing activities to pregnant women, families with newborns, adolescents, first-time eligible members, those not using the program for over two years and illiterate, blind, deaf and LEP members. Pregnant women are informed about the availability of EPSDT for their children prior to the delivery date (provided the MCO is informed of the pregnancy) and are offered EPSDT services for the child when it is born. The MCO treats a woman's request for EPSDT services during pregnancy as a request for EPSDT services for the child at birth. | ☑ Has criteria to target activities to pregnant women, families with newborns, adolescents, first-time eligible members, those not using the program for over two years, and illiterate, blind, deaf and LEP members | 0.250 | | |
| | ☑ Offers services for children when born | 0.250 | | |

*CD ¶ 40 [39(l) and (n)]; CRA § 2.7.5.2.9 (E/W); CRA § 2.7.6.2.9 (Middle); CRA § 2.6.13.2.9 (TCS)*

P&P #HS HFS 2: Perinatal Care Coordination discussed the methods used to target pregnant women and families with newborns. The P&P indicated that outreach would begin the day eligibility was determined and included appointment scheduling assistance and arranging transportation. It also indicated that the Healthy First Steps (HFS) CM would educate members regarding TENNderCare services for the newborn and other children in the household and would assist the member in selecting a PCP for the baby either before or after birth. Newsletters targeted at adolescents were sent in each quarter of 2009. All adolescent newsletters contained language assistance information and instructed members on how to obtain materials in alternate formats. The teen newsletters were also translated and distributed in Spanish upon request. All new members received welcome telephone calls informing them of TENNderCare services. The call scripts provided members the opportunity to hear the message in Spanish. Members who had not used services within two years were included in quarterly TENNderCare reminder mailings.

SUGGESTION: To further enhance its outreach efforts, the MCO should consider revising its TENNderCare/EPSDT policy (#HS QM PWE 1) to more specifically address outreach to members who have not used services in more than two years. Telephone scripts used with these members could remind them that they have not used services in a two-year time period.

| | | | | |
|---|---|---|---|---|
| **9 Outreach to illiterate, blind, deaf and LEP** | | | 0.500 | 0.500 |
| The MCO customizes methods to inform individuals who are illiterate, blind, deaf or LEP about the availability of EPSDT services. | ☑ Customized methods | 0.250 | | |
| | ☑ Items distributed to identified members | 0.250 | | |

*CD ¶ 40 [39(d)]; CRA § 2.7.5.2.2.2 (E/W); CRA § 2.7.6.2.2.2 (Middle); CRA § 2.6.13.2.2.2 (TCS)*

During new member telephone calls, members were given the option to hear the message in Spanish. All member newsletters, including teen newsletters, were printed in English and Spanish. Both contained instructions for members needing information in alternate formats. The Member Handbook informed members that materials were also available in Braille or compact disk (CD). DM staff supplied examples of requests and mailed information in other languages or formats.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **10 Community contacts approved** | | | 2.000 | 0.000 |
| All of the MCO's community health education and outreach activities are approved by TennCare prior to implementation. The MCO maintains documentation of this approval. | ☒ First quarter | 0.500 | | |
| | ☒ Second quarter | 0.500 | | |
| | ☒ Third quarter | 0.500 | | |
| | ☐ Fourth quarter | 0.500 | | |

*CRA § 2.7.3.2, 2.16.2 and 2.17.1.1 (E/W); CRA § 2.7.4.2 and 2.17.1.1 (Middle); CRA § 2.16.2 and 2.17.1.1 (TCS)*

Three community outreach events were chosen from each quarter of 2009. In the first and second quarters, only one event of the three chosen for each quarter received appropriate TennCare approval. Two events chosen for the third quarter received approval. None of the events chosen for the fourth quarter received approval. Events for which approval was not available were either documented incorrectly in the quarterly EPSDT reports by the MCO, or the MCO was unable to demonstrate that approval had been obtained.

AREA OF NONCOMPLIANCE: The MCO should ensure that all community events involving member outreach/interaction receive appropriate approval from TennCare. The MCO should also ensure that events are documented accurately in quarterly EPSDT reports.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **11 Prenatal appointment assistance** | | | 2.000 | 2.000 |
| The MCO has policies and procedures to facilitate and take reasonable steps to assist pregnant members in accessing prenatal care and does the following:<br>● The MCO provides information on covered services to adolescent prenatal members who enter TennCare through presumptive eligibility;<br>● On the day eligibility is determined, the MCO offers assistance in making a timely first prenatal appointment after the diagnostic visit; and<br>● For a woman past her first trimester, this appointment occurs within 15 days of eligibility determination. | ☑ Policies and procedures | 0.500 | | |
| | ☑ Provides information on covered services | 0.500 | | |
| | ☑ On the day eligibility is determined, offers appointment assistance | 0.500 | | |
| | ☑ For a woman past her first trimester, appointment occurs within 15 days | 0.500 | | |

*CD ¶ 40 [39(m)]; CRA § 2.7.4.2.1 (E/W); CRA § 2.7.5.2.1 (Middle); CRA § 2.6.12 (TCS)*

P&P #HS HFS 2 outlined the processes used by the MCO to conduct outreach and coordinate services for pregnant members. It applied to all members - those who became enrolled in the MCO through presumptive eligibility and those enrolled at the time they became pregnant. The P&P stated that the HFS CM would assist or arrange for prenatal care to members on the date of their enrollment in the MCO. Assistance included arranging transportation and appointment scheduling. The P&P specified that if the woman was in her second or third trimester the appointment should be within 15 days. The P&P also stated that providers should be educated that failure to schedule an appointment for these members within 15 days would be considered a material breach of contract. Provider Manuals included this requirement in its Medical Appointment Scheduling Guidelines. The HFS Health Coach demonstrated the process used when contacting pregnant members. The assessment included offering appointment scheduling assistance - which was done within 15 days if the member was in her second or third trimester.

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| **12 Referrals from one level of screening to another** | | | 1.250 | 1.250 |
| The MCO has a policy and procedure to ensure that providers make and document appropriate referrals from one level of screening or diagnosis to another, more sophisticated level of diagnosis as needed to determine the child's physical health, behavioral health and developmental needs, as to medically necessary services. This is done regardless of whether the required services are covered by the MCO. | ☑ Policy and procedure | 0.500 | | |
| | ☑ Provider compliance | 0.750 | | |

*CD ¶ 53; CRA § 2.7.5.1.5.2 (E/W); CRA § 2.7.6.1.5.2 (Middle); CRA § 2.6.13.1.5.2 (TCS)*

P&P# HS QM stated that providers were required to refer members as appropriate and that all medically necessary services would be made available to the member regardless of whether the services were covered by the MCO. The MCO's EPSDT Medical Record Review Tool included a place for the reviewer to indicate if referrals had been made, and the TENNderCare Clinical Documentation Exit Summary Tool used by reviewers to discuss audit results with providers/office staff included a discussion point for referrals.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **13 Notify MCO if unable to make referral** | | | 1.000 | 1.000 |
| Procedures ensure a process for directing providers to notify the MCO in the event a screening reveals the need for other healthcare and the provider is unable to make an appropriate referral, including policies and procedures for the MCO to secure an appropriate referral and contact the member to offer scheduling assistance and transportation. | ☑ Yes | 1.000 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.7.5.1.6 (E/W); CRA § 2.7.6.1.6 (Middle); CRA § 2.6.13.1.6 (TCS)*

The Provider Manual informed providers that coordination of services for children should be done in accordance with TENNderCare requirements and that all referrals must be documented in the member's chart. The MCO included its toll-free telephone number for CM and instructed providers to call if assistance was needed with appointments or transportation. P&P #HS QM PWE 1 supported these instructions by stating that "Upon notification from a provider of the inability to make an appropriate referral, a care manager arranges a referral and offers scheduling assistance and transportation." The CM Manager indicated that this process was in place and documented in CareOne by CM staff.

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| **14 Medically necessary services** | | | 1.000 | 1.000 |
| The MCO has procedures in place to provide all medically necessary EPSDT services as required by law, including policies and procedures for educating providers about the necessity of documenting all components of a screen with accurate coding. | ☑ EPSDT services | 0.500 | | |
| | ☑ Educating providers | 0.500 | | |

*CD ¶ 54; CRA § 2.6.3.5 (E/W and Middle); CRA § 2.6.3.1 (TCS)*

P&P HS QM PWE 1 indicated that all medically necessary EPSDT services would be provided to TENNderCare-eligible members. The P&P also indicated that provider records would be monitored for appropriate coding and completion of EPSDT screenings. Providers were educated about documenting and coding all components of a TENNderCare screening in the Provider Manual. Instructions included details of the components of and correct billing codes for screening. Codes for preventive medicine visits, developmental, hearing and vision screenings were listed.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **15 Rehabilitation and maintenance services** | | | 0.500 | 0.500 |
| Rehabilitation services include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts for maximum reduction of physical or mental disability and restoration of a recipient to the best possible functional level. (These services may be, and where medically necessary to do so are, delivered in conjunction with the services listed in ¶ 54 of the John B. CD.) Covered services include maintenance services that prevent or mitigate the worsening of conditions or prevent the development of additional health problems. | ☑ Rehabilitation services provided as described | 0.250 | | |
| | ☑ Covered services include maintenance as described | 0.250 | | |

*CD ¶ 63 and 64*

P&P HS QM PWE 1 stated that "AmeriChoice provides all necessary healthcare, diagnostic services, treatment, and other measures to correct or ameliorate, or prevent from worsening; defects, physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan." The Provider Manual included similar statements indicating that all medically necessary services would be furnished for TENNderCare-eligible members.

| | | | | |
|---|---|---|---|---|
| **16 Medical necessity** | | | 2.000 | 2.000 |
| The MCO has a procedure that ensures consistent decisions are rendered concerning issues of medical necessity, which are compliant with federal and state laws. Only the definition of "medical necessity" as defined in the TennCare/MCO contract is used, or is no more restrictive than the definition in the contract. | ☑ Procedure in place | 0.500 | | |
| | ☑ Definition of medical necessity same as contract or no more restrictive | 0.500 | | |
| | ☑ Evidence of consistent decisions (e.g., Inter-Rater Reliability [IRR] testing) | 0.500 | | |
| | ☑ Appropriate follow-up to results of consistent decision process, as applicable | 0.500 | | |

*CD ¶ 55 and 56; CRA § 2.6.3.1 and .5 (E/W, Middle and TCS)*

The 2009 Sox Audit Summary indicated that UM cases were audited monthly to ensure compliance with MCO policies and procedures, clinical guidelines, CRA, the Centers for Medicare and Medicaid Services and the National Committee for Quality Assurance standards. P&P #HS UM 1: Medical Necessity Review indicated that the MCO used the definition of medical necessity as defined by the CRA. UM medical directors were audited annually. All medical directors scored above the required 90 percent compliance established by the MCO. UM staff scores were also expected to be at 90 percent or above. Staff who scored lower than the requirement were identified for additional training. The MCO provided examples of staff who received additional group and one on one training.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **17 Limitations/Capitations/Delays** | | | 0.750 | 0.750 |
| The MCO demonstrates that it does not impose benefit limitations, duration/scope limitations or monetary capitations upon EPSDT services. Services are provided based upon each child's individual needs. Utilization controls do not unreasonably delay the initial or continued receipt of services. | ☑ No limits/capitations | 0.250 | | |
| | ☑ Services based on individual needs | 0.250 | | |
| | ☑ UM controls do not delay services | 0.250 | | |

*CD ¶ 55(a) and 57; CRA § 2.6.3.2 and .4-.5 (E/W and Middle); CRA § 2.6.3.1 and .4-.5 (TCS)*

P&P #HS QM PWE 1 included multiple statements that indicated all medically necessary EPSDT services were covered for members. UM decisions were based on the individual needs of the child. Medically necessary services were to be provided regardless of whether they were covered by the plan. UM denials did not indicate any delays of services as a result of UM controls.

| | | | | |
|---|---|---|---|---|
| **18 Qualified UM personnel** | | | 3.000 | 3.000 |
| The MCO has a process in place that guarantees only qualified personnel with education, training or experience in child and adolescent health are employed to make utilization review and prior authorization decisions for members 20 and under. | ☑ Process in place | 0.500 | | |
| | ☑ Staff #1 trained/educated | 0.250 | | |
| | ☑ Staff #2 trained/educated | 0.250 | | |
| Personnel making utilization review and prior authorization decisions for members 20 and under are trained or experienced as described above. | ☑ Staff #3 trained/educated | 0.250 | | |
| | ☑ Staff #4 trained/educated | 0.250 | | |
| | ☑ Staff #5 trained/educated | 0.250 | | |
| | ☑ Staff #6 trained/educated | 0.250 | | |
| | ☑ Staff #7 trained/educated | 0.250 | | |
| | ☑ Staff #8 trained/educated | 0.250 | | |
| | ☑ Staff #9 trained/educated | 0.250 | | |
| | ☑ Staff #10 trained/educated | 0.250 | | |

*CD ¶ 58*

The QI Program Description indicated that only appropriately trained staff were responsible for UM decisions. This included registered nurses, licensed behavioral health clinicians (i.e., clinical social workers, professional counselors or senior psychological examiners) and physicians. P&P #HS UM 1 indicated that only a medical director made decisions on cases not meeting medical necessity criteria. Ten UM staff were selected for review. Licenses were verified and found to be current for all 10 staff. Resumes and education background were also reviewed. All staff received appropriate training and possessed sufficient experience to make UM decisions for members 20 and under.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **19 Services without prior authorization** | | | 1.000 | 1.000 |
| The MCO ensures that all medically necessary covered services (including interperiodic screens and continuation of services) are provided, whether the condition existed prior to any screening and regardless of whether or not the need for such services was identified by a provider whose services had received prior authorization from the MCO or by a network provider. | ☑ Yes | 1.000 | | |
| | ☐ No | 0.000 | | |

*CD ¶ 41(m), 42(c), 55(d) and 59; CRA § 2.7.5.1.7 (E/W); 2.7.6.1.7 (Middle); 2.6.13.1.7 (TCS)*

P&P #HS QM PWE 1 indicated that all medically necessary services were provided for members under the age of 21 regardless of whether or not the condition existed prior to a screening or the need for services was identified by a provider who received prior authorization from the MCO. Services were also provided regardless of the network status of the provider. P&P #HS UM 10: PriorAuth and Referral Exceptions indicated that prior authorization was not required for any EPSDT services.

| | | | | |
|---|---|---|---|---|
| **20 Specialist list** | | | 0.750 | 0.750 |
| The MCO demonstrates that it provides PCPs participating in EPSDT with an up-to-date list of specialists to whom referrals may be made for screens, lab tests, further diagnostic services and corrective treatment. The list is supplemented quarterly to indicate additions and deletions. The MCO also maintains an updated electronic, web-accessible version of the referral provider listing. | ☑ Yes | 0.750 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.14.3.5.1 (E/W, Middle and TCS); CD ¶ 62*

Mailing verifications showed that referral listings were mailed to PCPs in each quarter of 2009. The Provider Manual contained instructions for either contacting the MCO (toll-free telephone number included) or accessing the website for information on how to make referrals. Online provider directories were updated nightly via information received from Facets, the MCO's claims and network information system.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **21 MCO CM** | | | 0.750 | 0.750 |
| MCO CM services are provided consistent with federal law by providing assistance "in gaining access to needed medical, social, educational and other services." The MCO ensures that the CM provided "centers on the process of collecting information on health needs of the child, making and following up on referrals as needed, activating the examination/diagnosis/ treatment 'loop.'" Notification of the time members are due to receive a screening service is also a focus of the program. | ☑ Consistent with federal law | 0.250 | | |
| | ☑ Focused on information collection, making and following up on referrals | 0.250 | | |
| | ☑ Notification due for screening | 0.250 | | |
| *CD ¶ 66 and 68; CRA § 2.7.5.4.8(19) (E/W); CRA § 2.7.6.4.8(19) (Middle); CRA § 2.6.13.4.8(19) (TCS)* | | | | |

P&P HS QM PWE 1 indicated extensive CM involvement in multiple aspects of TENNderCare services provided by the MCO. CM staff assisted providers with referrals, made contact with pregnant members and assisted with appointment scheduling. The CM Manager indicated that initial assessments were conducted on all CM referrals and included assessments of medical and behavioral health needs and subsequent referrals as appropriate. CM staff followed up on referrals with members as soon as two weeks after the referral was made, but no later than 30 days. The CM system included specific assessments for pediatric and adolescent referrals. CM staff were able to access the MCO's UTD to determine a member's screening status. Staff were also kept aware of screenings that were due through follow up of the member's plan of care. These were flagged for follow up at least every 30 days. All initial CM assessments included an inquiry of the presence of children in the home, number of children and their EPSDT status, including the date of the most recent screening.

| | | | | |
|---|---|---|---|---|
| **22 Medically necessary CM services** | | | 1.000 | 1.000 |
| Mental health CM services, for children whose behavioral health needs require these services, are provided to all TennCare children for whom they are medically necessary. | ☑ Yes | 1.000 | | |
| | ☐ No | 0.000 | | |
| *CD ¶ 69* | | | | |

All CM cases were screened for behavioral health needs during the initial assessment. If the screening revealed the presence of behavioral health needs, a full behavioral assessment was performed in addition to the initial assessment. At this time the CM staff would assist the member with locating appropriate community resources or a behavioral health provider. If CM staff identified the presence of a behavioral health crisis during the assessment, appropriate MCO staff were contacted. P&P #HS QM PWE 1 indicated that CM staff were available to assist PCPs with behavioral health referrals when needed.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **23 CM central function** | | | 1.500 | 1.500 |
| EPSDT CM activities are a central function of the MCO, as evidenced by CM activities being integrated throughout the operations of the MCO. CM activities are individualized based on needs of the child and are not used only as a tool for prior authorizations. | ☑ Integrated throughout MCO | 0.750 | | |
| | ☑ Activities individualized | 0.750 | | |

*CD ¶ 70*

During interviews with the CM Manager and HFS Health Coach, it was evident that the MCO's CM activities crossed over to multiple areas within the organization. CM staff worked with members to develop a plan of care, which they followed up on at least every 30 days, and assisted the members in obtaining referrals for appropriate services. Such activities were conducted based on the needs of the member as identified through the initial CM assessment. They were not used as prior authorization tools. Medical and behavioral CM staff worked with one another to determine the most appropriate area of primary focus for the child. If the child was placed in behavioral CM, staff in that area consulted with medical CM staff as appropriate. The MCO provided an example of a case where the member's needs for additional therapy services were coordinated between medical and behavioral staff, and included input from the member's mother.

| | | | | |
|---|---|---|---|---|
| **24 Family involvement and accessible services** | | | 1.500 | 1.500 |
| Parents and family members are involved, to the greatest extent possible, in the determination of behavioral health services to be delivered to a particular child. The MCO provides a comprehensive and appropriate scope of geographically accessible child and adolescent behavioral health services in a range of treatment settings. | ☑ Parent/Family involvement | 0.375 | | |
| | ☑ Comprehensive/Appropriate scope | 0.375 | | |
| | ☑ Geographically accessible | 0.375 | | |
| | ☑ Range of treatment settings | 0.375 | | |

*CD ¶ 71(i and ii)*

The Manager of CM (Behavioral Health) provided examples of member cases which showed family member involvement in determining appropriate treatment of a child. CM notes indicated extensive efforts by the CM to work with families on obtaining the appropriate level of care. The CM also worked with facilities to assist each member's family in accessing the inpatient treatment required for the members. The MCO is contracted with all inpatient mental health facilities that provide services to children and adolescents in each region of the state. Services that were offered to families included inpatient options and therapeutic foster care. Family members were also offered assistance in coping with the children's behavioral health conditions.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **25 Follow-up after inpatient or residential treatment** | | | 2.000 | 2.000 |
| The MCO ensures through coordination efforts with its contracted facilities that psychiatric hospital and residential treatment facility discharges do not occur without a discharge plan in which the member, his/her family, or other caregivers, clinicians and social worker(s) have participated. This discharge plan includes an outpatient visit scheduled before discharge, which ensures access to proper provider/medication follow-up. Also, an appropriate placement or housing site is secured prior to discharge. | ☑ Discharge plan completed | 0.500 | | |
| | ☑ Required persons participated | 0.500 | | |
| | ☑ Outpatient appointment scheduled | 0.500 | | |
| | ☑ Appropriate placement or housing secured | 0.500 | | |

*CD ¶ 71(iii); CRA § 2.9.6.3.2 (E/W and TCS); CRA § 2.9.9.3.2 (Middle)*

The CM Manager (Behavioral Health) provided an example of discharge planning conducted as a member was prepared for discharge from a residential treatment facility. The case notes indicated that the MCO CM, facility CM and family were involved in determining the course of care to be provided upon discharge. The MCO CM also coordinated with the facility CM to ensure member had appropriate access to a provider upon discharge for medication follow-up. The MCO CM also worked with the member's family to ensure a safe home environment for the member and member's family.

| | | | | |
|---|---|---|---|---|
| **26 Screening components including follow-up** | | | 0.500 | 0.500 |
| The MCO has procedures in place for ensuring that all TENNderCare screens contain all required components, including follow-up components if all components of a screen cannot be completed in a single visit or whenever concerns or questions remain after the screening process. | ☑ Yes | 0.500 | | |
| | ☐ No | 0.000 | | |

*CD ¶ 41(a)-(l) and (n.v); CRA § 2.7.5.1.4 (E/W); CRA § 2.7.6.1.4 (Middle); CRA § 2.6.13.1.4 (TCS)*

The MCO used its Provider Manual to instruct providers that all parts of a TENNderCare screening should be documented in the medical record, and that in the event any part of a screening was not completed, a follow-up appointment should be scheduled. The MCO assessed provider compliance with this requirement during EPSDT medical record reviews. The TENNderCare Clinical Documentation Exit Summary Tool was used by MCO staff to discuss record review findings with providers/office staff. Providers were also given a handout at the time of the medical record review that included the excerpt from the Provider Manual with the TENNderCare documentation requirements.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **27 Interperiodic screen** | | | 1.000 | 1.000 |
| The MCO demonstrates that any encounter with a health professional practicing within the scope of his/her practice is an interperiodic screen and that any person who suspects a problem may refer a child for an interperiodic screen. An interperiodic screen does not have to include any screening elements required for a periodic screen. | ☑ Any encounter is interperiodic screen | 0.500 | | |
| | ☑ No required screening elements | 0.500 | | |

*CD ¶ 42(a) and (b)*

The MCO's provider manual indicated that interperiodic screenings were available whenever anyone (e.g., parent, guardian or teacher) identifies the need for a screening. The Member Handbook also contained language informing parents/guardians that if someone else, like a teacher, was concerned about the child's health, a screening could be obtained. P&P HS QM PWE 1 defined interperiodic screenings as "any encounter with any provider practicing within the scope of his/her license that does not include the screening elements required for a periodic TENNderCare exam. Anyone such as an educator, parent, or health professional who suspects a problem may refer a child for an interperiodic screening."

| | | | | |
|---|---|---|---|---|
| **28 Prior authorization prohibited** | | | 0.500 | 0.500 |
| The MCO does not impose prior authorization requirements on interperiodic screens conducted by the PCP. | ☑ Yes | 0.500 | | |
| | ☐ No | 0.000 | | |

*CD ¶ 42(c); CRA § 2.7.5.1.7 (E/W); CRA § 2.7.6.1.7 (Middle); CRA § 2.6.13.1.7 (TCS)*

P&P HS QM PWE 1 stated that the MCO did not require prior authorization for interperiodic screenings. The MCO's Physician, Health Care Professional, Facility and Ancillary Administrative Guide informed providers that "Interperiodic screens are available whenever a person like a teacher or parent notices a change that might require a screening."

| | | | | |
|---|---|---|---|---|
| **29 Screening standards met** | | | 1.500 | 1.500 |
| The MCO demonstrates that EPSDT screening standards are met or that all children who have not received complete screenings have been subject to outreach efforts reasonably calculated to ensure participation. In the event that screening rates do not meet compliance standards, the MCO may demonstrate compliance by showing that such failure to achieve standards was due to factors beyond the MCO's control. | ☑ Yes | 1.500 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.7.5.1.1 (E/W); CRA § 2.7.6.1.1 (Middle); CRA § 2.6.13.1.1 (TCS); CD ¶ 51*

The screening rate for 2009 was 101.76 percent. The MCO continued to conduct multiple forms of outreach for all TENNderCare-eligible members throughout 2009. This included numerous community events throughout the year.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **30 Transportation** | | | 2.000 | 2.000 |
| The MCO has protocols and procedures for ensuring access to non-emergency transportation services in accordance with state and federal laws. The MCO does not place blanket restrictions/requirements because of age or lack of parental accompaniment. Transportation assistance includes related travel expenses, meals, lodging, and cost of an attendant to accompany the child if necessary. The MCO has protocols/procedures for making referrals to TennCare transportation providers. | ☑ Protocols and procedures | 0.500 | | |
| | ☑ No blanket restrictions | 0.500 | | |
| | ☑ Assistance is inclusive of identified components | 0.500 | | |
| | ☑ Protocols for transportation referral | 0.500 | | |

*CD ¶ 74-77; CRA § 2.7.5.4.6 (E/W); CRA § 2.7.6.4.6 (Middle); CRA § 2.16.13.4.6 (TCS)*

P&P #GR NEMT A.4: Approving NEMT Services outlined the MCO's procedures for providing members access to transportation services as well as referring members to transportation providers. P&P #HS QM PWE 1 stated that "AmeriChoice provides TENNderCare transportation assistance, for a child to include related travel expenses, cost of meals, and lodging in route to and from care, and the cost of an attendant to accompany child if necessary." This same P&P also indicated that blanket restrictions were not used when determining a child's needs for transportation services.

| | | | | |
|---|---|---|---|---|
| **31 Program coordination** | | | 1.000 | 1.000 |
| The MCO coordinates TENNderCare outreach, screening, and treatment services with other children's health and education services and programs. | ☑ Yes | 1.000 | | |
| | ☐ No | 0.000 | | |

*CD ¶ 78; CRA § 2.7.5.1.3 (E/W); CRA § 2.7.6.1.3 (Middle); CRA § 2.6.13.1.3 (TCS)*

P&P #HS QM PWE 3: Health Education and Outreach Programs and Activities described the MCO's activities and efforts to coordinate TENNderCare services with other agencies and its efforts to engage members through outreach activities. Such activities were to include, but not be limited to the following: health fairs, baby showers, faith-based activities, school-based screenings and parent-teacher organizations.

STRENGTH: As part of the Emergency Department (ED) Diversion program, the MCO identified children with more than five ED visits in a seven- month period to determine if they had a medical home. During this process, several members were identified whose "troublesome patterns of service utilization" ultimately resulted in referrals and coordination with Department of Children Services.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **32 Individual education plans (IEPs)** | | | 1.000 | 1.000 |
| The MCO has a process to facilitate coordination of EPSDT services when TennCare-enrolled children have been identified as needing to receive medically related services in an educational setting, as listed in their IEPs. Annually, TennCare sends a letter to all School Directors and Special Education Directors requesting the IEPs on behalf of the MCOs. If the MCO becomes aware that a member has an IEP (for example, through the internal CM process), then the MCO is obligated to request a copy of the IEP from the school.<br><br>After receipt of the IEP, the MCO:<br>● either accepts the IEP as indication of a medical problem and treats the IEP as a request for service to which the MCO responds within 14 days or assists in making an appointment to have the child appropriately evaluated within the time frames specified in the TennCare Waiver Terms and Conditions for access to care;<br>● sends a copy of the IEP and related information to the PCP; and<br>● notifies the designated school contact of the ultimate disposition of the request.<br><br>Coordination by the MCO is calculated to reduce gaps and overlaps in services. | ☑ Requests IEPs | 0.200 | | |
| | ☑ Accepts problem or has tested | 0.200 | | |
| | ☑ Shares with PCP | 0.200 | | |
| | ☑ Notifies school contact of disposition of request | 0.200 | | |
| | ☑ Coordination calculated to reduce gaps and overlaps | 0.200 | | |

*CD ¶ 81; TENNderCARE Connection Policy; CRA § 2.9.11.5.1, 2.9.11.5.2 and 2.9.11.5.2.1-.3 (E/W); CRA § 2.9.14.8.1, 2.9.14.8.2 and 2.9.14.8.2.1-.3 (Middle); CRA § 2.9.12.6.1, 2.9.12.6.2 and 2.9.12.6.2.1-.3 (TCS)*

P&P #HS CM 11: Coordinating Services For a child With an Individualized Education Program (IEP) described the MCO's process for ensuring that members with IEPs receive the necessary services. All components listed above were identified in the P&P. Attachment B of the P&P, Individualized Education Program/IEP Workflow Process, also contained all components listed above. The CM Manager described the process in place by the MCO which mirrored that outlined in its P&P. She also provided an example of an IEP from the IEP Tracking Database. The database included a field that identified when the IEP was sent to the member's PCP. This process was effective in reducing gaps and overlaps in care.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **33 Tracking system** | | | 2.000 | 2.000 |
| Tracking system data is used to take action to improve the EPSDT services. The tracking system information has been utilized to contact providers regarding the need to set appointments for the individual member. The tracking system information has been used to contact parents/ guardians/members regarding the need to make an appointment and receive EPSDT services. (For more detailed information refer to EPSDT Information System Tracking Review Tool). | ☑ Contact providers | 1.000 | | |
| | ☑ Contact parent/guardian/member | 1.000 | | |

*CD ¶ 94; CRA § 2.7.5.1.8 and 2.7.5.2.4 (E/W); CRA § 2.7.6.1.8 and 2.7.6.2.4 (Middle); CRA § 2.6.13.1.8 and 2.6.13.2.4 (TCS)*

The MCO's tracking system was reviewed during Performance Activity file review. Members who were noncompliant with TENNderCare screens were referred to providers for outreach and appointment scheduling, and were subject to all appropriate outreach efforts by the MCO.

SUGGESTION: The MCO used its online provider portal to supply PCPs with current lists of members not up-to-date on TENNderCare screens. Providers were instructed to use this list to identify members who needed to be contacted for appointment scheduling. Provider newsletters and training conducted by the Provider Relations department informed PCPs of the list and how to access it. Hard copy lists were also made available upon request. To further ensure that PCPs use the online TENNderCare list, the MCO could include more specific instructions in newsletters and training that directs the PCP to the website.

| | | | | |
|---|---|---|---|---|
| **34 EPSDT language in contracts** | | | 1.750 | 1.750 |
| All contracts with appropriate providers contain language requiring the EPSDT elements:<br>● comprehensive health history<br>● comprehensive physical exam<br>● laboratory testing<br>● vision and hearing testing<br>● dental screening<br>● health education<br>● immunizations | ☑ Comprehensive health history | 0.250 | | |
| | ☑ Comprehensive physical exam | 0.250 | | |
| | ☑ Laboratory testing | 0.250 | | |
| | ☑ Vision and hearing testing | 0.250 | | |
| | ☑ Dental screening | 0.250 | | |
| | ☑ Health education | 0.250 | | |
| | ☑ Immunizations | 0.250 | | |

*CRA § 2.12.7.48 (E/W and TCS); CRA § 2.12.9.56 (Middle)*

Provider contracts informed providers that all requirements in the provider manual must be followed. Medical Records Standards for TENNderCARE (EPSDT) Examinations in the provider manual were specific to the required exam components.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **35 EPSDT contract review** | | | 0.500 | 0.500 |
| Review of contracts ensures that there are no provisions which would encourage violations of EPSDT mandate. | ☑ Yes (no provisions) | 0.500 | | |
| | ☐ No | 0.000 | | |

*CD ¶ 102*

Provider agreements were reviewed, and no provisions were found that would encourage violations of the John B. CD.

**Total Score: 37.250 out of 39.500 = 94.3 % Compliance**

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Grier Revised Consent Decree** | | | | |
| **1 Appeals unit** | | | 0.750 | 0.750 |
| The MCO has sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting members. | ☑ Yes<br>☐ No | 0.750<br>0.000 | | |
| *Grier Revised CD; CRA § 2.19.2.3 (E/W and TCS); CRA § 2.19.3.3 (Middle)* | | | | |
| The Appeals Organization Chart indicated that the MCO had sufficient staff (one Manager, one nurse and nine Clinical Appeals Reviewers) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting members. | | | | |
| **2 Grier/Appeals procedures** | | | 0.500 | 0.500 |
| The MCO has internal appeal procedures for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees, or court orders governing the appeals process. | ☑ Yes<br>☐ No | 0.500<br>0.000 | | |
| *CRA § 2.19.1 (E/W, Middle and TCS)* | | | | |
| P&P #GR 12.2: Member Complaint and Appeal Process-(TennCare Only) describes the MCO's internal appeal procedure for members in accordance with the TennCare rules and regulations, the TennCare waiver, consent decrees or court orders governing the appeals process. | | | | |

**Total Score: 1.250 out of 1.250 = 100 % Compliance**

# 2010 Annual Quality Survey - Quality Process Standards

CONFIDENTIAL

AmeriChoice-West

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Non-Discrimination Compliance** | | | | |
| **1 Non-Discrimination Compliance Plan** | | | 0.250 | 0.250 |
| There is documentation of the MCO's annual submission of a Non-Discrimination Compliance Plan to TennCare, no later than 90 days after the end of the calendar year. | ☑ Yes | 0.250 | | |
| | ☐ No | 0.000 | | |
| *CRA § 2.30.20.5 (E/W and TCS); CRA § 2.30.21.5 (Middle)* | | | | |
| An e-mail from MCO to TennCare indicated the submission of Non-Discrimination Compliance for 2008 on 03/31/09. | | | | |
| **2 Assurance of Non-Discrimination** | | | 0.250 | 0.250 |
| There is documentation of the MCO's annual submission of its Assurance of Non-Discrimination Certification, which has been signed and dated by the MCO's Chief Executive Officer (CEO) or his/her authorized agent. The annual date of the Assurance coordinates with the annual date of the Non-Discrimination Compliance Plan as documented in Element #1 above. (The certification is the MCO's assurance of compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981, the Church Amendments, Public Health Service Act Sec. 245 and the Weldon Amendments.) | ☑ Documented submission of signed and dated Assurance | 0.125 | | |
| | ☑ Date of Assurance coordinates with Non-Discrimination Compliance Plan | 0.125 | | |
| *CRA § 2.30.20.5 (E/W and TCS); CRA § 2.30.21.5 (Middle)* | | | | |
| An e-mail from MCO to TennCare indicated the submission of Annual Non-Discrimination Title VI Compliance & Assurance Plans for 2008 on 3/31/09.The MCO's Assurance of Non-Discrimination certification was signed and dated by the MCO's CEO on 3/31/09.The annual date of the Assurance coordinates with the annual date of the Non-Discrimination Compliance Plan as documented in Element #1 above. | | | | |

# 2010 Annual Quality Survey - Quality Process Standards

CONFIDENTIAL

AmeriChoice-West

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Non-Discrimination Compliance** | | | | |
| **3 Display of non-discrimination posters** | | | 0.250 | 0.000 |
| Posters informing MCO employees of their rights and obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 are displayed in conspicuous places, such as breakrooms, lunchrooms, human resource offices and near elevators. | ☐ Yes<br>☑ No | 0.250<br>0.000 | | |

*CRA § 4.32.3 (E/W and Middle); CRA § 5.21 (TCS)*

Posters located in the breakroom did not have information on the Omnibus Budget Reconciliation Act of 1981.

AREA OF NONCOMPLIANCE: The MCO should include the information on the posters located in their breakrooms informing their employees regarding the Omnibus Budget Reconciliation Act of 1981. The MCO should continue to include the current information like employees rights and obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990 and the Age Discrimination Act of 1975.

# 2010 Annual Quality Survey - Quality Process Standards

CONFIDENTIAL

AmeriChoice-West

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Non-Discrimination Compliance** | | | | |
| **4 Non-discrimination written materials** | | | 0.500 | 0.500 |
| All vital MCO documents and member materials are made available to members in compliance with the LEP requirements of Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act of 1990. | ☑ Documents are translated as described | 0.250 | | |
| | ☑ Written materials made available in alternate formats at no cost | 0.250 | | |

There is evidence that they are being provided as noted below:

- All vital MCO documents and member materials are translated and available in Spanish. Within 90 calendar days of notification from TennCare, all vital MCO documents are translated and available to each LEP group identified by TennCare that constitutes five percent of the TennCare population or 1,000 members, whichever is less;
- All written materials are made available in alternative formats for persons with special needs, or appropriate interpretation/translation services are provided by the health plan at no cost to the member; and
- The MCO can show proof of its capability to provide vital documents to members with impaired sensory skills (visually impaired) who require communication assistance in alternative formats.

*CRA § 1 and 2.17.2.5-.7 (E/W and Middle); CRA § 1.3 and 2.17.2.5-.7 (TCS)*

P&P #GR 24.1.1 stated that all vital MCO documents and member materials are being translated into Spanish. Also, if any LEP group is identified the MCO would translate the documents and make them available to the members within 90 days of notification from TennCare. There were no LEP groups identified in 2009, and hence no vital documents were needed to be translated. The policy also stated that all written materials are made available in an alternative format at no cost to persons with special needs. The Manager of TennCare Compliance mentioned that all vital documents would be available to members with impaired sensory skills in alternative formats such as live interpretation service.

# 2010 Annual Quality Survey - Quality Process Standards

CONFIDENTIAL

AmeriChoice-West

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Non-Discrimination Compliance** | | | | |
| **5 Written policy and procedure** | | | 1.000 | 1.000 |
| The MCO has a written policy and procedure on file for the provision of language interpretation and translation services for any member with LEP. The policy and procedure also addresses the provision of language assistance for members who require communication assistance in alternative formats (e.g., members who are visually impaired, deaf and/or deaf/blind). It has been approved by TennCare. | ☑ Language interpretation and translation services addressed; | 0.200 | | |
| | ☑ Communication assistance in alternative formats addressed; | 0.200 | | |
| The MCO shows that it:<br>● instructs its staff, including but not limited to all providers and direct service subcontractors, regarding the policy and procedure; and<br>● has available language/communication help-lines with specific numbers that are made known to its members and subcontractors for the provision of member translation services and communication assistance in alternative formats. | ☑ Staff, providers and direct service subcontractors instructed; | 0.200 | | |
| | ☑ Proof of available help-lines demonstrated; and | 0.200 | | |
| | ☑ Phone numbers made known to members and subcontractors. | 0.200 | | |

*CRA § 2.18.1.3, 2.28.2-.3 and 2.30.20.4 (E/W and TCS);*
*CRA § 2.18.1.3, 2.28.2-.3 and 2.30.21.4 (Middle)*

P&P #GR 24.1.1 addressed the provision of language interpretation and translation services for any member with LEP, and the provision of language assistance to members who require communication in alternative format. The inclusion of visually impaired or blind members could have been more explicit. An email from TennCare to the MCO provided the proof of approval of the policy. The Tackling TennCare Training PowerPoint presentation instructed the staff regarding the policy and procedures. The Member Handbook and the Physician, Health Care Professional, Facility and Ancillary Administrative Guide, as well as the MCO's website facilitated the providers and direct service subcontractors with information on policy and procedure. The Member Handbook and the Physician Health Care Professional, Facility and Ancillary Administrative Guide included the language/communication help-lines with specific numbers that were made available to members and subcontractors for the provision of member translation services and communication assistance in alternative formats.

SUGGESTION: The health plan's policy and procedure regarding language and interpretation services could more clearly state that assistance is available to visually impaired or blind members.

# 2010 Annual Quality Survey - Quality Process Standards

CONFIDENTIAL

AmeriChoice-West

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Non-Discrimination Compliance** | | | | |
| **6 Complaint resolution and reporting** | | | 1.000 | 1.000 |
| The MCO has on file a written policy and procedure, approved by TennCare, for monitoring, investigating and resolving discrimination complaints. The MCO has written documentation that all discrimination complaints are investigated and resolved. The MCO submits a quarterly *Alleged Discrimination Report* to TennCare. The report lists all complaints of alleged discrimination filed against the MCO by employees, members, providers and subcontractors. | ☑ Policy and procedure | 0.200 | | |
| | ☑ Approved by TennCare | 0.200 | | |
| | ☑ Complaints documented, investigated and resolved, and are reported quarterly | 0.300 | | |
| | ☑ Quarterly report submitted with required information | 0.300 | | |

*CRA § 2.28.7 and 2.30.20.3 (E/W and TCS); CRA § 2.28.7 and 2.30.21.3 (Middle)*

P&P #AD CL 4: Non-discrimination Complaint Resolution addressed the process for monitoring, investigating and resolving discrimination complaints. The Desk Audit Tool provided the proof of approval of the policy. The Quarterly Non-Discrimination Compliance Report for all four quarters indicated that all discrimination complaints were investigated and resolved. An email from TennCare to the MCO indicated that the quarterly Alleged Discrimination Reports were received by TennCare. The report list included all complaints of alleged discrimination filed by employees, members, providers and subcontractors.

| | | | | |
|---|---|---|---|---|
| **7 Member Handbook notification and Complaint Form** | | | 0.500 | 0.500 |
| The MCO has included a notice of the right to file a discrimination complaint and a copy of a Discrimination Complaint Form in its English and Spanish Member Handbooks. | ☑ Notice of right placed in Member Handbooks | 0.250 | | |
| | ☑ Copy of form placed in English and Spanish Member Handbooks | 0.250 | | |

*CRA § 2.17.4.5.11 (E/W and TCS); CRA § 2.17.4.7.19 (Middle)*

The MCO included a notice of the right to file a discrimination complaint and a copy of a Discrimination Complaint Form in its English and Spanish Member Handbook.

# 2010 Annual Quality Survey - Quality Process Standards

CONFIDENTIAL

AmeriChoice-West

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Non-Discrimination Compliance** | | | | |
| **8 Quarterly newsletter notification** | | | 0.500 | 0.500 |
| Each quarterly newsletter sent by the MCO to members includes a notice of the right to file a complaint and a contractor phone number for doing so, as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981. The notice is in English and Spanish. | ☑ Notice of right and a phone number for making complaint | 0.250 | | |
| | ☑ Notice is in English and Spanish | 0.250 | | |

*CRA § 2.17.5.3.3 (E/W and TCS); CRA § 2.17.5.3.5 (Middle)*

Each quarterly newsletter sent by the MCO to members include a notice of the right to file a complaint and a contractor phone number for doing so. The notice was in English and Spanish.

| | | | | |
|---|---|---|---|---|
| **9 Subcontractor compliance education** | | | 0.250 | 0.250 |
| The MCO can document that its subcontractors have been made aware of their obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981. | ☑ Yes | 0.250 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.26.5 (E/W and TCS); CRA § 2.26.7 (Middle)*

Physician, Health Care Professional, Facility and Ancillary Administrative Guide provided by the MCO to its subcontractors made them aware of their obligations under the necessary federal laws.

**Total Score: 4.250 out of 4.500 = 94.4 % Compliance**

# APPENDIX B | *Performance Activity Review Tool Instructions*

*for **AmeriChoice-West***

This section contains the instructions for the Annual Quality Survey (AQS) Performance Activity (PA) Review Tools for Managed Care Organizations (MCOs), 2010 Edition.

# *MCC Utilization Management (UM) Denials* (age 20 and younger only)—File Review Tool Instructions

***Authority:*** *Contractor Risk Agreement (CRA) between TennCare and Dental Benefits Manager (DBM)—§A.8.3.2.1; CRA between TennCare and East, Middle and West Managed Care Organizations (MCOs)—§ 2.6, 2.7, 2.13 and 2.14; CRA between TennCare and TennCareSelect—§ 2.6 and 2.9; and 42 Code of Federal Regulations (CFR) § 438.210 and .214, and § 431.211 and .213.*

## Time Standard

Review the MCC's policy and procedure regarding UM denials and note the maximum hours/days allowable for: 1) a decision to be made and 2) the member and provider to be notified of the decision to deny/reduce requested service. Then, compare the MCC's standards to the 21 days allowed by the CRA and to the CFR time frames listed below. **The time standard used for this review is the shortest of the three (MCC, CRA and CFR).** Record this number in the tool database and indicate whether this standard is based on calendar or business days.

The time frames the federal government has listed in 42 CFR § 438.210 and .214, and § 431.211 and .213 are as follows:

- *Standard authorization decisions* "may not exceed **14 calendar days** following receipt of the request for service, with a possible extension of up to 14 additional calendar days" if certain conditions apply.
- *Expedited authorization decisions* must be provided "as expeditiously as the…[member's] health condition requires and no later than 3 working days after receipt of the request for service." The MCC "may extend the 3 working days time period by up to 14 calendar days if the…[member] requests an extension, or if the MCC justifies a need for additional information and how the extension is in the…[member's] interest."
- *Timing of notice*. The health plan must mail the notice "…**at least 10 days before** the date of action, except … The agency [MCC] may mail a notice not later than the date of action if":
  a. the plan has factual information confirming the death of a…[member];
  b. the plan receives written notice from…[member] that she/he – "1) …no longer wishes services; or 2) gives information that requires termination or reduction of services and indicates that [she/he] understands that this must be the result of supplying that information;
  c. the…[member] has been admitted to an institution where she/he is ineligible under the plan for further services;
  d. the …[member's] whereabouts are unknown;
  e. the plan establishes the fact that the …[member] has been accepted for Medicaid services elsewhere;
  f. a change in the level of medical care is prescribed by the…[member's] physician;
  g. the notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or

h. the date of action will occur in less than 10 days, in accordance with § 483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of § 483.12(a)(5)(i)."

## Tool Components

Record the name of the MCC and the date of the review in the spaces provided.

Review the previously selected UM denial files for members under the age of 21 to complete **columns 2 – 15** on the *MCC UM Denials – File Review Tool* until there is a denominator of 10 files, all of which are denials. If a file is not applicable (i.e., anything other than a denial, or member is 21 years or older), it may be necessary to review additional files from the oversample to reach a denominator of 10 denials.

- **Column 1–File #:** This column is pre-populated with 1 through 10 to identify the number of files required for review.
- **Column 2–Case ID:** The Case ID represents the order of the file taken from the file review list (comprised of those files randomly abstracted from the MCC's data). The Case ID and the File # may not always match. For example, the first file examined (File # 1) may be the third file from the file review list (Case ID 3). This occurs when a file from the review list does not contain the required data for proper analysis. Because the Case ID is based on the file review list, QSource and the MCC are able to determine which file was reviewed should that be needed at a later date.
- **Column 3–Request Rcvd. Date:** Enter the month, day and year (MM/DD/YY) the request for the service or procedure was received by the MCC.
- **Column 4–Decision Made Date:** Enter the month, day and year (MM/DD/YY) the decision to deny was made.
- **Column 5–Wait (days) on Decision:** Enter the number of days it took the MCC to make the decision. Calculate by subtracting **column 3** from **column 4**.
- **Column 6–Decision Time Std.:** Enter the most stringent number of days after comparing MCC, CRA and CFR standards (e.g., if the MCC allows 10 days for a decision while the CRA allows 21 and the CFR allows 14, enter 10 days as the standard).
- Column 7 – Met Decision Time Std.: If column 5 is ≤ column 6, mark the "Y" cell. If column 5 is > column 6, mark the "N" cell.
- **Column 8–Decision Review Criteria Apropos to Condition:** Mark the "Y" cell in each row if a condition-appropriate review criterion was used to make the decision and to take action either to deny or reduce the amount, duration, or scope of the requested service; otherwise, mark the "N" cell.
- **Column 9–Consulted Requesting Provider as Apropos:** Mark the "Y" cell if the requesting provider was consulted prior to making the denial decision. Mark the "N" cell if not consulted, but there is evidence that she/he should have been. Otherwise, mark the "NA" cell.
- **Column 10–Final Denial by Qualified Med. Prof.:** A licensed physician or Doctor of Dental Surgery (DDS) must make all final denial and reduction of service decisions regarding inpatient hospital services. All other decisions to deny or reduce a service should be made

by a qualified clinical professional. Mark the "Y" cell if an appropriate professional made the decision; otherwise mark the "N" cell.

- **Column 11–Decision Not Arbitrary = Yes:** MCCs may not arbitrarily deny or reduce the amount, duration, or scope of a requested service solely because of the type of illness, diagnosis, or condition of the member. Mark the "Y" cell if the decision was NOT arbitrary; otherwise mark the "N" cell.
- **Column 12–Initial Notification Date:** Enter the month, day and year (MM/DD/YY) the MCC notified the member and provider about the decision to deny.
- **Column 13–Wait (days) to be Initially Notified:** Enter the number of business days it took the MCC to make the notification. Calculate by subtracting **column 3 from 12**.
- **Column 14–Initial Notification Time Std.:** Enter the most stringent number of days used to notify members and providers about a denial/reduction in service decision after comparing the MCC, CRA and CFR time standards.
- **Column 15–Met Initial Notification Time Std.:** If **column 13** is ≤ **column 14** mark the "Y" cell; otherwise mark the "N" cell.

## Scoring Directions

- **Applicable Answers, column 9:** Enter the number of cells in this column (i.e., all of those with "Ys" and "Ns"). All other columns for **Applicable Answers** are pre-populated with the applicable points for the number of files reviewed.
- **Compliant Answers, columns 7–11 and 15:** Enter the total number of **Compliant Answers** for each column (i.e., the number of "Y" cells).
- **Total Compliant:** Enter the sum of the numbers from **Compliant Answers**, **columns 7–11** and **15**.
- **Total Applicable:** Enter the sum of the numbers from **Applicable Answers**, **columns 7–11** and **15**.
- **Percent Compliant:** Divide the **Total Compliant** by the **Total Applicable** and enter that number as a percentage (e.g., 1/4 = 0.25 = 25 percent).

# *EPSDT Information System Tracking*—File Review Tool Instructions

***Authority:*** *John B. Consent Decree (EPSDT) ¶ 94; Contractor Risk Agreement (CRA) between TennCare and East, West and Middle Managed Care Organizations (MCOs)—§ 2.7.5.1; and CRA between TennCare and TennCareSelect—§ 2.6.13.*

## Tool Components

Record the name of the MCO and the date of the review in the spaces provided.

Review the previously selected EPSDT files to complete **columns 2–9** on the *EPSDT Information System Tracking–Review Tool* until there is a denominator of 10 files, all of which are EPSDT. If a file is not applicable (i.e., anything other than an EPSDT file), it may be necessary to review additional files from the oversample in order to reach a denominator of 10 EPSDT files.

- **Column 1–File #:** This column is pre-populated with 1 through 10 to identify the number of files required for review.
- **Column 2–Case ID:** The Case ID represents the order of the file taken from the file review list (comprised of those files randomly abstracted from the MCC's data). The Case ID and the File # may not always match. For example, the first file examined (File # 1) may be the third file from the file review list (Case ID 3). This occurs when a file from the review list does not contain the required data for proper analysis. Because the Case ID is based on the file review list, QSource and the MCC are able to determine which file was reviewed should that be needed at a later date.
- **Column 3–Medical Record (MR) or Information System (IS):** There are two rows per file for **columns 3–7.** The **MR** row is used to document information found in the member's medical record; the **IS** row is used to document information found in the health plan's IS tracking program.
- **Column 4–Receipt of Screening:** Mark the "Y" cell in the **MR** row if the member's receipt is documented in the medical record; otherwise, mark the "N" cell. Mark the "Y" cell in the **IS** row if the member's receipt is documented in the health plan's IS tracking program; otherwise, mark the "N" cell.
- **Column 5–Diagnosis Documented:** Mark the "Y" cell in the appropriate row if the diagnosis for this encounter is documented; otherwise, mark the "N" cell. Complete this process in the **MR** and **IS** rows for each file.
- **Column 6–Treatment, Immunization, Lab Work Documented:** Mark the "Y" cell in the appropriate row if any treatment, immunization or laboratory work was *done, given to* or *prescribed* for the member. Mark the "N" cell if none was *done, given* or *prescribed* but there is evidence that treatment, immunization, or laboratory work was indicated; otherwise, mark the "NA" cell.
- **Column 7–Ability to Determine Screening Status:** Mark the "Y" cell in the appropriate row if the member's current screening status is documented; otherwise, mark the "N" cell. Complete this process in the **MR** and **IS** rows for each file.

- **Column 8–Actions Taken to Improve Member's Screenings by Contacting Provider:** Mark the "Y" cell if the PCP was contacted regarding the need to set appointments for the member as a direct result of the information in the MCO's tracking system; otherwise, mark "N" cell. Mark the "NA" cell if contacting the PCP was not indicated because the medical record and tracking system showed evidence that the member was up to date.
- **Column 9–Actions Taken to Improve Member's Screenings by Contacting Parent/ Guardian/Member:** Mark the "Y" cell if the parent/guardian/member was contacted regarding the need to make an appointment and receive EPSDT services as a direct result of the information in the MCO's tracking system; otherwise, mark the "N" cell. Mark the "NA" cell if contacting the parent/guardian/member was not indicated because the medical record and tracking system showed evidence that the member was up to date.

## Scoring Directions

- **Applicable Answers, columns 6, 8 and 9:** Enter the applicable number of cells for each column (i.e., all of those with "Ys" and "Ns"). All other columns for **Applicable Answers** are pre-populated with the applicable points for the number of files reviewed.
- **Compliant Answers, columns 4–9:** For **columns 4–7** enter the total number of rows where the "Ys" or "Ns" are the same for each member. For **columns 8** and **9** enter the total number of rows that are marked "Y."
- **Total Compliant:** Enter the sum of the numbers from **Compliant Answers**, **columns 4–9**.
- **Total Applicable:** Enter the sum of the numbers from **Applicable Answers**, **columns 4–9**.
- **Percent Compliant:** Divide the **Total Compliant** by the **Total Applicable** and enter that number as a percentage (e.g., 1/4 = 0.25 = 25 percent).

# *MCC Appeals (Grier)* —File Review Tool Instructions

***Authority:*** *Grier v. Wadley Revised Consent Decree (Grier Revised CD) § C.7 and C.16.b; Tennessee Code Annotated (TCA) § 4-5-202, 4-5-301, et seq., 71-5-105 and 71-5-109; Executive Order No. 23 of 1999 (Amendment filed February 1, 2001, and made effective April 17, 2001); 42 Code of Federal Regulations (CFR) § 438.406 and .408; Contractor Risk Agreement (CRA) between TennCare and East, Middle, West and TennCare*Select *Managed Care Organizations (MCOs)—§ 2.19; and CRA between TennCare and Dental Benefits Manager (DBM)—§ A.17.*

## Tool Components

Record the name of the Managed Care Contractor (MCC) and the date of the review in the spaces provided.

**MCC decision time standards:** Review the MCC's policy and procedure regarding *Grier Revised CD* (appeal) handling. Record in the tool database the maximum number of hours/days allowable (most stringent) for appeal decisions. The *Grier Revised CD* maximum lengths of time for decisions are five days if expedited and 14 days if routine.

**MCC notification time standards:** From the policy, record in the tool database the number of days the MCC has determined to be the maximum amount of time allowable to notify the member of the decision, with regard to the concurrent-routine TennCare and CFR regulations. Indicate whether this standard is based on calendar or business days.

**For concurrent-routine:** The *Grier Revised CD* states that notice must be given **10 days** prior to action taking effect. **Two days** notice is allowed ***only*** if the member's provider initiates a reduction, termination, or suspension in the following instances:

- Any behavioral health service for a severely and persistently mentally ill adult member or severely emotionally disturbed child member;
- Any inpatient psychiatric or residential service;
- Any service being provided to treat a member's chronic condition across a continuum of services when the next appropriate level of medical services is not immediately available; or
- Home health services.

The Rules of the Tennessee Department of Finance and Administration, Bureau of TennCare, Chapters 1200-13-13 and 1200-13-14 state that in the "instances of Managed Care Contractor-initiated reduction, termination, or suspension of inpatient hospital treatment, the notice must be…at least 2 business days in advance of the proposed action. Where applicable and not in conflict with this rule, the exceptions set out at 42 CFR 431.211-.214 permit or require reduction of the time frames within which advance notice must be given."

Review the previously selected appeal files completing **columns 2–18** on the *MCC Appeals (Grier) – File Review Tool*. If a file is not applicable (i.e., anything other than an appeal), it may be necessary to review additional files from the oversample to reach a denominator of 10 appeals.

- **Column 1–File #:** This column is pre-populated with 1 through 10 to identify the number of files required for review.
- **Column 2–Case ID:** The Case ID represents the order of the file taken from the file review list (comprised of those fi**les** randomly abstracted from the MCC's data). The Case ID and the File # may not always match. For example, the first file examined (File # 1) may be the third file from the file review list (Case ID 3). This occurs when a file from the review list does not contain the required data for proper analysis. Because the Case ID is based on the file review list, QSource and the MCC are able to determine which file was reviewed should that be needed at a later date.
- **Column 3–E/R and C/N:** Indicate the type of file under review by writing an "E" (expedited) or "R" (routine) **AND** "C" (concurrent) or "N" (non-concurrent).
- **Column 4–Appeal Rcvd. Date:** Enter the month, day and year (MM/DD/YY) on which the appeal request was received by the MCC from the TennCare Solutions Unit.
- **Column 5–Authorization Request with Named Provider:** Mark the "Y" cell if the practitioner/provider is listed by name. If the appeal is from a practitioner/provider, or if the member wants the practitioner/provider to be able to provide a service and the practitioner/provider's name is not listed, mark the "N" cell. If no practitioner/provider was involved in the case (e.g., member appeals on behalf of him/herself), mark the "NA" cell.
- **Column 6–Reviewed by Same Practitioner Type as Requester:** If the appealed denial is being upheld, the file is to be reviewed by a qualified professional, which is a practitioner with experience in the condition for which the request was made. Mark the "NA" cell if the denial is being overturned. Mark the "Y" cell if a qualified professional reviewed the file. Mark the "N" cell if not reviewed by a qualified professional.
- **Column 7–Appeal Investigation Documented:** Mark the "Y" cell if the appeal was appropriately investigated; otherwise, mark the "N" cell. A proper investigation includes the following steps:
  - Documentation of the substance of the appeal and the MCC's actions, including any aspects of medical care involved;
  - Investigation of the appeal, including a description of the medical assistance requested;
  - The MCC considered any additional information provided by the member and/or practitioner/provider and determined if additional information was available that was not considered when it made the first decision; and
  - The MCC gathered information to help understand the member's report of the situation and collected information from involved MCC departments, as well as the practitioner/provider's office, if applicable.
- **Column 8–Decision Made Date:** Enter the month, day and year (MM/DD/YY) the appeal decision was sent to the member and/or the practitioner/provider. This can be delivered by mail, phone, fax, or other method as appropriate.
- **Column 9–Wait (days) on Decision:** Enter the number of days it took the MCC to make the decision. The date of receipt is day zero. Exclude state holidays and weekends if the standard is business days.

- **Column 10–Decision Time Std.:** Enter the most stringent number of days after comparing the MCC and *Grier Revised CD* standards (e.g., for an Expedited file, if the MCC allows 3 days for a decision and the *Grier Revised CD* allows 5 days, enter 3 days as the standard).
- **Column 11–Met Decision Time Std.:** If **column 9** is ≤ **column 10**, mark the "Y" cell; otherwise mark the "N" cell.
- **Column 12–Member Notified Date:** Enter the month, day and year (MM/DD/YY) on which the MCO notified the member of the resolution.
- **Column 13–Wait (days) to be Notified:** Enter the number of days it took the MCC to contact the member. The date of decision is day zero.
- **Column 14–Notification time standard (most stringent):** Enter the number of hours/days listed for the type of file after comparing the MCO and *Grier Revised CD* standards.
- **Column 15–Met Notification Time Std.:** If **column 13** is ≤ **column 14**, mark the "Y" cell; otherwise mark the "N" cell.
- **Column 16–Used State Letter Template and 6th Grade Level:** Mark the "Y" cell if the letter sent to the member met these requirements. The letter must include a statement of reasons for the decision (such as state rule or health plan provision). If the letter was not the appropriate template from the Bureau of TennCare, mark the "N" cell.
- **Column 17–Instructions on contesting:** For cases where the denial was upheld, mark the "Y" cell if the letter contains instructions on how to contest decisions at the MCO level **and** if those instructions include all three of the following components:
  - Information about the opportunity to contest the decision;
  - Instructions on how to contest the decision, including the right to an expedited process concerning urgent care; and
  - An explanation of the circumstances under which on-going medical services will be continued if a hearing is requested.

  Mark the "N" cell if the denial was upheld but not all components were included. Mark the "NA" cell if the denial was overturned by the MCC based on this appeal.
- **Column 18–For Delayed Decision, Notification <21 days:** Mark the "Y" cell if it took more than 14 days to make a decision but the MCC notified the member of the delay by day 21 and made the services available. Mark the "N" cell if it took more than 14 days **AND** the member was **NOT** notified by day 21 **OR** if the member was notified of the delay, but the services were not offered. Mark "NA" cell if notification of the decision occurred prior to day 14.

## Scoring Directions

- **Applicable Answers, columns 5, 6, 17 and 18:** Enter the applicable number of cells in each column (i.e., all of those with "Ys" and "Ns"). All other columns for **Applicable Answers** are pre-populated with the applicable points for the number of files reviewed.
- **Compliant Answers, columns 5–7, 11, and 15–18:** Enter the total number of compliant answers for each column (i.e., the number of "Y" cells marked in each).

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- **Total Compliant:** Enter the sum of the numbers from **Compliant Answers**, **columns 5–7**, **11**, and **15–18**.
- **Total Applicable:** Enter the sum of the numbers from **Applicable Answers**, **columns 5–7**, **11**, and **15–18**.
- **Percent Compliant:** Divide the **Total Compliant** by the **Total Applicable,** and enter that number as a percentage (e.g., 1/4 = 0.25 = 25 percent).

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# APPENDIX C | *Performance Activity Review Tools*

*for **AmeriChoice-West***

This section contains the completed Annual Quality Survey (AQS) Performance Activity (PA) Review Tools for Managed Care Organizations (MCOs), 2010 Edition.

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## MCC UM Denials – File Review Tool

MCC: AmeriChoice-West | Time Standard Calculation: Calendar Days | Date: 4/20/10

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | | 8 | | 9 | | | 10 | | 11 | | 12 | 13 | 14 | 15 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| File # | Case ID* | Request Rcvd. Date | Decision Made Date | Wait (days) on Deci-sion | Deci-sion Time Std. | Met Decision Time Std. | | Decision Review Criteria Apropos to Condition | | Consulted Requesting Provider as Apropos | | | Final Denial by Qualified Med. Prof. | | Decision Not Arbitrary = Yes | | Initial Notifica-tion Date | Wait (days) to be Initially Notified | Initial Notifica-tion Time Std. | Met Initial Notification Time Std. | |
| | | | | | | Y | N | Y | N | Y | N | NA | Y | N | Y | N | | | | Y | N |
| 1 | 1 | 10/20/09 | 10/22/09 | 2 | 14 | X | | X | | | | X | X | | X | | 10/22/09 | 2 | 14 | X | |
| 2 | 2 | 10/13/09 | 10/15/09 | 2 | 14 | X | | X | | | | X | X | | X | | 10/15/09 | 2 | 14 | X | |
| 3 | 3 | 07/20/09 | 07/21/09 | 1 | 14 | X | | X | | | | X | X | | X | | 07/21/09 | 1 | 14 | X | |
| 4 | 11 | 05/21/09 | 05/27/09 | 6 | 14 | X | | X | | | | X | X | | X | | 05/29/09 | 8 | 14 | X | |
| 5 | 5 | 03/04/09 | 03/05/09 | 1 | 14 | X | | X | | | | X | X | | X | | 03/06/09 | 2 | 14 | X | |
| 6 | 12 | 11/11/09 | 11/17/09 | 6 | 14 | X | | X | | | | X | X | | X | | 11/18/09 | 7 | 14 | X | |
| 7 | 7 | 10/29/09 | 11/09/09 | 11 | 14 | X | | X | | | | X | X | | X | | 11/10/09 | 12 | 14 | X | |
| 8 | 8 | 06/08/09 | 06/16/09 | 8 | 14 | X | | X | | | | X | X | | X | | 06/16/09 | 8 | 14 | X | |
| 9 | 9 | 03/18/09 | 03/26/09 | 8 | 14 | X | | X | | | | X | X | | X | | 03/26/09 | 8 | 14 | X | |
| 10 | 10 | 10/23/09 | 10/23/09 | 0 | 14 | X | | X | | | | X | X | | X | | 11/03/09 | 11 | 14 | X | |
| Applicable Answers | | | | | | 10 | | 10 | | 0 | | | 10 | | 10 | | | | | 10 | |
| Compliant Answers | | | | | | 10 | | 10 | | 0 | | | 10 | | 10 | | | | | 10 | |

*Case IDs have been altered to protect patient information.*

| | |
|---|---|
| Total Compliant | 50 |
| Total Applicable | 50 |
| Percent Compliant | 100% |

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## EPSDT Information System Tracking – Review Tool

| MCO: AmeriChoice-West | | | Time Standard Calculation: NA | | | | | | | | | | | | | | Date: 4/20/10 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | | 5 | | 6 | | | 7 | | 8 | | | 9 | | |
| File # | Case ID* | Medical Record (MR) / Information System (IS) | Receipt of Screening | | Diagnosis Documented | | Treatment, Immunization, Lab Work Documented | | | Ability to Determine Screening Status | | Actions Taken to Improve Member's Screenings by Contacting Provider | | | Actions Taken to Improve Member's Screenings by Contacting Parent/Guardian/Member | | |
| | | | Y | N | Y | N | Y | N | NA | Y | N | Y | N | NA | Y | N | N/A |
| 1 | 1 | MR | | X | X | | X | | | X | | X | | | X | | |
| | | IS | | X | X | | X | | | X | | | | | | | |
| 2 | 2 | MR | | X | X | | X | | | X | | X | | | X | | |
| | | IS | | X | X | | X | | | X | | | | | | | |
| 3 | 3 | MR | X | | X | | X | | | X | | | | X | | | X |
| | | IS | X | | X | | X | | | X | | | | | | | |
| 4 | 4 | MR | X | | X | | X | | | X | | | | X | | | X |
| | | IS | X | | X | | X | | | X | | | | | | | |
| 5 | 5 | MR | X | | X | | X | | | X | | | | X | | | X |
| | | IS | X | | X | | X | | | X | | | | | | | |
| 6 | 6 | MR | X | | X | | X | | | X | | | | X | | | X |
| | | IS | X | | X | | X | | | X | | | | | | | |
| 7 | 7 | MR | X | | X | | X | | | X | | | | X | | | X |
| | | IS | X | | X | | X | | | X | | | | | | | |
| 8 | 8 | MR | X | | X | | X | | | X | | | | X | | | X |
| | | IS | X | | X | | X | | | X | | | | | | | |
| 9 | 9 | MR | X | | X | | X | | | X | | | | X | | | X |
| | | IS | X | | X | | X | | | X | | | | | | | |
| 10 | 10 | MR | X | | X | | X | | | X | | | | X | | | X |
| | | IS | X | | X | | X | | | X | | | | | | | |
| Applicable Answers | | | 10 | | 10 | | 10 | | | 10 | | 2 | | | 2 | | |
| Compliant Answers | | | 10 | | 10 | | 10 | | | 10 | | 2 | | | 2 | | |

*Case IDs have been altered to protect patient information.*

| | |
|---|---|
| Total Compliant | 44 |
| Total Applicable | 44 |
| Percent Compliant | 100% |

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## MCC Appeals (*Grier*) – File Review Tool

**MCC: AmeriChoice-West** | **Time Standard Calculation: Calendar Days** | **Date: 4/20/10**

| 1 | 2 | 3 | 4 | 5 | | | 6 | | | 7 | | 8 | 9 | 10 | 11 | | 12 | 13 | 14 | 15 | | 16 | | 17 | | | 18 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| File # | Case ID* | E/R and C/N** | Appeal Rcvd. Date | Authorization Request with Named Provider | | | Reviewed by Same Practitioner Type as Requester | | | Appeal Investigation Documented | | Decision Made Date | Wait (days) on Decision | Decision Time Std. | Met Decision Time Std. | | Member Notified Date | Wait (days) to be Notified | Notification Time Std. | Met Notification Time Std. | | Used State Letter Template & 6th Grade Level | | Contesting Instructions in Letter | | | For Delayed Decision, Notification <21 days | | |
| | | | | Y | N | NA | Y | N | NA | Y | N | | | | Y | N | | | | Y | N | Y | N | Y | N | NA | Y | N | NA |
| 1 | 1 | RN | 11/25/09 | | | x | | | X | x | | 12/07/09 | 12 | 14 | X | | 12/09/09 | 14 | 14 | X | | x | | | | X | | | X |
| 2 | 2 | RN | 06/08/09 | X | | | X | | | X | | 06/10/09 | 2 | 14 | X | | 06/12/09 | 4 | 14 | X | | X | | X | | | | | X |
| 3 | 3 | RN | 07/15/09 | X | | | X | | | X | | 07/27/09 | 12 | 14 | X | | 07/28/09 | 13 | 14 | X | | X | | | | X | | | X |
| 4 | 5 | EC | 08/04/09 | | | X | | | X | X | | 08/10/09 | 6† | 5 | X | | 08/18/09 | 14† | 5 | X | | X | | X | | | | | X |
| 5 | 6 | RN | 08/06/09 | X | | | X | | | X | | 08/19/09 | 13 | 14 | X | | 08/20/09 | 14 | 14 | X | | X | | X | | | | | X |
| 6 | 7 | EC | 08/05/09 | X | | | X | | | X | | 08/13/09 | 8† | 5 | X | | 08/19/09 | 14† | 5 | X | | X | | X | | | | | X |
| 7 | 8 | RN | 11/10/09 | X | | | X | | | X | | 11/18/09 | 8 | 14 | X | | 11/24/09 | 14 | 14 | X | | X | | X | | | | | X |
| 8 | 9 | RN | 07/02/09 | X | | | X | | | X | | 07/08/09 | 6 | 14 | X | | 07/09/09 | 7 | 14 | X | | X | | | | X | | | X |
| 9 | 10 | EC | 03/06/09 | | | X | | | X | X | | 03/18/09 | 12† | 5 | X | | 03/20/09 | 14† | 5 | X | | X | | | | X | | | X |
| 10 | 11 | EC | 06/29/09 | | | X | | | X | X | | 07/06/09 | 7 | 5 | x | | 07/06/09 | 7 | 5 | x | | X | | | | X | | | X |
| **Applicable Answers** | | | | 6 | | | 6 | | | 10 | | | | | 10 | | | | | 10 | | 10 | | 5 | | | 0 | | |
| **Compliant Answers** | | | | 6 | | | 6 | | | 10 | | | | | 10 | | | | | 10 | | 10 | | 5 | | | 0 | | |

| | |
|---|---|
| **Total Compliant:** | **57** |
| **Total Applicable:** | **57** |
| **Percent Compliant:** | **100%** |

**Case IDs have been altered to protect patient information.*

***Expedited or routine and concurrent or non-concurrent.*

*†Extension granted by TennCare to 14 days.*

# APPENDIX D | *Response to AQS Findings*

*for **AmeriChoice-West***

**AmeriChoice-West** had the opportunity to respond to the draft of this report. No comments were received.

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| AmeriChoice-West's Responses to QP Standard Areas of Noncompliance and Suggestions | | | |
|---|---|---|---|
| **Report Finding** | **Health Plan Comment** | **QSource Response** | **Additional Comments** |
| | None | | |

| AmeriChoice-West's Responses to PA Areas of Noncompliance and Suggestions | | | |
|---|---|---|---|
| **Report Finding** | **Health Plan Comment** | **QSource Response** | **Additional Comments** |
| | None | | |

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AmeriChoice **West** 2010 AQS Plan Of Correction

| 2010 Annual Quality Survey<br>Corrective Action Plan | | | |
|---|---|---|---|
| **Areas of Noncompliance** | **Action Steps/Progress** | **Intended Completion Date** | **Responsible Person/Titles** |
| **Notification of changes to written materials**<br>The MCO had updates to the policy regarding co-pay changes effective 1/1/2010, but the members were not provided the written 30 days in advance. | As benefit changes are identified, Americhoice will contact the state and request template changes at least 90 days prior to the effective date of the change. If the state does not intend to provide a template for the member communication, AmeriChoice will develop the communication and submit for approval no later than 60 days prior to the effective date of the change. AmeriChoice will communicate with the approved language no later than 30 days prior to the effective date of the change. If AmeriChoice is given less than 60 days notice, then AmeriChoice will request that the state clarify contract expectations around member notification for that benefit change event. The Health Plan will update the member communication policy to reflect the notification requirements around benefit change communications. | September 1, 2010 | Compliance Officer and<br>Vice President of Community Development |
| **Undeliverable Mail (EPSDT)**<br>The MCO should ensure that, when mail is returned as undeliverable, both attempts to find family occur within the required time frames. | In 2010, the Health Plan initiated a new process for EPSDT returned mail by adding a bar code to all EPSDT mail so that when mail is returned, it is scanned electronically and a list generated for automated calls. The 1st attempt process did not change and continues to meet the 30 day timeframe. The bar code scanning process was completed and the first 2010 monthly "Returned Mail Call Campaign" was conducted March 12, 2010. Returned Mail Call Campaigns continue monthly to meet the 90 day 2nd attempt timeline. | Completed | Manager, Prevention and Wellness Education<br>TENNderCare/EPSDT |

| | | | |
|---|---|---|---|
| **Community contacts approved (EPSDT)**<br>The MCO should ensure that all community events involving member outreach/interaction receive appropriate approval from TennCare. The MCO should also ensure that events are documented accurately in quarterly EPSDT reports. | AMC will strengthen quality controls around EPSDT community outreach to ensure a) prior approval of 100% of events and b) 100% reporting compliance for all completed EPSDT community outreach events.<br><br>Step 1: Revise tracking mechanism to include all events for approval.<br><br>Step 2: Update Policy & Procedure to reflect new database process and quality controls<br><br>Step 3: Update Policy & Procedure to reflect quarterly report process including increased quality controls<br><br>Step 4: Implement new P&Ps | <br><br><br><br>Step 1: July 1, 2010<br><br>Step 2: July 15, 2010<br><br>Step 3: July 15, 2010<br><br>Step 4: August 1, 2010 | Vice President of Community Development |
| **Display of non-discrimination posters**<br>The MCO should include the information on the posters located in their break rooms informing their employees regarding the Omnibus Budget Reconciliation Act of 1981. The MCO should continue to include the current information like employees' rights and obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990 and the Age Discrimination Act of 1975. | Order new posters which include required non-discrimination language and display in the employee break rooms. | Completed | Compliance Officer |

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# State of Tennessee
# Department of Finance and Administration
# Bureau of TennCare

# UnitedHealthcare Plan of the River Valley, Inc. (AmeriChoice-Middle)

## 2010 Annual Quality Survey

## June 2010

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# Updates to AQS Terminology

Beginning with the 2010 AQS, the following terms have been changed at TennCare's request:

- **enrollee** is referred to as **member**
- **area of opportunity** is referred to as **area of noncompliance**
- **Plan of Correction (POC)** is referred to as **Corrective Action Plan (CAP)**

This new wording is used in all instances throughout this report, including references to items from the 2009 AQS.

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# Acronyms, Abbreviations and Initialisms

ANA ..... Annual Network Adequacy
..... also known as Annual Provider Network Adequacy and Benefit Delivery Review
AQS ..... Annual Quality Survey
BBA ..... *Balanced Budget Act of 1997*
C/N ..... Concurrent or Non-Concurrent (*Grier*)
CAP ..... Corrective Action Plan
CD ..... Consent Decree
CEO ..... Chief Executive Officer
CFR ..... *Code of Federal Regulations*
CM ..... Case Management
CMS ..... Centers for Medicare & Medicaid Services
CRA ..... Contractor Risk Agreement
d.b.a. ..... doing business as
DBM/DBMC ..... Dental Benefits Manager/DBM Contract
DDS ..... Doctor of Dental Surgery
E/R ..... Expedited or Routine (*Grier* file review)
ED ..... Emergency Department
EPSDT ..... Early and Periodic Screening, Diagnosis, and Treatment (federal standard)
..... also used in reference to the *John B. Consent Decree* (state mandate)
..... and to TENNderCare (Tennessee's EPSDT program)
EQR/EQRO ..... External Quality Review/External Quality Review Organization
*Grier* ..... *Grier Revised Consent Decree* (state mandate)
..... also used in reference to member appeals
HIPAA ..... *Health Insurance Portability and Accountability Act*
HS ..... Health Services
IEP ..... Individual Education Plan
IRR ..... Inter-Rater Reliability
IS ..... Information System
ISO ..... International Organization for Standardization
LEP ..... Limited English Proficiency
MCC/MCO ..... Managed Care Contractor/Managed Care Organization
MR/MRR ..... Medical Record/MR Review
NA ..... Not Applicable
NCQA ..... National Committee for Quality Assurance
OCCP ..... Office of Contract Compliance and Performance
ORR ..... On Request Report
P&P ..... Policy and Procedure
PA ..... Performance Activity
PAS ..... Provider Affairs Subcommittee
PCP ..... Primary Care Physician/Provider

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PEP ..... Provider Evaluation of Performance
PHI ..... Protected Health Information
PIHP ..... Prepaid Inpatient Health Plan
POC ..... Plan of Correction
Q ..... Quarter
QI ..... Quality Improvement
QM/QMP ..... Quality Management/Quality Management Program
QOC ..... Quality of Care
QP ..... Quality Process
SEC ..... Sentinel Event Committee
TCA ..... Tennessee Code Annotated
TDMHDD ..... Tennessee Department of Mental Health and Developmental Disabilities
TennCare ..... Tennessee Department of Finance and Administration, Bureau of TennCare
UM ..... Utilization Management
UTD ..... Universal Tracking Database

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# Executive Summary

*for **AmeriChoice-Middle***

## *Introduction*

As the External Quality Review Organization (EQRO) for the Tennessee Department of Finance and Administration, Bureau of TennCare (TennCare), QSource is required by the *Balanced Budget Act of 1997* (BBA) to assess each TennCare health plan's "…strengths and weaknesses with respect to the quality, timeliness, and access to healthcare services furnished to Medicaid recipients" (42 *Code of Federal Regulations* [CFR] 438.364[a][2]). One requirement of the External Quality Review (EQR) contract with TennCare is to conduct an Annual Quality Survey (AQS) of each Managed Care Organization (MCO), and the Dental Benefits Manager (DBM), collectively referred to as the state's Managed Care Contractors (MCCs). This is the fifth year that QSource has performed the AQS. The purpose of the AQS is to determine the extent to which each TennCare MCC is in compliance with:

- its Contractor Risk Agreement (CRA) with the State of Tennessee, Bureau of TennCare;
- 42 CFR Parts 417.106, 430, 433, 434 and 438; and
- other quality standards established by the state of Tennessee.

In addition, QSource's review of MCCs incorporates two state mandates that address services and due process for managed care Medicaid members: *John B. Consent Decree* (supports the federal Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] standard of care for children age 20 and younger) and the *Grier Revised Consent Decree* (governs contested denials).

QSource also follows the Centers for Medicare & Medicaid Services (CMS) *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs), Final Protocol, Version 1.0*, February 11, 2003. In compliance with these protocols, this *UnitedHealthcare Plan of the River Valley, Inc. (**AmeriChoice-Middle**) 2010 Annual Quality Survey* (herein referred to as the *2010 AQS Report)* includes the Executive Summary and the following sections:

- Methodology
- Evaluation of Plan Process
- Evaluation of Plan Results
- Summary and Recommendations
- Appendices

## *Methodology*

The general scope of AQS assessment activity was previously defined by 10 state-specific MCO quality process (QP) standards and five performance activities (PAs). All MCOs under contractual obligation with TennCare have now achieved accreditation from the National Committee for Quality Assurance (NCQA). This accreditation reduced the number of QP

standards and PAs requiring EQRO assessment, preventing duplication of activities as prescribed by federal guidelines. **Table 1-1** lists all QP standards assessed for the 2010 AQS.

| Table 1-1. 2010 AQS QP Standards for AmeriChoice-Middle |
|---|
| Quality Improvement (QI) Program |
| Network: Contracting, Availability, Access and Documentation |
| QI Activities |
| Clinical Criteria for Utilization Management (UM) Decisions |
| Member Rights and Responsibilities |
| *John B. Consent Decree* (EPSDT) |
| *Grier Revised Consent Decree* |
| Non-Discrimination Compliance |

Two QP standards/PAs—**Credentialing/Recredentialing** and **Benefit Delivery Review**—were assessed as part of the 2010 Annual Provider Network Adequacy and Benefit Delivery Review (ANA); results were detailed in **AmeriChoice-Middle**'s *2010 ANA Report* and, as such, do not appear here.

The PAs for the **AmeriChoice-Middle** 2010 AQS appear in **Table 1-2**. Because all MCOs are now NCQA accredited, complaint review is no longer required. Additionally, the *Newberry Dispute Resolution* that mandated a review specific to home health denials has expired. UM denials pertain to members age 20 years and younger only.

| Table 1-2. 2010 AQS PAs for AmeriChoice-Middle |
|---|
| **MCO Activity by Standard** |
| Clinical Criteria for UM Decisions: Denial File Review (age 20 and younger only) |
| *John B. Consent Decree* (EPSDT): Information System Tracking Review |
| *Grier Revised Consent Decree*: Appeal File Review |

Detailed lists of all 2010 MCO evaluation elements are presented in **Tables 2-2** and **2-3** of the Methodology section.

## *Evaluation of Plan Process*

Plan performance values/star ratings for the 2010 AQS are indicated in **Table 1-3**.

| Table 1-3. AQS Rating Scale Key | | |
|---|---|---|
| **Plan Performance** | **Level of Compliance** | **Star Rating** |
| 90—100% | Total Compliance | ☆☆☆☆☆ |
| 80—89% | Substantial Compliance | ☆☆☆☆ |
| 65—79% | Partial Compliance | ☆☆☆ |
| 55—64% | Minimal Compliance | ☆☆ |
| 0—54% | Noncompliance | ☆ |

# *Evaluation of Plan Results*

## Scores and Ratings

**Table 1-4** summarizes **AmeriChoice-Middle**'s specific compliance percentage for each QP standard assessed for the 2010 AQS review. The health plan's star ratings from the 2010 AQS are also included by QP standard. A single score for *all* QP standards, as well as multi-year trending, is no longer calculable due to the reduction of standards and elements following NCQA accreditation.

**Table 1-4. 2010 QP Standard Scores and Ratings for AmeriChoice-Middle**

| MCO Standard | Percent Compliant | Star Rating |
|---|---|---|
| Quality Improvement (QI) Program | 100% | ☆☆☆☆☆ |
| Network: Contracting, Availability, Access and Documentation | 100% | ☆☆☆☆☆ |
| QI Activities | 100% | ☆☆☆☆☆ |
| Clinical Criteria for Utilization Management (UM) Decisions | 100% | ☆☆☆☆☆ |
| Member Rights and Responsibilities | 95.0% | ☆☆☆☆☆ |
| *John B. Consent Decree* (EPSDT) | 96.8% | ☆☆☆☆☆ |
| *Grier Revised Consent Decree* | 100% | ☆☆☆☆☆ |
| Non-Discrimination Compliance | 94.4% | ☆☆☆☆☆ |

**Table 1-5** summarizes **AmeriChoice-Middle**'s specific compliance percentage for each PA assessed for the 2010 AQS review. The health plan's star ratings from the 2010 AQS are also included by PA. As with QP standards, neither an overall PA score nor trending can be calculated due to NCQA accreditation, which eliminated complaint file review, and the expiration of the *Newberry Dispute Resolution*, which required the review of home health denials. UM denials pertain to members age 20 years and younger only.

**Table 1-5. 2010 PA Scores and Ratings for AmeriChoice-Middle**

| MCO Activity by Standard | Percent Compliant | Star Rating |
|---|---|---|
| Clinical Criteria for UM Decisions: Denial File Review (age 20 and younger only) | 98.0% | ☆☆☆☆☆ |
| *John B. Consent Decree* (EPSDT): Information System Tracking Review | 100% | ☆☆☆☆☆ |
| *Grier Revised Consent Decree*: Appeal File Review | 100% | ☆☆☆☆☆ |

## Corrective Action Plan Process

TennCare requires the MCO to submit a Corrective Action Plan (CAP) for *any* QP standard element or PA that has been identified as an area of noncompliance (i.e., less than 100 percent compliance), regardless of overall performance on the corresponding QP standard or PA. At the direction of TennCare, CAPs will also be required for deficiencies noted in the unscored elements of the QI Activities standard. CAPs are considered On Request Reports (ORRs), meaning that

TennCare may request them at its discretion and not solely based on the MCO's performance outcomes. All CAPs must be designed to improve performance in areas of noncompliance.

**AmeriChoice-Middle** did not achieve full compliance on:

- Member Rights and Responsibilities, Element #6: Notification of changes to written materials.
- *John B. Consent Decree* (EPSDT):
  - Element #6: Undeliverable mail
  - Element #10: Community contacts approved
- Non-Discrimination Compliance, Element #3: Display of non-discrimination posters

The MCO also did not achieve full compliance on the UM denial file review PA.

A CAP will be required for each of these items. Within 14 days of the posting notification of its final AQS report, the **AmeriChoice-Middle** must electronically submit all required CAPs to **OCCP.Reports@tn.gov** with copies to **Judy.M.Womack@tn.gov**, **Pauline.S.McIntyre@tn.gov** and **aqs-cap@qsource.org**. CAPs will not be considered submitted if they are not received by all four parties within the required time frame.

## *Summary and Recommendations*

The health plan achieved 100 percent compliance on five of eight QP standards, and two of three PAs. Where full compliance was not met, the MCO's performance ranged from 94.4 to 96.8 percent. The following section summarizes the areas of noncompliance, strengths and suggestions that QSource identified during the 2010 AQS. These are discussed in greater detail in the full-length **Summary and Recommendations** of this report, as are the health plan's medical-behavioral health integration efforts.

### Integration of Medical-Behavioral Services

**AmeriChoice-Middle**'s policies and procedures (P&Ps) helped ensure the coordination of medical and behavioral health activities. The roles and responsibilities of primary care providers (PCPs) and mental health/substance abuse treatment providers were well defined. Collaboration was promoted via the health plan's P&Ps, processes, Provider Manual, website and provider newsletters. Screening tools were utilized to identify the need for case management (CM) and to assess the behavioral health needs of those already in CM. **AmeriChoice-Middle** used multiple tools to evaluate provider performance in these areas, and evidence produced on-site demonstrated collaboration, the monitoring of implementation and outcomes, and follow-up for members at least every 30 days.

There were distinct P&Ps for adverse occurrences, which were reported, reviewed, investigated and addressed through corrective action by the Provider Affairs Subcommittee (PAS). QSource

verified these actions in staff interviews and document review. **AmeriChoice-Middle** demonstrated compliance with tracking and trending, reporting requirements and the availability of MCO adverse occurrence documentation to TennCare.

The health plan's coordination efforts for children were also evident. Family involvement, accessible services, and follow-up after inpatient or residential treatment were just a few of the actions noted for TENNderCare members.

## Areas of Noncompliance

Areas of noncompliance were identified where **AmeriChoice-Middle** achieved less than 100 percent compliance. This includes the unscored elements in the QI Activities QP standard. Areas of noncompliance reflect what the health plan *should do* and may be accompanied by recommended policy, procedure or process changes from QSource. **AmeriChoice-Middle's** areas of noncompliance centered primarily on member communication, outreach approval/ documentation and display of non-discrimination posters. Upon changing the policies regarding co-pay rates, the MCO failed to notify members 30 days in advance, as is required by TennCare. Also, the MCO did not ensure that undeliverable mail was followed up on with attempts to locate family members within required time frames. The MCO should make sure to secure approval for and accurately document community outreach activities with TennCare prior to the events; they should also ensure that events are documented accurately in quarterly EPSDT reports. The MCO is also required to display non-discrimination posters that contain all of the federally required statutes regarding employee rights and obligations. The posters located in the MCO's breakroom did not have information on the *Omnibus Budget Reconciliation Act of 1981*.

All areas of noncompliance addressed during the 2009 AQS report were successfully resolved.

## Strengths

Strengths indicate that the MCO demonstrated particular proficiency on a given QP standard element or PA and can be identified independent of 100 percent compliance. QSource documented strengths under the *John B. Consent Decree* during the 2010 AQS. The MCO chose to conduct new member calls on all new members despite having exceeded the required screening rate standard. Another strength in the same area was attributed to program coordination. As part of the Emergency Department (ED) Diversion program, the MCO identified children with more than five ED visits in a seven- month period to determine if they had a medical home. During this process, several members were identified whose "troublesome patterns of service utilization" ultimately resulted in referrals and coordination with the Department of Children Services.

## Suggestions

During the 2010 AQS, QSource made suggestions that are encouraged for **AmeriChoice-Middle** but not required. These are detailed in the full-length Summary and Recommendations section of this report.

# Methodology

*for **AmeriChoice-Middle***

## *Purpose of the Evaluation*

The Tennessee Department of Finance and Administration, Bureau of TennCare (TennCare) contracts with QSource to perform Annual Quality Survey (AQS) evaluations, which provide meaningful information that TennCare and **AmeriChoice-Middle** can use for:

1. measuring the quality of both the healthcare and services that it provides to its members;
2. evaluating its application of the *John B. Consent Decree* and the *Grier Revised Consent Decree* state mandates;
3. evaluating its policies, tracking processes and rates of compliance with the activities of TENNderCare, TennCare's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program;
4. identifying variations in healthcare services across Tennessee; and
5. implementing proactive measures for more effective/efficient service delivery.

To complete these components for the 2010 AQS, QSource assembled a team of experienced health plan surveyors to collect and analyze data; complete a review of contractual, clinical and administrative outcomes; and prepare a report for TennCare and **AmeriChoice-Middle**.

## *Results Evaluated*

This *2010 AQS Report* documents the evaluation of **AmeriChoice-Middle**'s compliance with its *Contractor Risk Agreement (CRA) between the State of Tennessee, doing business as (d.b.a.) TennCare and UnitedHealthcare Plan of the River Valley, Inc. (AmeriChoice-Middle) – August 15, 2006–Blended Document – Includes General Amendment 4 (Updated September 1, 2009),* and the quality process (QP) standards and performance activities (PAs) derived from it. The *2010 AQS Report* also documents compliance with:

- QP standards derived from the *John B. Consent Decree* (EPSDT), *Grier Revised Consent Decree,* and for non-discrimination;
- PAs derived from the *John B. Consent Decree* (EPSDT) and *Grier Revised Consent Decree*; and an additional PA regarding UM Denials File Review;
- 42 *Code of Federal Regulations* (CFR) Parts 417.106, 430, 433, 434 and 438; and
- other quality standards established by the state of Tennessee.

## *Quality Assessment Activities*

For each Managed Care Contractor (MCC), the AQS includes a pre-assessment documentation review, an on-site visit and post-on-site analyses. QSource developed the AQS tools to be used

on-site and forwarded them to **AmeriChoice-Middle**. The pre-assessment phase gave both QSource and the health plan an opportunity to ask questions before the on-site visit. QSource surveyors conducted **AmeriChoice-Middle**'s on-site visit **April 20–22, 2010**. **Table 2-1** details the assessment activities QSource performed for the AQS.

| Table 2-1. 2010 AQS Activities Performed |
|---|
| **Step 1: Establish survey schedule.** |
| ♦ Before the on-site visit, QSource submitted the survey schedule to TennCare for approval. |
| **Step 2: Prepare data collection survey tools and submit them to TennCare for review/approval.** |
| ♦ QSource developed evidence-based oversight/monitoring tools in consultation with TennCare representatives to ensure CRA-specific criteria were met and all data sought were collected.<br>♦ Approved tools completed for **AmeriChoice-Middle** are in **Appendices A** and **C.** |
| **Step 3: Submit survey tools to the MCC.** |
| ♦ QSource forwarded the survey tools to the health plan, giving it the opportunity to gather the required data and facilitate process streamlining for the on-site visit. |
| **Step 4: Prepare/Submit the Pre-Assessment Documentation List to the MCC.** |
| ♦ QSource sent a letter to TennCare MCCs requesting that specific desk review documents be submitted to QSource. The Pre-Assessment Documentation List was accompanied by instructions on how to organize and prepare the documents for the surveyors. |
| **Step 5: Respond to MCC questions/information requests prior to on-site review.** |
| ♦ QSource remained in contact via telephone and e-mail to respond to questions and to provide additional information as needed to key **AmeriChoice-Middle** personnel and TennCare representatives, particularly concerning clarification of the **Pre-Assessment Documentation List** and the on-site assessment process. |
| **Step 6: Receive pre-assessment documentation and gather information before the on-site visit.** |
| ♦ QSource used the survey tools to examine and document all information received before the on-site visit to offer surveyors insight into **AmeriChoice-Middle**'s structure, member population, providers, services, operations, resources and delegated functions to enable initial compiling of data.<br>♦ From the PA data submitted by the health plan, QSource abstracted a random sample of files, including an oversample, for desk review.<br>♦ During the desk review process, the surveyors:<br>(1) took notes to assist in the completion of the survey tools and guide determination about compliance with the regulatory provisions;<br>(2) identified those areas and issues requiring further clarification or follow-up during the on-site interviews; and<br>(3) clarified which requested information was not found in the pre-assessment documentation. |
| **Step 7: Develop an on-site agenda.** |
| ♦ QSource surveyors developed a general agenda to assist the **AmeriChoice-Middle** staff in participation planning, documentation gathering and addressing logistical issues (such as arranging locations for surveyors to conduct document reviews and interviews). |
| **Step 8: Discuss the on-site agenda with the MCC.** |
| ♦ Through setting the tone and expectations in an on-site agenda and discussing it with **AmeriChoice-Middle** in preparation for the on-site assessment, QSource helped ensure that all participants understood the time frames involved so that the process was more efficient and effective. |

| Table 2-1. 2010 AQS Activities Performed |
|---|
| **Step 9: Conduct the on-site visit.** |
| ♦ During the on-site document assessment, **AmeriChoice-Middle** staff was available to answer questions or assist the QSource review team in locating specific documents or information sources.<br>♦ QSource coordinated interviews/discussions with staff to maximize results while minimizing disruption to plan operations, as document review alone is generally insufficient to determine compliance since content and actual performance of the procedures outlined in the documents can typically be determined only by interaction and interviews with plan staff.<br>♦ The review team interacted with staff to determine the degree of compliance with contract requirements, to explore any issues not fully addressed in the documents reviewed and to increase overall understanding of **AmeriChoice-Middle**'s performance. |
| **Step 10: Review information and documentation using the survey tools.** |
| ♦ Throughout the documentation review and on-site assessment processes, QSource reviewers used the survey tools to obtain information and to document findings regarding **AmeriChoice-Middle**'s compliance with set standards through a review of policies/procedures, committee minutes, quality studies, reports, medical record/file review and other related health plan documentation.<br>♦ Surveyors took notes during staff interviews and document review to obtain the required data. (These notations were included in the completed survey tools in this report as **Appendices A** and **C** to serve as a comprehensive record of the assessment activity.) |
| **Step 11: Summarize findings at the completion of the survey.** |
| ♦ As a final step for completing the on-site survey, QSource met with **AmeriChoice-Middle** to summarize initial findings and recommendations. |
| **Step 12: Calculate the individual ratings for the MCC's performance.** |
| ♦ For comparing performance and determining **AmeriChoice-Middle**'s compliance with QP standards and program requirements, QSource incorporated nationally recognized guidelines from:<br>(1) *Standards and Guidelines for the Accreditation of Health Plans* from the National Committee for Quality Assurance (NCQA);<br>(2) protocols of the Centers for Medicare & Medicaid Services (CMS); and<br>(3) state and federal regulations.<br>♦ QSource analyzed every element in the survey tools using weighted point values to determine **AmeriChoice-Middle**'s performance on each standard. |
| **Step 13: Prepare a report of findings and recommendations.** |
| ♦ After completing data analyses, QSource prepared this report of the review findings and recommendations. A draft AQS report was due 30 days after the survey was completed, with the final AQS report due 60 days after completion of the survey. Both reports were forwarded to TennCare for approval within these deadlines. |
| **Step 14: Provide post-survey support to the MCC.** |
| ♦ QSource provided **AmeriChoice-Middle** with technical assistance as needed to foster performance improvement. |

## *Standards and Measures Reviewed*

As part of the 2010 AQS, QSource's surveyors evaluated the elements of the QP standards and PAs identified in **Tables 2-2** and **2-3**. *Please note that the element titles in these tables do not necessarily reflect*

*the entirety of the content reviewed for each QP standard or PA identified. Also, recall that Credentialing/Recredentialing and Benefits Delivery Review were included in* ***AmeriChoice-Middle****'s* 2010 Annual Network Adequacy (ANA) Report *and, as such, are not included in this* 2010 AQS Report.

| Table 2-2. QP Standard Elements for AmeriChoice-Middle | |
|---|---|
| **Quality Improvement (QI) Program** | |
| 1) Member safety and quality | |
| **Network: Contracting, Availability, Access and Documentation** | |
| 1) Specialist termination | 2) Notice of provider termination |
| **QI Activities** | |
| 1) Coordination between physical and behavioral health<br>2) Adverse occurrences policies and procedures<br>3) Adverse occurrences definition<br>4) Adverse occurrences to be reported | 5) Adverse occurrences and quality of care issues<br>6) Adverse occurrence tracking and trending<br>7) Adverse occurrence reporting requirements<br>8) Availability of adverse occurrence documents |
| **Clinical Criteria for Utilization Management (UM) Decisions** | |
| 1) Availability of criteria | 2) Transition to other care |
| **Member Rights and Responsibilities** | |
| 1) Member Handbook development and distribution<br>2) Complaint procedures<br>3) Communication of rights and responsibilities in Member Handbook | 4) Member Handbook inclusions<br>5) Notice of right to file a complaint<br>6) Notification of changes to written materials<br>7) Translation services<br>8) Translated vital documents |
| ***John B. Consent Decree* (EPSDT)** | |
| 1) New member calls<br>2) Outreach contacts<br>3) Documenting outreach<br>4) Declined services<br>5) Re-notification if no services used<br>6) Undeliverable mail<br>7) Accurate provider lists<br>8) Targeted activities<br>9) Outreach to illiterate, blind, deaf and LEP<br>10) Community contacts approved<br>11) Prenatal appointment assistance<br>12) Referrals from one level of screening to another<br>13) Notify MCO if unable to make referral<br>14) Medically necessary services<br>15) Rehabilitation and maintenance services<br>16) Medical necessity<br>17) Limitations/Capitations/Delays<br>18) Qualified UM personnel | 19) Services without prior authorization<br>20) Specialist list<br>21) MCO CM<br>22) Medically necessary CM services<br>23) CM central function<br>24) Family involvement and accessible services<br>25) Follow-up after inpatient or residential treatment<br>26) Screening components including follow-up<br>27) Interperiodic screen<br>28) Prior authorization prohibited<br>29) Screening standards met<br>30) Transportation<br>31) Program coordination<br>32) IEPs<br>33) Tracking system<br>34) EPSDT language in contracts<br>35) EPSDT contract review |
| ***Grier Revised Consent Decree*** | |
| 1) Appeals unit | 2) *Grier*/Appeals procedures |

| Table 2-2. QP Standard Elements for AmeriChoice-Middle | |
|---|---|
| **Non-Discrimination Compliance** | |
| 1) Non-Discrimination Compliance Plan<br>2) Assurance of Non-Discrimination<br>3) Display of non-discrimination posters<br>4) Non-discrimination written materials<br>5) Written policy and procedure | 6) Complaint resolution and reporting<br>7) Member Handbook notification and Complaint Form<br>8) Quarterly newsletter notification<br>9) Subcontractor compliance education |

| Table 2-3. PAs by Standard for AmeriChoice-Middle |
|---|
| **MCO Activity by Standard** |
| Clinical Criteria for UM Decisions: Denial File Review (age 20 and younger only) |
| *John B. Consent Decree* (EPSDT): Information System Tracking Review |
| *Grier Revised Consent Decree*: Appeal File Review |

## *Conducting the Survey*

QSource worked closely with TennCare and with the health plan throughout the survey process, ensuring a supportive and coordinated approach in carrying out survey activities. All tools were approved by TennCare prior to conducting the survey.

Before the on-site visit, QSource contacted **AmeriChoice-Middle** to exchange information, to set dates for the visit, and to discuss other activities needed to complete the evaluation methodically and accurately. Dates for the contract term, the reporting period under review and QSource's on-site visit to **AmeriChoice-Middle** are detailed in **Table 2-4**.

| Table 2-4. Principal Dates for the AmeriChoice-Middle 2010 AQS | |
|---|---|
| **Key Stages** | **Time Span** |
| Contract Term | August 15, 2006—Present |
| Reporting Period Under Review | January 1—December 31, 2009 |
| Dates of Review | April 20—22, 2010 |

## *Producing and Delivering the Survey Report*

In compliance with CMS protocol, this report includes:

- a detailed assessment of **AmeriChoice-Middle**'s strengths regarding the quality, timeliness and accessibility of its healthcare services;
- specific areas of noncompliance to help the health plan improve performance; and
- QSource's assessment to ensure the health plan's continued improvement on standards with less than 100 percent compliance.

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**AmeriChoice-Middle** had the opportunity to respond to the draft of this report. No comments were received, as indicated in **Appendix D**.

## *MCO Scores*

The total point value assigned to the QP standards section was 63.6 points (51.5 percent), and the total point value assigned to the PA section was 60 points (48.5 percent). The processes used for calculating QP standards and PA scores are detailed below.

### QP Standards–Element Scores

Using specific criteria, each QP standard score was calculated by adding its individual evaluation element scores (see **Table 2-2**). For example, *John B. Consent Decree* (EPSDT) has a total value of 39.50 points, which represents the sum of its 35 evaluation element scores (ranging from 0.500 to 3.000 each). The scored QP standard review tool for **AmeriChoice-Middle** is located in **Appendix A**.

### PA Scores

Each PA evaluation is unique and, as such, has its own distinct review tool. Each of the PAs was assigned a 20-point value. The scored PA tools for **AmeriChoice-Middle** are in **Appendix C**. Any tool component considered not applicable (NA) was excluded from scoring.

### Rating Determination

A rating of one to five stars was assigned for every QP standard and PA based on the percentage of total points earned for each. **Table 2-5** provides a summary.

**Table 2-5. AQS Rating Scale Key**

| Plan Performance | Compliance Rating | Star Rating |
|---|---|---|
| 90—100% | Total Compliance | ☆☆☆☆☆ |
| 80—89% | Substantial Compliance | ☆☆☆☆ |
| 65—79% | Partial Compliance | ☆☆☆ |
| 55—64% | Minimal Compliance | ☆☆ |
| 0—54% | Noncompliance | ☆ |

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# Evaluation of Plan Process

*for **AmeriChoice-Middle***

Using Centers for Medicare & Medicaid Services (CMS) protocol for External Quality Review Organizations (EQROs), QSource reviewed documentation from **AmeriChoice-Middle** and conducted on-site interviews to identify the health plan's progress toward quality standard goals set in 2009. This protocol, and QSource's 2010 survey tools, helped to determine the Managed Care Organization's (MCO's) compliance with contractual standards specified in the Contractor Risk Agreement (CRA); 42 *Code of Federal Regulations (*CFR*)* Parts 417.106, 430, 433, 434 and 438; and other quality standards established by the state of Tennessee.

QSource has met the federal qualifications for EQROs set forth in 42 CFR § 433.354. In brief, these include demonstrated experience and knowledge of Medicaid as well as managed care policies, processes, and data systems. The organization is a 501(c)(3) not-for-profit whose survey staff includes registered nurses, master's level public health and healthcare administration professionals, and those experienced in research design and statistical analysis. QSource holds a 9001:2008 quality management certification from the International Organization for Standardization (ISO) and is certified by the state of Tennessee as a utilization review agent. QSource has met all standards of independence required of EQROs in their contracts with governmental and/or other agencies.

## *Pre-Assessment Review*

To expedite the 2010 Annual Quality Survey (AQS), QSource sent a written request for documentation to each Managed Care Contractor (MCC) of the Tennessee Department of Finance and Administration, Bureau of TennCare (TennCare), prior to the scheduled on-site survey. The request included a Pre-Assessment Documentation List of items pertaining to the quality process (QP) standards and performance activities (PAs) to be evaluated.

Pre-assessment documentation review facilitates a more efficient on-site survey and helps surveyors conduct better MCC staff interviews in the time allotted. **AmeriChoice-Middle** was compliant in providing the requested pre-assessment information in a timely manner.

The documentation QSource requested and reviewed consisted of the following:

1. Member Handbooks in English and Spanish
2. Provider Manual
3. 2009 Quality Improvement (QI) Program Description
4. QI Program Evaluation of 2008 activities
5. TENNderCare Program Description
6. All provider and member newsletters
7. 2009 quarterly and annual EPSDT reports
8. 2009 Utilization Management (UM) Program Description

9. UM Program Evaluation of 2008 activities
10. All provider and member satisfaction surveys
11. Information and documentation related to 2009 AQS Corrective Action Plan (CAP) activities and interventions
12. Policies that define the MCC's time standards for handling all denials and appeals
13. Completed table of time standards used for the resolution of UM denials and appeals

In addition to these pre-assessment documents, QSource asked that **AmeriChoice-Middle** have available on-site all curricula vitae/resumes for UM staff involved in medical necessity decision-making, as well as:

- 15 UM denial files (EPSDT-eligible members only)
- 15 EPSDT files
- 15 appeal (*Grier*) files

# *On-Site Review*

## Survey Participants

The MCC representative interview is integral to the AQS. Interview participants supplement, clarify and confirm what is learned during the pre-assessment review; they supply further evidence that what the MCC documents and what it practices are congruent. **Table 3-1** lists the on-site surveyors and the **AmeriChoice-Middle** staff members they contacted during the survey.

**Table 3-1. Participants in the AmeriChoice-Middle 2010 AQS**

| Name | Credentials | Title |
|---|---|---|
| **QSource On-Site Surveyors** | | |
| Ginger Botts | RN, BSN | QI Clinical Specialist |
| Michelle North | RN, BSN | QI Clinical Specialist |
| Swapna Jamode | MHA | Health Analyst |
| **AmeriChoice-Middle Staff Facilitating the Evaluation** | | |
| Amanda Hamblen | | Manager, DM |
| Beth Fortenberry | RN, BSN | Associate Director, Clinical Medical Operations |
| Charles Nails | BSW | Quality Specialist |
| Christa Thomas | RN | Manager, Case Management (CM); Private Duty Nurse |
| David O. Hollis | MD, FACP | Chief Medical Officer |
| Elliot Sparks | MSW, LMSW | Manager, Behavioral Health CM |
| Hayley Clothier | BA | Quality Manager |
| Jerry Sullivan | PsyD | Executive Director, Behavioral Health |
| Judith Black | RN | Director, Special Projects |
| Kim Seay | BS | Senior Director, Quality Management |

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| Table 3-1. Participants in the AmeriChoice-Middle 2010 AQS | | |
|---|---|---|
| **Name** | **Credentials** | **Title** |
| Lisa Ellis | RN,BSN, MSA | Southeast Regional Director, Integrated Care Coordinator, Teen-Medicaid |
| Sandy Sanderson | RN | Manager, Care Management |
| Sara (Dusti) Williams | RN, BSN | Manager, EPSDT & Preventive Health |
| Sarah Marcel | MBA | Manager, TennCare Compliance |
| Stephanie McNeal | RN | Associate Director, Appeals/Clinical Letter Compliance |
| Tristin Blade | | Health Coach II, Healthy First Steps (HFS) |

## On-Site Documentation

Once on-site, QSource surveyors examined additional documents (detailed in **Table 3-2**) that were not included in the pre-assessment review.

**Table 3-2. On-Site Documentation for the AmeriChoice-Middle 2010 AQS**

1) 2009 QI Work Plan
2) Adverse Incident Work Guide
3) Adverse Occurrence Investigation Files and Tracking Log
4) Appeals Organization Chart
5) Availability of Behavioral Health Practitioners and Providers - 2009 Annual Analysis
6) Behavioral Health Inter-Rater Reliability (IRR) Vignettes
7) Completed Medical Record Audit Tool
8) Desk Audit Tool
9) Emails Regarding:
   - QM Health Programs to be Posted to Web in 2009 (email chain from 12/2/08 – 12/4/08 )
   - TennCare Approval of a Letter Stating that the Complaint Was Investigated and Resolved
   - TennCare Approval of Policies and Procedures (P&P)
10) Final Version of P&P #HS UM 10: Prior Authorization and/or Referral Exceptions
11) IEP Tracking Database Screenshots
12) Member Notes For CM – Collaboration of Physical & Behavioral Health
13) New Member Packet Monthly Log
14) Postal Confirmation Forms on Annual Member Packets Mailing
15) Regional Sample of CM Case Notes for Member's Home Health Care Providers that would Term with MCO
16) Sarbanes-Oxley UM Audit Process Summary
17) UM Quality Audit Examples; Redesign Workshop PowerPoint; and Staff List, Licenses and Resumes

## *Overview of Findings*

During the review, QSource surveyors used the tools in **Appendices A** and **C** – along with personal observations, interviews with key health plan staff and on-site file/document reviews – to facilitate analyses and compilation of findings. The results include:

- quality process (QP) standard evaluation results (**Table 4-1**)
- performance activity (PA) evaluation results (**Table 4-2**)
- QP standard strengths and opportunities (**Table 4-3**)
- PA strengths and opportunities (**Table 4-4**)

**AmeriChoice-Middle**'s individual element and PA file compliance scores can also be found in **Appendices A** and **C**.

### Scores and Ratings

**Table 4-1** summarizes **AmeriChoice-Middle**'s specific compliance percentage for each QP standard assessed for the 2010 Annual Quality Survey (AQS). The Managed Care Organization's (MCO's) star ratings from the 2010 AQS are also included by QP standard. A single score for all QP standards, as well as multi-year trending, is no longer calculable due to the reduction of standards and elements following National Committee for Quality Assurance (NCQA) accreditation.

As shown, **AmeriChoice-Middle** achieved 100 percent compliance on five of eight QP standards. On the remaining standards, performance ranged from 94.4 to 96.8 percent.

**Table 4-1. 2010 QP Standard Scores and Ratings for AmeriChoice-Middle**

| MCO Standard | Percent Compliant | Star Rating |
|---|---|---|
| Quality Improvement (QI) Program | 100% | ☆☆☆☆☆ |
| Network: Contracting, Availability, Access and Documentation | 100% | ☆☆☆☆☆ |
| QI Activities | 100% | ☆☆☆☆☆ |
| Clinical Criteria for Utilization Management (UM) Decisions | 100% | ☆☆☆☆☆ |
| Member Rights and Responsibilities | 95.0% | ☆☆☆☆☆ |
| *John B. Consent Decree* (EPSDT) | 96.8% | ☆☆☆☆☆ |
| *Grier Revised Consent Decree* | 100% | ☆☆☆☆☆ |
| Non-Discrimination Compliance | 94.4% | ☆☆☆☆☆ |

**Table 4-2** summarizes **AmeriChoice-Middle**'s specific compliance percentage for each PA evaluated for the 2010 AQS review. Star ratings for the 2010 AQS are also included. As with QP

standards, neither an overall PA score nor trending can be calculated due to NCQA accreditation, which eliminated complaint file review, and the expiration of the Newberry Dispute Resolution, which required the review of home health denials. UM denials pertain to members age 20 years and younger only.

**AmeriChoice-Middle** achieved 100 percent compliance on two of three PAs.

**Table 4-2. 2010 PA Scores and Ratings for AmeriChoice-Middle**

| MCO Activity by Standard | Percent Compliant | Star Rating |
|---|---|---|
| Clinical Criteria for UM Decisions: Denial File Review (age 20 and younger only) | 98.0% | ☆☆☆☆☆ |
| *John B. Consent Decree* (EPSDT): Information System Tracking Review | 100% | ☆☆☆☆☆ |
| *Grier Revised Consent Decree*: Appeal File Review | 100% | ☆☆☆☆☆ |

## Strengths and Areas of Noncompliance

The AQS aids QSource and the Tennessee Department of Finance and Administration, Bureau of TennCare (TennCare) in the identification of strengths and areas of noncompliance to benefit **AmeriChoice-Middle**. **Strengths** indicate that the health plan demonstrated particular proficiency on a given QP standard element or PA, and can be identified independent of 100 percent compliance. The lack of an identified strength should not be interpreted as a shortcoming on the part of **AmeriChoice-Middle**.

**Areas of noncompliance** were identified where **AmeriChoice-Middle** achieved less than 100 percent compliance. They reflect what the health plan *should do* and may be accompanied by recommended policy, procedure or process changes from QSource. A score of 100 percent on a standard indicates that **AmeriChoice-Middle** fully met the criteria and, therefore, is in full compliance. **Tables 4-3** and **4-4** detail **AmeriChoice-Middle**'s strengths and areas of noncompliance for the 2010 AQS. No areas of noncompliance items repeated from the 2009 survey.

**Table 4-3. 2010 QP Standard Strengths and Areas of Noncompliance for AmeriChoice-Middle**

| Strengths | Areas of Noncompliance |
|---|---|
| **Quality Improvement (QI) Program** | |
| **AmeriChoice-Middle** was in full compliance with this standard. | |
| **Network: Contracting, Availability, Access and Documentation** | |
| **AmeriChoice-Middle** was in full compliance with this standard. | |
| **QI Activities** | |
| **AmeriChoice-Middle** was in full compliance with this standard. | |

| Table 4-3. 2010 QP Standard Strengths and Areas of Noncompliance for AmeriChoice-Middle | |
|---|---|
| **Strengths** | **Areas of Noncompliance** |
| **Clinical Criteria for Utilization Management (UM) Decisions** | |
| **AmeriChoice-Middle** was in full compliance with this standard. | |
| **Member Rights and Responsibilities** | |
| | **Element #6: Notification of changes to written materials.** The MCO had updates to the policy regarding co-pay changes effective 01/01/2010, but the members were not provided the written notice 30 days in advance. |
| ***John B. Consent Decree* (EPSDT)** | |
| **Element #1: New member calls.** The MCO chose to conduct new member calls on all new members despite having exceeded the required screening rate standard.<br><br>**Element #31. Program Coordination.** As part of the Emergency Department (ED) Diversion program, the MCO identified children with more than five ED visits in a seven- month period to determine if they had a medical home. During this process, several members were identified whose "troublesome patterns of service utilization" ultimately resulted in referrals and coordination with Department of Children Services. | **Element #6: Undeliverable mail.** The MCO should ensure that, when mail is returned as undeliverable, both attempts to find family occur within the required time frames.<br><br>**Element #10: Community contacts approved.** The MCO should ensure that all community events involving member outreach/interaction receive appropriate approval from TennCare. The MCO should also ensure that events are documented accurately in quarterly EPSDT reports. |
| ***Grier Revised Consent Decree*** | |
| **AmeriChoice-Middle** was in full compliance with this standard. | |
| **Non-Discrimination Compliance** | |
| | **Element # 3: Display of non-discrimination posters.** The MCO should include the information on the posters located in their breakrooms informing their employees regarding the Omnibus Budget Reconciliation Act of 1981. The MCO should continue to include the current information like employees' rights and obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990 and the Age Discrimination Act of 1975. |

| Table 4-4. 2010 PA Strengths and Areas of Noncompliance for AmeriChoice-Middle | |
|---|---|
| **Strengths** | **Areas of Noncompliance** |
| **Clinical Criteria for UM Decisions: Denial File Review (age 20 and younger only)** | |
| **AmeriChoice-Middle** was in full compliance with this PA. | |
| ***John B. Consent Decree* (EPSDT): Information System Tracking Review** | |
| **AmeriChoice-Middle** was in full compliance with this PA. | |
| ***Grier Revised Consent Decree*: Appeal File Review** | |
| **AmeriChoice-Middle** was in full compliance with this PA. | |

## *Corrective Action Plan Process*

CAPs are designed to improve performance in areas of noncompliance. TennCare requires that the MCO submit a CAP for *any* QP standard element or PA that has been identified as an area of noncompliance (i.e., less than 100 percent compliance), regardless of overall performance on the corresponding QP standard or PA. At the direction of TennCare, CAPs will also be required for deficiencies noted in the unscored elements of the QI Activities standard. The AQS represents an opportunity for health plans to receive technical assistance – from TennCare or QSource – while developing a CAP for areas that require improvement. CAPs are considered On Request Reports (ORRs), meaning that TennCare may request them at its discretion and not solely based on the MCO's performance outcomes.

Within 14 days of the posting notification of its final AQS report, **AmeriChoice-Middle** must electronically submit all required CAPs to the following:

- TennCare Office of Contract Compliance and Performance (OCCP): **OCCP.Reports@tn.gov**
- TennCare Division of Quality Oversight:
  - Director: **Judy.M.Womack@tn.gov**
  - Assistant Director: **Pauline.S.McIntyre@tn.gov**
- QSource: **aqs-cap@qsource.org**

CAPs will not be considered as submitted if they are not received by all four parties within the required time frame. Following CAP evaluation, TennCare will send the health plan either a letter of approval or a denial with a request for additional clarifying information.

**AmeriChoice-Middle** did not achieve full compliance on:

- Member Rights and Responsibilities, Element #6: Notification of changes to written materials.

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- *John B. Consent Decree* (EPSDT):
  - Element #6: Undeliverable mail
  - Element #10: Community contacts approved
- Non-Discrimination Compliance, Element #3: Display of non-discrimination posters

The MCO also did not achieve full compliance on the UM denial file review PA.

A CAP will be required for each of these items. Each CAP must address and meet the intent of the identified area of noncompliance, show progress made in meeting the CAP, include an intended completion date, and the titles of those responsible for its completion.

## *Quality Improvements since the Previous AQS*

Each year, the AQS summarizes the quality improvements made by each MCC since the previous year's survey. As detailed in **Tables 4-5** and **4-6**, this summary includes areas of noncompliance that were identified by QSource in 2009 and **AmeriChoice-Middle**'s planned action as described in its CAP(s). With its CAPs, the MCO satisfied all areas of noncompliance identified during the 2009 AQS. For more detailed results, see **AmeriChoice-Middle**'s *2009 AQS Report*.

| Table 4-5. QP Standard Improvements since the 2009 AQS | | |
|---|---|---|
| **2009 Area of Noncompliance** | **AmeriChoice-Middle's Planned Action** | **Action Accomplished** |
| **Member Rights and Responsibilities** | | |
| **Element #5: Translation services.** All quarterly member newsletters should include the procedure on obtaining information in alternative formats or how to access interpretation services. The health plan should continue to mention that these services are free. | Review current practice of Member Newsletters and add to all Member Newsletters as a standard article/procedure. | All quarterly member newsletters included the procedure on obtaining information in alternative formats or how to access interpretation services. The newsletters also indicated that these services are free. This satisfies this area of noncompliance. |
| **Comment:** None. | | |
| ***John B. Consent Decree* (EPSDT)** | | |
| **Element #27: Individual education plans (IEPs).** After receipt of the IEP, the MCO should send a copy of it and any related information (e.g., action taken by the MCO in response to receipt of the IEP, action the MCO expects the provider to take) to the primary care provider/physician (PCP). | A tracking log is maintained on a common drive so that all IEPs are documented and tracked in one central location.<br><br>One of the tracking elements includes documentation of the date the copy of the IEP was sent to the PCP. Quality audits are conducted in the Medical CM [Care Management] Dept. on a monthly basis.<br><br>As part of the monthly Quality audit - the region manager will review the assigned CM CareOne notes for all new IEPs for that month to be certain that the notification/IEP was sent to the member's PCP. | Quality audits occurred monthly until October 2009, at which time the corporate standard transitioned to quarterly audits. The CM Manager showed online examples at her desk of audit results from 2009. The audits included an evaluation of CareOne documentation by CMs, in which documentation regarding IEPs was included. The IEP Tracking Database contained all pertinent dates related to the IEP process, including the date of PCP contact for member evaluation and the date the IEP was sent to the PCP. This satisfies the CAP for 2009. |
| **Comment:** None. | | |

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| Table 4-6. PA Improvements since the 2009 AQS | | |
|---|---|---|
| **2009 Area of Noncompliance** | **AmeriChoice-Middle's Planned Action** | **Action Accomplished** |
| **Member Rights and Responsibilities: Complaint File Review** | | |
| **AmeriChoice-Middle** should ensure it makes the required notification to members regarding the resolution of complaints. | We are developing a letter to go to members to advise that a complaint has been investigated and resolved. The drafted letter will be sent to TennCare to be approved prior to implementation. The AmeriChoice QM 10 policy is currently being reviewed so changes can be made to reflect the above changes. | The MCO developed a letter template that would be mailed to the members stating the complaint was investigated and resolved. An e-mail from TennCare to the MCO indicated that the letter template was approved. P&P #HS QM 10: Addressing Potential Quality of Care/Quality of Service Issues indicated that the results/findings would be reported to the members via the Member Complaint Resolution Letter. These actions satisfy the 2009 CAP. |
| **Comment:** None. | | |
| ***Newberry Dispute Resolution*: Home Health Denial File Review** | | |
| **AmeriChoice-Middle** should take steps to ensure that members are notified of Home Health service request denial decisions in a timely manner. | **AmeriChoice** will work to ensure that members are notified of home health service request denial decisions timely. Health Services (HS) staff will receive retraining on end-to-end process for home health denials including notification time standards. HS staff will attend Grier retraining. | A PowerPoint presentation on the UM Redesign Workshop was used to provide the staff with training on end-to-end processes for home health denials, including the policy on timeliness. The presentation also covered topics on *Grier*. These actions satisfy the 2009 CAP. |
| **Comment:** None. | | |

# Summary and Recommendations

*for **AmeriChoice-Middle***

Overall, **AmeriChoice-Middle** demonstrated a commitment to quality and TennCare contractual compliance. The health plan achieved 100 percent compliance on five of eight quality process (QP) standards, and on two of three performance activities (PAs). Where full compliance was not met, the Managed Care Organization's (MCO's) performance ranged from 94.4 to 96.8 percent. This section includes a comparison with the previous year's compliance results and a detailed discussion of areas of noncompliance, strengths and suggestions identified during the 2010 Annual Quality Survey (AQS).

## *Integration of Medical-Behavioral Services*

**AmeriChoice-Middle**'s policies and procedures (P&Ps) helped ensure the coordination of medical and behavioral health activities. The roles and responsibilities of primary care providers (PCPs) and mental health/substance abuse treatment providers were well defined. Collaboration was promoted via the health plan's P&Ps, processes, Provider Manual, website and provider newsletters. Screening tools were utilized to identify the need for case management (CM) and to assess the behavioral health needs of those already in CM. **AmeriChoice-Middle** used multiple tools to evaluate provider performance in these areas, and evidence produced on-site demonstrated collaboration, the monitoring of implementation and outcomes, and follow-up for members at least every 30 days.

There were distinct P&Ps for adverse occurrences, which were reported, investigated and addressed through corrective action by the Provider Affairs Subcommittee (PAS). QSource verified these actions in staff interviews and document review. **AmeriChoice-Middle** demonstrated compliance with tracking and trending, reporting requirements and the availability of MCO adverse occurrence documentation to TennCare.

The health plan's coordination efforts for children were also evident. Family involvement, accessible services, and follow-up after inpatient or residential treatment were just a few of the actions noted for TENNderCare members.

## *Areas of Noncompliance*

Areas of noncompliance were identified where **AmeriChoice-Middle** achieved less than 100 percent compliance. This includes the unscored elements in the QI Activities QP standard. Areas of noncompliance reflect what the health plan *should do* and may be accompanied by recommended policy, procedure or process changes from QSource. **AmeriChoice-Middle's** areas of noncompliance centered primarily on member communication, outreach approval/ documentation and display of non-discrimination posters. Upon changing the policies regarding co-pay rates, the MCO failed to notify members 30 days in advance, as is required by TennCare. Also, the MCO did not ensure that undeliverable mail was followed up on with

attempts to locate family members within required time frames. The MCO should make sure to receive appropriate approval for all community outreach activities with TennCare prior to the events; they should also ensure that events are documented accurately in quarterly reports of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) efforts. The MCO is also required to display non-discrimination posters that contain all of the federally required statutes regarding employee rights and obligations. The posters located in the MCO's breakroom did not have information on the *Omnibus Budget Reconciliation Act of 1981*.

All areas of noncompliance addressed during the 2009 AQS report were successfully resolved.

## Strengths

Strengths indicate that the MCO demonstrated particular proficiency on a given QP standard element or PA and can be identified independent of 100 percent compliance. QSource documented strengths under the *John B. Consent Decree* during the 2010 AQS. The MCO chose to conduct new member calls on all new members despite having exceeded the required screening rate standard.

Another strength in the same area was attributed to program coordination. As part of the Emergency Department (ED) Diversion program, the MCO identified children with more than five ED visits in a seven- month period to determine if they had a medical home. During this process, several members were identified whose "troublesome patterns of service utilization" ultimately resulted in referrals and coordination with the Department of Children Services.

## Suggestions

During the 2010 AQS, QSource made suggestions that are encouraged for **AmeriChoice-Middle** but not required. The MCO should consider including a statement in the quarterly member newsletter indicating the availability and location of safety and quality performance information. To further enhance its outreach efforts, the MCO should consider revising its TENNderCare/EPSDT policy (#HS QM PWE 1) to more specifically address outreach to members who have not used services in more than two years. Telephone scripts used with these members could remind them that they have not used services in a two-year time period.

To further ensure that PCPs use the online list of TENNderCare members who are not up-to-date on their screenings, the MCO could include more specific instructions in newsletters and training materials that direct providers to the health plan website.

Additionally, to aid non-discrimination compliance, the health plan's policy and procedure regarding language and interpretation services could more clearly state that assistance is available to visually impaired or blind members.

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# APPENDIX A | *Quality Process Standard Survey Tool*

*for **AmeriChoice-Middle***

This section contains the completed Annual Quality Survey (AQS) Quality Process (QP) Standard Survey Tool for Managed Care Organizations (MCOs), 2010 Edition.

Each evaluation element is referenced with the relevant paragraphs/sections of the Contractor Risk Agreement (CRA) and/or other applicable state or federal rules or laws.

# 2010 Annual Quality Survey - Quality Process Standards

## AmeriChoice-Middle

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Quality Improvement (QI) Program** | | | | |
| **1 Member safety and quality** | | | 0.750 | 0.750 |
| The MCO has a written plan for collecting and providing information on member safety that includes actions taken to:<br>● document provider efforts to improve member safety; and<br>● make performance data available for members and practitioners. | ☑ Plan for collecting<br>☑ Plan for distributing | 0.375<br>0.375 | | |

*CRA § 2.15.1.3 (E/W, Middle and TCS)*

The health plan's 2009 QI Program reported supporting the prevention and elimination of healthcare errors through a commitment to the practice of evidence-based medicine using a variety of mechanisms, including but not limited to measurement tools and reporting metrics focused on patient safety, evidence-based claims and prescription reports to identify adverse events, quality of care (QOC) referrals, and databases that identify, track and address safety concerns. The QI Program also stated that patient safety goals are developed and integrated into the QI Work Plan annually. The 2009 Work Plan was reviewed on-site and evidenced that the Managed Care Organization (MCO) is addressing member safety through activities such as on-site office assessments of primary care provider (PCP) initial credentialing, pharmacy audits (e.g., audits of quarterly prescribing pattern, narcotic drug utilization review program and polypharmacy program), and preventive/ambulatory screening of all age members throughout the year. Also, the Provider Manual addressed many areas of patient safety, including preventive initiatives, hospital safety and medication safety. The website (uhcrivervalley.com) was accessed by reviewers and found to contain a link that directed the member to The Joint Commission website to compare hospital and provider quality. Also, the 2nd quarter (Q2) member newsletter, Health Talk, featured an article titled "We Make Sure You Get Great Care and Service." At the end of the article, members were referred to the health plan's website for additional information on their quality management, utilization management, MCO structure, etc.

SUGGESTION: The MCO could include a statement in the quarterly member newsletter informing members that information on safety and quality performance is available on the website or by making a request to Customer Service.

**Total Score: 0.750 out of 0.750 = 100 % Compliance**

# 2010 Annual Quality Survey - Quality Process Standards

## AmeriChoice-Middle

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Network: Contracting, Availability, Access and Documentation** | | | | |
| **1 Specialist termination** | | | 0.250 | 0.250 |
| Contracts with specialists and specialty group practices require timely notification (no less than 30 days prior when possible) to MCO members affected by the termination of a specialist or the entire specialty group. | ☑ Yes<br>☐ No | 0.250<br>0.000 | | |

*CRA § 2.11.8.1.4 (E/W and TCS); CRA § 2.11.9.1.4 (Middle)*

The section on Term and Termination in the Tennessee Program Network Practitioner Provider Agreement Between UnitedHealthcare Plan of the River Valley, Inc., and [Contracting Practitioner] as well as the Tennessee Program Network Practitioner Group Provider Agreement Between UnitedHealthcare Plan of the River Valley, Inc. and [Contracting Practitioner Group] stated that the contracting practitioner and contracting practitioner group shall provide 60 days written notification of termination of the agreement to MCO Members.

| | | | | |
|---|---|---|---|---|
| **2 Notice of provider termination** | | | 0.250 | 0.250 |
| If a Primary Care Physician (PCP) ceases participation in the MCO, the MCO immediately provides written notice--no less than 30 days prior to the effective date of the termination and no more than 15 days after receipt or issuance of the termination notice--to each member who has chosen the provider as his/her Primary Care Provider (PCP). | ☑ Yes<br>☐ No | 0.250<br>0.000 | | |

*Notice template provided by TennCare;*
*CRA § 2.11.8.1.2 (E/W and TCS); CRA § 2.11.9.1.2 (Middle)*

Policy and Procedure (P&P) #GR AC 2: Member Notification of Physician Change or Termination addressed that if a PCP or non-PCP provider no longer provides services for health plan members, the health plan will notify members at least 30 calendar days prior to the effective termination date. It also included that, in those instances when the practitioner leaves the network without prior notice of termination, the members who had chosen the provider as his/her PCP will be notified no more than 15 calendar days after termination.

**Total Score: 0.500 out of 0.500 = 100 % Compliance**

# 2010 Annual Quality Survey - Quality Process Standards

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AmeriChoice-Middle

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **QI Activities** | | | | |
| **1 Coordination between physical and behavioral health** | | | 5.500 | 5.500 |
| The MCO has policies and procedures and ensures coordination between physical and behavioral health services by including key elements to the right: | ☑ Screening for behavioral health needs | 0.500 | | |
| | ☑ Referral to physical and behavioral health providers | 0.500 | | |
| | ☑ Exchange of information | 0.500 | | |
| | ☑ Confidentiality | 0.500 | | |
| | ☑ Assessment | 0.500 | | |
| | ☑ Treatment plan development | 0.500 | | |
| | ☑ Collaboration | 0.500 | | |
| | ☑ Case Management (CM) and Disease Management (DM) | 0.500 | | |
| | ☑ Provider training | 0.500 | | |
| | ☑ Monitoring implementation and outcomes | 0.500 | | |
| | ☑ Encourages PCPs and other providers to use state-approved behavioral health screening tool | 0.500 | | |

*CRA § 2.9.5.1 and 2.9.5.3.2 (E/W and TCS);*
*CRA § 2.9.8.1 and 2.9.8.3.2 (Middle)*

P&P #HS GEN 7: Coordination of Physical and Behavioral Health Services described in detail the roles and responsibilities for both PCPs and specialty care providers (e.g., mental health providers and substance abuse providers). These roles were clearly outlined in the Provider Manual as well. PCPs were responsible for assessing members' mental health and substance abuse problems using screening tools such as the Behavioral Health Toolkit (available on the provider website). P&P #HS GEN 7 Attachments A (Provider Evaluation of Performance [PEP] Plan), B (audit tool) and C (medical record review tool) were used to evaluate the provider's performance. CM processes were discussed with the Manager of Care Management in detail regarding coordination of physical and behavioral health. The process was reported to include behavioral health screening for all members, using the screening tool to determine if there is a behavioral component present. In addition to the behavioral screening tool, it was reported that a health risk assessment was performed. When a behavioral problem is identified with the screening, it was noted that the member is offered participation in the internal behavioral health CM program. It was further reported that when the internal program is declined, the member is offered outside assistance opportunities (e.g. community counseling, outreach assessment, behavioral providers.) The Manager of Care Management reported that, once the assessment is completed, the screening tool auto-populates an easily customized plan of care for the member. She also provided a case to validate collaboration between DM and Behavioral Health; there was evidence of collaboration and monitoring of implementation and outcomes as well. There was a follow-up at least every 30 days, or more frequently as the situation required. Newsletters for both members and providers addressed coordination of behavioral healthcare. The MCO website was also accessed, and it provided detailed information on coordination of physical and behavioral services. The PEP Plan provided evidence that the MCO reviewed provider records to ensure that behavioral health and substance abuse screening was performed and that coordination of care occurred. P&P #HS GEN 7 also cited the following tools and resources to inform clinicians and facilities of the requirement to communicate, coordinate and collaborate healthcare delivery with other active healthcare providers: Provider Manual, provider newsletters, provider trainings and the health plan website.

# 2010 Annual Quality Survey - Quality Process Standards

## AmeriChoice Middle

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **QI Activities** | | | | |
| **2 Adverse occurrences policies and procedures** | | | 0.000 | 0.000 |
| The MCO has policies and procedures in place for reporting, investigating and managing adverse occurrences (also known as sentinel events and critical incidents) related to the provision of behavioral services. | ☑ Yes<br>☐ No | 0.000<br>0.000 | | |

P&P #HS QM 10: Addressing Potential Quality of Care/Quality of Service stated that "all potential…QOC…complaints and referrals will be handled in a professional and timely manner in accordance with applicable legal and governing bodies requirements. The information will be maintained in a manner consistent with preserving peer review privilege when it applies, protecting Protected Health Information from improper use and disclosure as required by federal law." The policy further stated that behavioral health issues would be referred to appropriate behavioral health resources in the health plan or in a United Behavioral Health Regional Center. P&P #BH: Peer Review of Behavioral Health Adverse Occurrences defined an adverse event and outlined the scope, purpose and process for this occurrence. The Provider Affairs Subcommittee (PAS) minutes were reviewed and documented on-site, they showed the PAS reported and investigated QOC/Quality of Services for each quarter of 2009 with their determination/severity level and any corrective action that was required.

| | | | | |
|---|---|---|---|---|
| **3 Adverse occurrences definition** | | | 0.000 | 0.000 |
| The MCO identifies what constitutes an adverse occurrence, sentinel event or critical incident that requires reporting and review. | ☑ Yes<br>☐ No | 0.000<br>0.000 | | |

P&P: BH Peer Review of Behavioral Health Adverse Occurrence defined an adverse occurrence as "an unexpected occurrence involving death or serious physical injury or the risk thereof that occurs during the course of a member receiving behavioral health treatment. For the purpose of this policy occurrences are defined as any of the following or the risk thereof: Completed suicides on either an outpatient or inpatient basis; homicides attributed to members; assault, including an alleged assault, of a patient while in treatment at an inpatient, partial hospitalization or residential mental health or substance abuse facility; death or serious injury of a patient while in treatment at an inpatient, partial hospitalization, or residential mental health or substance abuse facility." The Adverse Occurrence Provider Letter reviewed on-site defined adverse occurrence for the provider, cited examples to be reported, and outlined the steps to be taken when reporting an adverse occurrence. The report form was included with the letter as well as a reference to its location on the website. The quarterly Adverse Occurrence Reports for all three regions were also reviewed in a grid format. The report was broken down into the number of occurrences for that quarter, a summary of the findings and any intervention required.

# 2010 Annual Quality Survey - Quality Process Standards

## AmeriChoice Middle

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **QI Activities** | | | | |
| **4 Adverse occurrences to be reported** | | | 0.000 | 0.000 |
| The MCO collects reports on adverse occurrences, including but not limited to the events listed at right: | ☑ Unexpected death of a member | 0.000 | | |
| | ☑ Suicide or attempted suicide | 0.000 | | |
| | ☑ Suspected physical, sexual or mental abuse of a member while the member is undergoing treatment, or if it is alleged that the suspected abuse was done by a provider or employee of a provider | 0.000 | | |
| | ☑ Injury sustained by a member while in a behavioral health treatment facility | 0.000 | | |
| | ☑ Medication errors involving a member | 0.000 | | |

P&P: BH Peer Review of Behavioral Health Adverse Occurrences identified adverse occurrence events as: unexpected death of a member, incomplete or completed suicides in either an inpatient or outpatient setting, suspected physical, sexual, or mental abuse during the course of treatment of the member that was alleged to be due to the actions of a provider or employee of the provider; or injury sustained by a member while in a behavioral health treatment facility. The Adverse Occurrence Provider Letter cited treatment complications (adverse medication errors and reaction), accidents or injuries to the member, death and attempted suicide, as well as suspected physical, sexual, or mental abuse while undergoing treatment as examples of occurrences to be reported. The 2009 Adverse Occurrence Report documented all reported occurrences on a quarterly basis with a synopsis of the findings for each quarter.

# 2010 Annual Quality Survey - Quality Process Standards

AmeriChoice Middle

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **QI Activities** | | | | |
| **5 Adverse occurrences and quality of care issues** | | | 0.000 | 0.000 |
| The MCO shows evidence that it uses data related to adverse occurrences to identify and address potential and actual quality of care and/or health and safety issues through the following actions: | ☑ Identifying adverse occurrences; | 0.000 | | |
| | ☑ Tracking adverse occurrences; | 0.000 | | |
| | ☑ Reviewing adverse occurrences; and | 0.000 | | |
| | ☑ Analyzing adverse occurrences. | 0.000 | | |

P&P: BH Peer Review of Behavioral Health Adverse Occurrences stated that adverse occurrences must be reported by network providers to all appropriate agencies as required by licensure and state/federal laws within specified time frames required immediately following the event. The health plan noted that it required network providers to report adverse occurrences, that it peer reviews adverse occurrences and submits a quarterly report of all adverse occurrences in a format prescribed by the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD). Examples of adverse occurrences cited in the P&P included but were not limited to: treatment complications (including medication errors and adverse medication reactions); accidents or injuries to the member; morbidity; suicide attempts; death of the member; allegations of physical abuse or sexual abuse, neglect; mistreatment, and/or verbal abuse; abuse of isolation, mechanical restraint or physical holding restraint. The following documents were reviewed on-site: PAS minutes, Adverse Occurrence Report and Adverse Occurrence Tracking log. All documents validated that the adverse occurrences were being properly reported, reviewed, investigated, and sent to Medical Director review for determination and assignment of a severity level. It was noted when appropriate corrective actions were taken. In some situations/adverse occurrence cases were taken for peer review.

| | | | | |
|---|---|---|---|---|
| **6 Adverse occurrence tracking and trending** | | | 0.000 | 0.000 |
| The MCO regularly reviews the number and types of adverse occurrences (including, for example, the number and type of adverse occurrences across settings, providers, and provider types) and findings from investigations by both the MCO and agencies external to the MCO. It identifies trends, patterns and opportunities for improvement, and develops and implements strategies to reduce the occurrence of these incidents. | ☑ Regularly reviews the number and types of adverse occurrences | 0.000 | | |
| | ☑ Reviews findings from investigations by MCO and external agencies | 0.000 | | |
| | ☑ Identifies trends and patterns | 0.000 | | |
| | ☑ Identifies opportunities for improvement | 0.000 | | |
| | ☑ Develops and implements strategies to reduce occurrences | 0.000 | | |

P&P: BH Peer Review of Behavioral Health Adverse Occurrences stated that the health plan required network providers to report all adverse occurrences. The health plan was noted to have peer-reviewed adverse occurrences and submitted a quarterly report of all adverse occurrences in a format prescribed by TDMHDD. The PAS Sentinel Event Committee (SEC)…“will serve as the peer review committee for adverse occurrences and will review all such occurrences and make recommendations for improving patient care and safety." The scope, purpose and procedure were outlined in detail in this P&P. The following documents were reviewed on-site: PAS minutes, Adverse Occurrence Reports and tracking log; all documents supported that the MCO was reviewing adverse occurrences within standard time frames and reporting them on a quarterly basis. When adverse occurrences were confirmed, appropriate action was noted to be taken with the provider.

# 2010 Annual Quality Survey - Quality Process Standards

## AmeriChoice Middle

CONFIDENTIAL

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **QI Activities** | | | | |
| **7 Adverse occurrence reporting requirements** | | | 0.000 | 0.000 |
| The MCO requires staff and providers to report adverse occurrences in accordance with applicable requirements. The MCO requires its staff and providers to report, respond to and document adverse occurrences in a manner specified by the MCO. The MCO develops and implements an adverse occurrence reporting process, including the form to be used to report adverse occurrences and reporting time frames. | ☑ MCO requires staff and providers to report adverse occurrences | 0.000 | | |
| | ☑ MCO requires staff and providers to respond to and document adverse occurrences | 0.000 | | |
| | ☑ MCO has a reporting process and form in use | 0.000 | | |

P&P: BH Peer Review of Behavioral Health Adverse Occurrences stated: "Adverse Occurrence reports must be reported by network providers to all appropriate agencies as required by licensure and state/federal laws within the specified time frames required immediately following the event. Per the P&P, health plan Care Management staff are required to report all adverse occurrences to the Chief Medical Officer and Behavioral Health Medical Director who, within three business days, was required to begin administrative review of the case and complete a written summary on the proper form. The PAS and SEC were reported to serve as the peer review committee for adverse occurrences, providing review of all such occurrences and making recommendations for improving patient care and safety. The P&P noted that results of any reviews may be used to make recommendations to suspend, terminate, conduct a site audit, and/or alter the participation status of programs, providers, and/or practitioners. On-site review of the Adverse Occurrence Provider Letter documented that physicians were provided a copy of the form to be submitted when reporting an adverse occurrence. The letter also directed the provider to the MCO website to obtain the adverse report form. PAS minutes documented behavioral health adverse actions/sentinel events reported and related discussions at each committee meeting.

| | | | | |
|---|---|---|---|---|
| **8 Availability of adverse occurrence documents** | | | 0.000 | 0.000 |
| The MCO makes available for review to TennCare or its designated contractor all minutes, files, notes and committee actions related to the reporting and review of adverse occurrences. | ☑ Yes | 0.000 | | |
| | ☐ No | 0.000 | | |

PAS minutes, Adverse Occurrence Reports, and Investigation Files for adverse occurrences were provided for review on-site and evidenced that they were available for review by TennCare.

**Total Score: 5.500 out of 5.500 = 100 % Compliance**

# 2010 Annual Quality Survey - Quality Process Standards

AmeriChoice Middle

CONFIDENTIAL

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Clinical Criteria for Utilization Management (UM) Decisions** | | | | |
| **1 Availability of criteria** | | | 1.000 | 1.000 |
| The MCO includes the following information in its provider manuals:<br>● medical necessity standards and clinical practice guidelines; and<br>● prior authorization, referral and other UM requirements and procedures. | ☑ Medical necessity standards and clinical practice guidelines included | 0.500 | | |
| | ☑ Prior authorization, referral and other UM requirements included | 0.500 | | |

*CRA § 2.18.5.1.7 and .10 (E/W and TCS); CRA § 2.18.5.3.8 and .16 (Middle)*

The MCO's Provider Manual stated medical necessity was determined using nationally recognized review criteria (e.g., Milliman), and appropriateness using internal criteria (e.g., Level of Care guidelines). All criteria were reported to be reviewed on an annual basis. The Provider Manual also stated that other criteria may be used when there is published peer-review literature that supports admission or continued stay criteria. Updates were noted to be provided to the MCO as they were developed by Milliman, on an annual or as-needed basis. In the July 2009 Network Bulletin, the MCO was reported to have "gone live" with the 13th Edition of Milliman Care Guidelines. The internal guidelines, however, were noted to be reviewed and revised annually with a review of the literature. The medical necessity criteria and clinical guidelines were noted and reviewed on the website (uhcrivervalley.com/10Provider) or may be requested from the Customer Service Department. Prior authorization, referral and other UM procedures were also found in the Provider Manual and on the website above.

| | | | | |
|---|---|---|---|---|
| **2 Transition to other care** | | | 0.500 | 0.500 |
| The MCO has policies and procedures and shows evidence it assists with either a member's transition to other care or to another provider when the current provider has terminated participation with the MCO. | ☑ Yes | 0.500 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.9.3.1 (E/W and TCS); CRA § 2.9.4.1 (Middle)*

P&P #HS GEN 3: Transitional Care for Members of Terminated Providers stated that there was a "defined process in place to provide for an orderly transfer of care to appropriate network providers, with attention to the individual needs of the member, timely information exchange between providers and maintaining the member confidentiality; while minimizing disruption in the care process." The P&P detailed the process that would take place in the event such a transition occurred. The policy stated the health plan "is responsible for the cost of continuation of medically necessary services the member is receiving. Continuation of such services is covered up to 90 calendar days or until the member may be transferred without disruption, whichever is less. No prior approval is necessary for the first 30 days, regardless as to whether such services are being provided by a contracted or non-contracted provider." The MCO provided a regional sample (one member case from each grand region documenting the transition from a terminated provider to the new in-network provider) that showed evidence of compliance with this element. The CM's clinical notes documented that continuous care was available or given from a provider who would cover the term at the end of the year until the transition to the new provider.

**Total Score: 1.500 out of 1.500 = 100 % Compliance**

# 2010 Annual Quality Survey - Quality Process Standards

## AmeriChoice-Middle

CONFIDENTIAL

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Member Rights and Responsibilities** | | | | |
| **1 Member Handbook development and distribution** | | | 1.000 | 1.000 |
| The Member Handbook is:<br>● developed and updated annually based on TennCare-provided templates;<br>● distributed to members within 30 days of receiving notice of enrollment in the MCO;<br>● distributed to all contracted providers upon initial credentialing; and<br>● re-distributed to all members and providers annually and as updates occur. | ☑ Developed/Updated using TennCare templates | 0.200 | | |
| | ☑ Sent to members within 30 days of enrollment | 0.200 | | |
| | ☑ Sent to providers upon credentialing | 0.200 | | |
| | ☑ Re-distributed annually | 0.200 | | |
| | ☑ Re-distributed as updated | 0.200 | | |

*CRA § 2.17.4.1, .2 and .4 (E/W, Middle and TCS)*

P&P #GR 24.1.2: Member Handbook Development and Distribution addressed a process by which the Member Handbook would be developed and updated annually based on TennCare-provided templates. The policy also indicated that the Member Handbooks would be distributed to members within 30 days of receiving a notice of enrollment in the MCO, and the New Member Packet Monthly Log provided proof of this. The mailing log provided proof of the annual mailing as well. The TennCare Addendum to the Provider Agreement indicated that the health plan should either send a copy of the Member Handbook to the provider or include notification via the Provider Manual that it is accessible online. An active link to the Member Handbook was available.

| | | | | |
|---|---|---|---|---|
| **2 Complaint procedures** | | | 0.500 | 0.500 |
| The MCO has internal complaint procedures for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees, or court orders governing the appeals process. | ☑ Yes | 0.500 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.19.1.1 (E/W, Middle and TCS)*

P&P #GR 12.2: Member Complaint and Appeal Process-TennCare Only addressed the MCO's internal complaint procedure for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees, or court orders governing the appeals process.

# 2010 Annual Quality Survey - Quality Process Standards

CONFIDENTIAL

## AmeriChoice-Middle

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Member Rights and Responsibilities** | | | | |
| **3 Communication of rights and responsibilities in Member Handbook** | | | 2.000 | 2.000 |
| The Member Handbook contains the following rights and responsibilities:<br>a. a right to file a complaint and a complaint form on which to do so;<br>b. the right to file an appeal;<br>c. a notice to the member that, in addition to the right to file an appeal of actions taken by the MCO, she/he has the right to request reassessment of eligibility-related decisions related directly to TennCare;<br>d. the member's responsibility to notify the MCO and TennCare each and every time the member moves to a new address;<br>e. the right to change MCOs;<br>f. the right to disenroll from TennCare;<br>g. the right to amend their data in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations;<br>h. the right to obtain information regarding the structure and operation of the MCO and physician incentive plans;<br>i. the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand; and<br>j. the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. | ☑ a. Right to file a complaint and form | 0.200 | | |
| | ☑ b. Right to file an appeal | 0.200 | | |
| | ☑ c. Right to request reassessment of eligibility-related decisions | 0.200 | | |
| | ☑ d. Responsibility to notify MCO and TennCare of address change | 0.200 | | |
| | ☑ e. Right to change MCOs | 0.200 | | |
| | ☑ f. Right to disenroll | 0.200 | | |
| | ☑ g. Right to amend their data | 0.200 | | |
| | ☑ h. Right to obtain information on structure/operation of MCO and physician incentive plans | 0.200 | | |
| | ☑ i. Right to receive information on available treatment options and alternatives | 0.200 | | |
| | ☑ j. Right to be free from restraint or seclusion | 0.200 | | |

*CRA § 2.17.4.5.11-.13, .17, .19-.21, .24-.27 and .29 (E/W and TCS);*
*CRA § 2.17.4.7.19, .23, .24, .28 -.32, .35 -.38 and .40 (Middle)*

The Member Handbook addressed each of the criteria mentioned in this element in its entirety.

# 2010 Annual Quality Survey - Quality Process Standards

CONFIDENTIAL

## AmeriChoice Middle

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Member Rights and Responsibilities** | | | | |
| **4 Member Handbook inclusions** | | | 2.600 | 2.600 |
| The Member Handbook is, at a minimum, in accordance with the following guidelines:<br>a. includes a description of services provided including benefit limits, exclusions and use on non-contract providers;<br>b. includes a description of TennCare cost share responsibilities for members including an explanation that providers and/or the MCO may utilize whatever legal actions that are available to collect these amounts;<br>c. indicates that members may not be billed for covered services except for the amounts of the specified TennCare cost share responsibilities and of their right to appeal in the event that they are billed;<br>d. includes procedures for obtaining required services, including procedures for obtaining referrals to network specialists and providers outside of the plan;<br>e. advises members that if they need a service that is not available within the plan, they will be referred to a provider outside of the plan and any co-payment requirements would be the same as if this provider were in the plan;<br>f. includes an explanation on how members will be notified of member specific information such as effective date of enrollment;<br>g. includes notice to the member that enrollment in the MCO's plan invalidates any prior authorization for services granted by another plan but not utilized prior to enrollment in the new MCO and notice of continuation of an active treatment plan or pregnancy;<br>h. includes information on how to access the PCP on a 24-hour basis as well as the 24-hour nurse line;<br>i. includes an explanation of emergency services and procedures on how to obtain them both in and out of the MCO's service area, including but not limited to: the use of 911, locations of emergency settings, and locations for services;<br>j. includes information about preventive services for adults and children, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for Medicaid-eligible members, listing of preventive services and notice that preventive services are at no cost and without cost share responsibilities;<br>k. includes written information concerning advance directives;<br>l. includes member services toll free telephone numbers, including the TennCare Hotline, the MCO's customer service line, and the MCO's | ☑ a. Description of service parameters | 0.200 | | |
| | ☑ b. Description of TennCare cost share responsibilities | 0.200 | | |
| | ☑ c. Billing for covered services and appeal of billed services | 0.200 | | |
| | ☑ d. Procedures for obtaining services and referrals in and out of plan | 0.200 | | |
| | ☑ e. Out-of-plan referrals co-pays | 0.200 | | |
| | ☑ f. Explanation of member notification | 0.200 | | |
| | ☑ g. Notice of continuation/discontinuation of previously authorized services | 0.200 | | |
| | ☑ h. Accessing PCP and nurse line 24/7 | 0.200 | | |
| | ☑ i. Obtaining emergency services | 0.200 | | |
| | ☑ j. Preventive services information | 0.200 | | |
| | ☑ k. Advance directives information | 0.200 | | |
| | ☑ l. Includes all required telephone numbers and notice that members may contact the MCO or TennCare with questions | 0.200 | | |
| | ☑ m. Information on appropriate prescription drug usage | 0.200 | | |

# 2010 Annual Quality Survey - Quality Process Standards

CONFIDENTIAL

## AmeriChoice-Middle

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|

### Member Rights and Responsibilities

24/7 Nurse Triage Line with a statement that the member may contact the plan or TennCare regarding questions about TennCare as well as the service/information that may be obtained from each line; and

m. information on appropriate prescription drug usage.

*CRA § 2.17.4.5.3, .4, .6 -.10, .15, .16, .22 and .28 (E/W and TCS);*
*CRA § 2.17.4.7.3, .5, .9-.11, .16, .17, .26, .27, .33 and .39 (Middle)*

The Member Handbook included all the mentioned guidelines in the element.

**5 Notice of right to file a complaint** — 1.000 — 1.000

A notice of members' right to file complaints is included in quarterly newsletters sent by the MCO. The notice includes a contractor phone number for doing so and is written in English and Spanish.

- ☑ Notice in English and Spanish — 0.333
- ☑ Required information in each quarterly newsletter — 0.333
- ☑ Phone number for complaints — 0.334

*CRA § 2.17.5.3.3 (E/W and TCS); CRA § 2.17.5.3.5 (Middle)*

All quarterly newsletters sent by the MCO included a notice in English and Spanish of the members' right to file complaints and a phone number for doing so.

**6 Notification of changes to written materials** — 1.000 — 0.500

The MCO provides written notice to members of any changes in policies or procedures described in written materials previously sent to members at least 30 days before the effective date of change.

- ☑ Written notice to members — 0.500
- ☐ Members notified at least 30 days before effective date of change — 0.500

*CRA § 2.17.2.8 (E/W, Middle and TCS)*

P&P #GR 24.1.2 addressed that the MCO provides written notice to members of any changes in P&Ps 30 days before the effective date. The MCO had some changes to their policy regarding co-pay, effective 1/1/10, and the information was included as an insert to the Member Handbook. The MCO submitted the changes for approval to TennCare on 11/24/09 and received TennCare approval on 12/10/09. The MCO was unable to provide members with the written notice 30 days in advance.

AREA OF NONCOMPLIANCE: The MCO had updates to the policy regarding co-pay changes effective 1/1/10, but the members were not provided the written notice 30 days in advance.

# 2010 Annual Quality Survey - Quality Process Standards

## AmeriChoice Middle

CONFIDENTIAL

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Member Rights and Responsibilities** | | | | |
| **7 Translation services** | | | 1.000 | 1.000 |
| The MCO provides translation services for members as demonstrated by the following:<br>● Member Handbooks include information on how to obtain information in alternative formats or how to access interpretation services, as well as a statement that interpretation and translation services are free;<br>● Quarterly newsletters include the procedure on how to obtain information in alternative formats or how to access interpretation services, as well as a statement that interpretation and translation services are free;<br>● The MCO develops a written procedure for providing members language interpretation and translation services, including but not limited to members with hearing impairment and/or Limited English Proficiency (LEP);<br>● The MCO provides language help-lines with specific numbers for these members; and<br>● The MCO's Non-Discrimination Compliance Coordinator provides instruction for its staff, including but not limited to all providers and direct service subcontractors regarding the procedure. | ☑ Information listed in handbook | 0.200 | | |
| | ☑ Information in all quarterly newsletters | 0.200 | | |
| | ☑ Procedure for language interpretation and translation services | 0.200 | | |
| | ☑ Help-line numbers provided | 0.200 | | |
| | ☑ Instruction to staff, providers and subcontractors | 0.200 | | |

*CRA § 2.17.4.5.23 and 2.17.5.3.2 (E/W and TCS); CRA § 2.17.4.7.34 and 2.17.5.3.4 (Middle);*
*CRA § 2.18.1.3, 2.18.2.1-.2 and 2.28.2 (E/W, Middle and TCS)*

The Member Handbook, all quarterly newsletters and P&P #GR 24.1.2 included documentation on obtaining information in alternative formats and on how to access interpretation services for free. These documents also included that the translation services were not limited to members with hearing impairment and or LEP. The Member Handbook included language help-lines with specific numbers. The MCO provided Tackling TennCare Training to the staff that included the Non-Discrimination topic. The Providers could access this information on the MCO website under 'Welcome to AmeriChoice Tennessee's Provider University!' webpage.

# 2010 Annual Quality Survey - Quality Process Standards

## AmeriChoice-Middle

CONFIDENTIAL

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Member Rights and Responsibilities** | | | | |
| **8 Translated vital documents** | | | 1.000 | 1.000 |
| All vital MCO documents and the Member Handbook are translated and available in Spanish. Within 90 days of notification from TennCare, all vital MCO documents are translated and available to each LEP group identified by TennCare that constitutes five percent of the TennCare population or 1,000 members, whichever is less. | ☑ All vital documents translated | 0.500 | | |
| | ☑ Vital documents translated within 90 days | 0.500 | | |

*CRA § 2.17.2.5 (E/W, Middle and TCS)*

P&P #GR 24.1.1: Members Materials Development and Requirements stated that all vital MCO documents must be translated and available in Spanish. The policy also indicated that all vital MCO documents must be translated and available to each LEP group identified by TennCare.

**Total Score: 9.600 out of 10.100 = 95.0 % Compliance**

# 2010 Annual Quality Survey - Quality Process Standards

CONFIDENTIAL

AmeriChoice-Middle

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **1 New member calls** | | | 1.000 | 1.000 |
| The MCO conducts telephone calls to all new members under the age of 21 to inform them of TENNderCare services, including availability of assistance with appointment scheduling and transportation to appointments. (This is not applicable for East, West and Middle MCOs if the MCO's TENNderCare screening rate is above 90 percent, as determined in the most recent Centers for Medicare & Medicaid Services (CMS) 416 report.) | ☑ Yes or Not Applicable (CMS-416 screening rate above 90 percent) | 1.000 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.7.5.2.2.1 (E/W); CRA § 2.7.6.2.2.1 (Middle); CRA § 2.6.13.2.2.1 (TCS)*

Although the MCO was not required to conduct new member telephone calls based on the 2009 CMS-416 screening rate of 103.4 percent, telephone calls were made to new members throughout the year. This was verified in TENNderCare Welcome Calls reports provided on-site.

STRENGTH: The MCO chose to conduct new member calls on all new members despite having exceeded the required screening rate standard.

# 2010 Annual Quality Survey - Quality Process Standards

## AmeriChoice-Middle

CONFIDENTIAL

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **2 Outreach contacts** | | | 0.750 | 0.750 |
| The MCO distributes six outreach contacts a year, which include:<br>● a Member Handbook sent within 30 days of enrollment (annually thereafter upon the member's anniversary date of enrollment, the MCO sends an updated handbook, a supplemental update to the handbook, or a reminder of EPSDT services);<br>● four quarterly newsletters;<br>● one reminder before screens are due with transportation and scheduling assistance offered; and<br>● at least one of the six outreach attempts identified above advises members who are blind, deaf, illiterate, or non-English speaking regarding how to request and/or access such assistance and/or information. | ☑ Member Handbook sent within 30 days of enrollment | 0.125 | | |
| | ☑ Quarterly newsletters | 0.125 | | |
| | ☑ Screening due reminders | 0.125 | | |
| | ☑ Annual reminder of EPSDT services | 0.125 | | |
| | ☑ Annually informed regarding availability of information in alternative formats | 0.250 | | |

*John B. Consent Decree (CD) ¶ 40 [39(b), (d), (e), (g) and (h)]; CRA § 2.7.5.2.2 and 2.7.5.2.2.2 (E/W); CRA § 2.7.6.2.2 and 2.7.6.2.2.2 (Middle); CRA § 2.6.13.2.2.2 (TCS)*

Mailing verifications showed that updated Member Handbooks were sent to all members in December 2009. The MCO provided a log verifying the mailing of new member packets, including Member Handbooks. Mailings occurred at multiple times of each month during 2009. Member Newsletters were sent in each quarter of 2009. Each newsletter was also produced and distributed in Spanish. All member newsletters informed members of how to access materials in other languages or formats and informed them of transportation assistance. The MCO sent anniversary reminders titled Keeping Your Child Healthy that reminded parents of the need to take their child for a check-up. Additionally, the MCO sent monthly reminder cards, also titled Keeping Your Child Healthy. The information in these cards reminded parents of the ages when their child should be seen for a check-up. Monthly mailing verifications were available on-site as evidence that anniversary reminders and monthly reminders were sent throughout 2009.

| | | | | |
|---|---|---|---|---|
| **3 Documenting outreach** | | | 0.500 | 0.500 |
| The MCO maintains a process, approved by TennCare, for follow-up that includes provisions for documenting all outreach attempts with a mechanism for maintaining records of efforts to reach members missing screenings when scheduled or who have failed to schedule regular check-ups. This includes a different method of outreach effort at least quarterly to accomplish a missed screening. | ☑ Yes | 0.500 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.7.5.2.4 (E/W); CRA § 2.7.6.2.4 (Middle); CRA § 2.6.13.2.4 (TCS); CD ¶ 40 [39(j)]*

AmeriChoice used its Universal Tracking Database (UTD)–a proprietary software–to track and monitor each child's TENNderCare status. The database identified members who were overdue for screenings and immunizations. The database was capable of generating immediate reports on each member's screening status. The MCO provided four different outreach methods for 2009. Each mailer was different, yet each reminded the parent/child to schedule a TENNderCare screening. One mailer also included the childhood and adolescent immunization schedules.

# 2010 Annual Quality Survey - Quality Process Standards

## AmeriChoice-Middle

CONFIDENTIAL

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **4 Declined services** | | | 0.500 | 0.500 |
| The MCO requires providers to maintain a process for documenting services declined by a parent, guardian or mature competent child, specifying the service declined. | ☑ Yes | 0.500 | | |
| | ☐ No | 0.000 | | |

*CD ¶ 40 [39(i)]; CRA § 2.7.5.2.6 (E/W); CRA § 2.7.6.2.6 (Middle); CRA § 2.6.13.2.6 (TCS)*

P&P #HS QM PWE 1: TENNderCare/EPSDT stated that the MCO would "[r]equire providers to have a process for documenting declined services by a parent or guardian or mature competent child, specifying the particular service that was declined. This process must meet the requirements of the State Medicaid Manual." The MCO's EPSDT Medical Record Review Tool included a place for the reviewer to validate that the audited provider documented any refusal of EPSDT services by a parent/guardian or child. The TENNderCare Clinical Documentation Exit Summary Tool was used to discuss audit findings with providers/office managers. This tool included "Declination of Service by Parent" as a discussion point for the exit summary. Examples of medical record audits conducted in 2009 demonstrated that the MCO assessed the record for refusal of services, and the service (in this case an immunization) that was refused.

| | | | | |
|---|---|---|---|---|
| **5 Re-notification if no services used** | | | 0.750 | 0.750 |
| The MCO maintains a process for determining if someone eligible for EPSDT has used no services within a year and follows up with two reasonable attempts to re-notify that member. (One attempt can be [an individual] referral to a Health Dept.) These two attempts are in addition to the required quarterly attempts outlined in Element #3. The attempts are different in format or message. | ☑ Maintains process | 0.250 | | |
| | ☑ Two additional re-notifications | 0.250 | | |
| | ☑ Attempts in different format or message | 0.250 | | |

*CD ¶ 40 [39(a)]; CRA § 2.7.5.2.5 (E/W); CRA § 2.7.6.2.5 (Middle); CRA § 2.6.13.2.5 (TCS)*

P&P # HS QM PWE 1 indicated that two attempts would be made to re-notify members who had not used services within one year. The P&P cited a referral to the Health Department and quarterly mailed reminders as the two methods used for notification. The MCO provided its postcard, "Did You Miss a Check-up?" as evidence of one outreach effort used for members who have not used services within a year. Instead of Health Department referrals, the MCO chose to conduct telephone calls to members who had not used services within a year. The policy has since been revised to reflect the use of telephonic outreach rather than Health Department referrals.

# 2010 Annual Quality Survey - Quality Process Standards

AmeriChoice-Middle

CONFIDENTIAL

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **6 Undeliverable mail** | | | 0.750 | 0.500 |
| The MCO documents two reasonable attempts to find a family when mail is returned as undeliverable. One of the two attempts is made within 90 days of receipt of mail returned as undeliverable. (For TennCare*Select,* the second attempt is made within 30 days.) At least one attempt is by phone. | ☑ Oral attempt | 0.250 | | |
| | ☑ Other attempt | 0.250 | | |
| | ☐ Attempt made within required time frame | 0.250 | | |

*CD ¶ 40 [39(a)]; CRA § 2.7.5.2.7 (E/W); CRA § 2.7.6.2.7 (Middle); CRA § 2.6.13.2.7 (TCS)*

The MCO submitted its TENNderCare/EPSDT Returned Mail Flow Chart to outline the process used to find families whose mail was returned as undeliverable. The flow chart indicated that all mail was sent by first class United States Postal Service to ensure that an attempt to re-send the mail occurred automatically. This was to occur within 30 days. If the mail was then returned, it was entered into the MCO's Returned Mail Tracking Log. A TENNderCare/EPSDT Coordinator would then search both AmeriChoice and public databases for member telephone numbers, which were used to generate a call list. This list was then used for the TeleVox Campaign, an automated telephonic outreach to these members, which was to occur within 90 days of receipt of returned mail. The MCO revised its member mailing process during 2009. During the on-site interview, the Manager of EPSDT and Preventive Health indicated that as the process was updated with the vendor, the second telephonic attempt fell outside of the 90 day requirement. The manager also stated that the process was now fully implemented to ensure both attempts would occur within the required time frames.

AREA OF NONCOMPLIANCE: The MCO should ensure that, when mail is returned as undeliverable, both attempts to find a family occur within the required time frames.

| | | | | |
|---|---|---|---|---|
| **7 Accurate provider lists** | | | 0.500 | 0.500 |
| The MCO makes available to families accurate lists of names and phone numbers of contract providers who are currently accepting TennCare. | ☑ Yes | 0.500 | | |
| | ☐ No | 0.000 | | |

*CD ¶ 40 [39(f)]; CRA § 2.7.5.2.8 (E/W); CRA § 2.7.6.2.8 (Middle); CRA § 2.6.13.2.8 (TCS)*

The Member Handbook informed members that network providers were identified in the Provider Directory, which was distributed with the Member Handbook to all new members, and available online (at www.uhcrivervalley.com) or by calling the MCO at 1-800-690-1606. The MCO's website was accessed, and a link to the Provider Directory was found. New member packet mailing logs verified that Member Handbooks and Provider Directories were distributed to new members several times each month throughout 2009.

# 2010 Annual Quality Survey - Quality Process Standards

CONFIDENTIAL

## AmeriChoice-Middle

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **8 Targeted activities** | | | 0.500 | 0.500 |
| The MCO has established criteria for determining when to target specific informing activities to pregnant women, families with newborns, adolescents, first-time eligible members, those not using the program for over two years and illiterate, blind, deaf and LEP members. Pregnant women are informed about the availability of EPSDT for their children prior to the delivery date (provided the MCO is informed of the pregnancy) and are offered EPSDT services for the child when it is born. The MCO treats a woman's request for EPSDT services during pregnancy as a request for EPSDT services for the child at birth. | ☑ Has criteria to target activities to pregnant women, families with newborns, adolescents, first-time eligible members, those not using the program for over two years, and illiterate, blind, deaf and LEP members | 0.250 | | |
| | ☑ Offers services for children when born | 0.250 | | |

*CD ¶ 40 [39(l) and (n)]; CRA § 2.7.5.2.9 (E/W); CRA § 2.7.6.2.9 (Middle); CRA § 2.6.13.2.9 (TCS)*

P&P #HS HFS 2: Perinatal Care Coordination discussed the methods used to target pregnant women and families with newborns. The P&P indicated that outreach would begin the day eligibility was determined and included appointment scheduling assistance and arranging transportation. It also indicated that the Healthy First Steps (HFS) CM would educate members regarding TENNderCare services for the newborn and other children in the household and would assist the member in selecting a PCP for the baby either before or after birth. Newsletters targeted at adolescents were sent in each quarter of 2009. All adolescent newsletters contained language assistance information and instructed members on how to obtain materials in alternate formats. The teen newsletters were also translated and distributed in Spanish upon request. All new members received welcome telephone calls informing them of TENNderCare services. The call scripts provided members the opportunity to hear the message in Spanish. Members who had not used services within two years were included in quarterly TENNderCare reminder mailings.

SUGGESTION: To further enhance its outreach efforts, the MCO should consider revising its TENNderCare/EPSDT policy (#HS QM PWE 1) to more specifically address outreach to members who have not used services in more than two years. Telephone scripts used with these members could remind them that they have not used services in a two-year time period.

| | | | | |
|---|---|---|---|---|
| **9 Outreach to illiterate, blind, deaf and LEP** | | | 0.500 | 0.500 |
| The MCO customizes methods to inform individuals who are illiterate, blind, deaf or LEP about the availability of EPSDT services. | ☑ Customized methods | 0.250 | | |
| | ☑ Items distributed to identified members | 0.250 | | |

*CD ¶ 40 [39(d)]; CRA § 2.7.5.2.2.2 (E/W); CRA § 2.7.6.2.2.2 (Middle); CRA § 2.6.13.2.2.2 (TCS)*

During new member telephone calls, members were given the option to hear the message in Spanish. All member newsletters, including teen newsletters, were printed in English and Spanish. Both contained instructions for members needing information in alternate formats. The Member Handbook informed members that materials were also available in Braille or compact disk (CD). DM staff supplied examples of requests and mailed information in other languages or formats.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **10 Community contacts approved** | | | 2.000 | 1.000 |
| All of the MCO's community health education and outreach activities are approved by TennCare prior to implementation. The MCO maintains documentation of this approval. | ☑ First quarter | 0.500 | | |
| | ☐ Second quarter | 0.500 | | |
| | ☑ Third quarter | 0.500 | | |
| | ☐ Fourth quarter | 0.500 | | |

*CRA § 2.7.3.2, 2.16.2 and 2.17.1.1 (E/W); CRA § 2.7.4.2 and 2.17.1.1 (Middle); CRA § 2.16.2 and 2.17.1.1 (TCS)*

Three community outreach events were chosen from each quarter of 2009. The events chosen for the first and third quarters received the required approval from TennCare. Events for which approval was not available for the second and fourth quarters were either documented incorrectly in the quarterly EPSDT reports by the MCO, or the MCO was unable to demonstrate that approval had been obtained.

AREA OF NONCOMPLIANCE: The MCO should ensure that all community events involving member outreach/interaction receive appropriate approval from TennCare. The MCO should also ensure that events are documented accurately in quarterly EPSDT reports.

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|---|---|---|---|---|
| **11 Prenatal appointment assistance** | | | 2.000 | 2.000 |
| The MCO has policies and procedures to facilitate and take reasonable steps to assist pregnant members in accessing prenatal care and does the following:<br>● The MCO provides information on covered services to adolescent prenatal members who enter TennCare through presumptive eligibility;<br>● On the day eligibility is determined, the MCO offers assistance in making a timely first prenatal appointment after the diagnostic visit; and<br>● For a woman past her first trimester, this appointment occurs within 15 days of eligibility determination. | ☑ Policies and procedures | 0.500 | | |
| | ☑ Provides information on covered services | 0.500 | | |
| | ☑ On the day eligibility is determined, offers appointment assistance | 0.500 | | |
| | ☑ For a woman past her first trimester, appointment occurs within 15 days | 0.500 | | |

*CD ¶ 40 [39(m)]; CRA § 2.7.4.2.1 (E/W); CRA § 2.7.5.2.1 (Middle); CRA § 2.6.12 (TCS)*

P&P #HS HFS 2 outlined the processes used by the MCO to conduct outreach and coordinate services for pregnant members. It applied to all members - those who became enrolled in the MCO through presumptive eligibility and those enrolled at the time they became pregnant. The P&P stated that the HFS CM would assist or arrange for prenatal care to members on the date of their enrollment in the MCO. Assistance included arranging transportation and appointment scheduling. The P&P specified that if the woman was in her second or third trimester the appointment should be within 15 days. The P&P also stated that providers should be educated that failure to schedule an appointment for these members within 15 days would be considered a material breach of contract. Provider Manuals included this requirement in its Medical Appointment Scheduling Guidelines. The HFS Health Coach demonstrated the process used when contacting pregnant members. The assessment included offering appointment scheduling assistance - which was done within 15 days if the member was in her second or third trimester.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **12 Referrals from one level of screening to another** | | | 1.250 | 1.250 |
| The MCO has a policy and procedure to ensure that providers make and document appropriate referrals from one level of screening or diagnosis to another, more sophisticated level of diagnosis as needed to determine the child's physical health, behavioral health and developmental needs, as to medically necessary services. This is done regardless of whether the required services are covered by the MCO. | ☑ Policy and procedure | 0.500 | | |
| | ☑ Provider compliance | 0.750 | | |

*CD ¶ 53; CRA § 2.7.5.1.5.2 (E/W); CRA § 2.7.6.1.5.2 (Middle); CRA § 2.6.13.1.5.2 (TCS)*

P&P# HS QM stated that providers were required to refer members as appropriate and that all medically necessary services would be made available to the member regardless of whether the services were covered by the MCO. The MCO's EPSDT Medical Record Review Tool included a place for the reviewer to indicate if referrals had been made, and the TENNderCare Clinical Documentation Exit Summary Tool used by reviewers to discuss audit results with providers/office staff included a discussion point for referrals.

| | | | | |
|---|---|---|---|---|
| **13 Notify MCO if unable to make referral** | | | 1.000 | 1.000 |
| Procedures ensure a process for directing providers to notify the MCO in the event a screening reveals the need for other healthcare and the provider is unable to make an appropriate referral, including policies and procedures for the MCO to secure an appropriate referral and contact the member to offer scheduling assistance and transportation. | ☑ Yes | 1.000 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.7.5.1.6 (E/W); CRA § 2.7.6.1.6 (Middle); CRA § 2.6.13.1.6 (TCS)*

The Provider Manual informed providers that coordination of services for children should be done in accordance with TENNderCare requirements and that all referrals must be documented in the member's chart. The MCO included its toll-free telephone number for CM and instructed providers to call if assistance was needed with appointments or transportation. P&P #HS QM PWE 1 supported these instructions by stating that "Upon notification from a provider of the inability to make an appropriate referral, a care manager arranges a referral and offers scheduling assistance and transportation." The CM Manager indicated that this process was in place and documented in CareOne by CM staff.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **14 Medically necessary services** | | | 1.000 | 1.000 |
| The MCO has procedures in place to provide all medically necessary EPSDT services as required by law, including policies and procedures for educating providers about the necessity of documenting all components of a screen with accurate coding. | ☑ EPSDT services | 0.500 | | |
| | ☑ Educating providers | 0.500 | | |

*CD ¶ 54; CRA § 2.6.3.5 (E/W and Middle); CRA § 2.6.3.1 (TCS)*

P&P HS QM PWE 1 indicated that all medically necessary EPSDT services would be provided to TENNderCare-eligible members. The P&P also indicated that provider records would be monitored for appropriate coding and completion of EPSDT screenings. Providers were educated about documenting and coding all components of a TENNderCare screening in the Provider Manual. Instructions included details of the components of and correct billing codes for screening. Codes for preventive medicine visits, developmental, hearing and vision screenings were listed.

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| **15 Rehabilitation and maintenance services** | | | 0.500 | 0.500 |
| Rehabilitation services include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts for maximum reduction of physical or mental disability and restoration of a recipient to the best possible functional level. (These services may be, and where medically necessary to do so are, delivered in conjunction with the services listed in ¶ 54 of the John B. CD.) Covered services include maintenance services that prevent or mitigate the worsening of conditions or prevent the development of additional health problems. | ☑ Rehabilitation services provided as described | 0.250 | | |
| | ☑ Covered services include maintenance as described | 0.250 | | |

*CD ¶ 63 and 64*

P&P HS QM PWE 1 stated that "AmeriChoice provides all necessary healthcare, diagnostic services, treatment, and other measures to correct or ameliorate, or prevent from worsening; defects, physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan." The Provider Manual included similar statements indicating that all medically necessary services would be furnished for TENNderCare-eligible members.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **16 Medical necessity** | | | 2.000 | 2.000 |
| The MCO has a procedure that ensures consistent decisions are rendered concerning issues of medical necessity, which are compliant with federal and state laws. Only the definition of "medical necessity" as defined in the TennCare/MCO contract is used, or is no more restrictive than the definition in the contract. | ☑ Procedure in place | 0.500 | | |
| | ☑ Definition of medical necessity same as contract or no more restrictive | 0.500 | | |
| | ☑ Evidence of consistent decisions (e.g., Inter-Rater Reliability [IRR] testing) | 0.500 | | |
| | ☑ Appropriate follow-up to results of consistent decision process, as applicable | 0.500 | | |

*CD ¶ 55 and 56; CRA § 2.6.3.1 and .5 (E/W, Middle and TCS)*

The 2009 Sox Audit Summary indicated that UM cases were audited monthly to ensure compliance with MCO policies and procedures, clinical guidelines, CRA, the Centers for Medicare and Medicaid Services and the National Committee for Quality Assurance standards. P&P #HS UM 1: Medical Necessity Review indicated that the MCO used the definition of medical necessity as defined by the CRA. UM medical directors were audited annually. All medical directors scored above the required 90 percent compliance established by the MCO. UM staff scores were also expected to be at 90 percent or above. Staff who scored lower than the requirement were identified for additional training. The MCO provided examples of staff who received additional group and one on one training.

| | | | | |
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| **17 Limitations/Capitations/Delays** | | | 0.750 | 0.750 |
| The MCO demonstrates that it does not impose benefit limitations, duration/scope limitations or monetary capitations upon EPSDT services. Services are provided based upon each child's individual needs. Utilization controls do not unreasonably delay the initial or continued receipt of services. | ☑ No limits/capitations | 0.250 | | |
| | ☑ Services based on individual needs | 0.250 | | |
| | ☑ UM controls do not delay services | 0.250 | | |

*CD ¶ 55(a) and 57; CRA § 2.6.3.2 and .4-.5 (E/W and Middle); CRA § 2.6.3.1 and .4-.5 (TCS)*

P&P #HS QM PWE 1 included multiple statements that indicated all medically necessary EPSDT services were covered for members. UM decisions were based on the individual needs of the child. Medically necessary services were to be provided regardless of whether they were covered by the plan. UM denials did not indicate any delays of services as a result of UM controls.

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## AmeriChoice-Middle

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **18 Qualified UM personnel** | | | 3.000 | 3.000 |
| The MCO has a process in place that guarantees only qualified personnel with education, training or experience in child and adolescent health are employed to make utilization review and prior authorization decisions for members 20 and under. | ☑ Process in place | 0.500 | | |
| | ☑ Staff #1 trained/educated | 0.250 | | |
| | ☑ Staff #2 trained/educated | 0.250 | | |
| | ☑ Staff #3 trained/educated | 0.250 | | |
| Personnel making utilization review and prior authorization decisions for members 20 and under are trained or experienced as described above. | ☑ Staff #4 trained/educated | 0.250 | | |
| | ☑ Staff #5 trained/educated | 0.250 | | |
| | ☑ Staff #6 trained/educated | 0.250 | | |
| | ☑ Staff #7 trained/educated | 0.250 | | |
| | ☑ Staff #8 trained/educated | 0.250 | | |
| | ☑ Staff #9 trained/educated | 0.250 | | |
| | ☑ Staff #10 trained/educated | 0.250 | | |

*CD ¶ 58*

The QI Program Description indicated that only appropriately trained staff were responsible for UM decisions. This included registered nurses, licensed behavioral health clinicians (i.e., clinical social workers, professional counselors or senior psychological examiners) and physicians. P&P #HS UM 1 indicated that only a medical director made decisions on cases not meeting medical necessity criteria. Ten UM staff were selected for review. Licenses were verified and found to be current for all 10 staff. Resumes and education background were also reviewed. All staff received appropriate training and possessed sufficient experience to make UM decisions for members 20 and under.

| | | | | |
|---|---|---|---|---|
| **19 Services without prior authorization** | | | 1.000 | 1.000 |
| The MCO ensures that all medically necessary covered services (including interperiodic screens and continuation of services) are provided, whether the condition existed prior to any screening and regardless of whether or not the need for such services was identified by a provider whose services had received prior authorization from the MCO or by a network provider. | ☑ Yes | 1.000 | | |
| | ☐ No | 0.000 | | |

*CD ¶ 41(m), 42(c), 55(d) and 59; CRA § 2.7.5.1.7 (E/W); 2.7.6.1.7 (Middle); 2.6.13.1.7 (TCS)*

P&P #HS QM PWE 1 indicated that all medically necessary services were provided for members under the age of 21 regardless of whether or not the condition existed prior to a screening or the need for services was identified by a provider who received prior authorization from the MCO. Services were also provided regardless of the network status of the provider. P&P #HS UM 10: PriorAuth and Referral Exceptions indicated that prior authorization was not required for any EPSDT services.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **20 Specialist list** | | | 0.750 | 0.750 |
| The MCO demonstrates that it provides PCPs participating in EPSDT with an up-to-date list of specialists to whom referrals may be made for screens, lab tests, further diagnostic services and corrective treatment. The list is supplemented quarterly to indicate additions and deletions. The MCO also maintains an updated electronic, web-accessible version of the referral provider listing. | ☑ Yes | 0.750 | | |
| | ☐ No | 0.000 | | |
| *CRA § 2.14.3.5.1 (E/W, Middle and TCS); CD ¶ 62* | | | | |
| Mailing verifications showed that referral listings were mailed to PCPs in each quarter of 2009. The Provider Manual contained instructions for either contacting the MCO (toll-free telephone number included) or accessing the website for information on how to make referrals. Online provider directories were updated nightly via information received from Facets, the MCO's claims and network information system. | | | | |
| **21 MCO CM** | | | 0.750 | 0.750 |
| MCO CM services are provided consistent with federal law by providing assistance "in gaining access to needed medical, social, educational and other services." The MCO ensures that the CM provided "centers on the process of collecting information on health needs of the child, making and following up on referrals as needed, activating the examination/diagnosis/ treatment 'loop.'" Notification of the time members are due to receive a screening service is also a focus of the program. | ☑ Consistent with federal law | 0.250 | | |
| | ☑ Focused on information collection, making and following up on referrals | 0.250 | | |
| | ☑ Notification due for screening | 0.250 | | |
| *CD ¶ 66 and 68; CRA § 2.7.5.4.8(19) (E/W); CRA § 2.7.6.4.8(19) (Middle); CRA § 2.6.13.4.8(19) (TCS)* | | | | |
| P&P HS QM PWE 1 indicated extensive CM involvement in multiple aspects of TENNderCare services provided by the MCO. CM staff assisted providers with referrals, made contact with pregnant members and assisted with appointment scheduling. The CM Manager indicated that initial assessments were conducted on all CM referrals and included assessments of medical and behavioral health needs and subsequent referrals as appropriate. CM staff followed up on referrals with members as soon as two weeks after the referral was made, but no later than 30 days. The CM system included specific assessments for pediatric and adolescent referrals. CM staff were able to access the MCO's UTD to determine a member's screening status. Staff were also kept aware of screenings that were due through follow up of the member's plan of care. These were flagged for follow up at least every 30 days. All initial CM assessments included an inquiry of the presence of children in the home, number of children and their EPSDT status, including the date of the most recent screening. | | | | |

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **22 Medically necessary CM services** | | | 1.000 | 1.000 |
| Mental health CM services, for children whose behavioral health needs require these services, are provided to all TennCare children for whom they are medically necessary. | ☑ Yes | 1.000 | | |
| | ☐ No | 0.000 | | |

*CD ¶ 69*

All CM cases were screened for behavioral health needs during the initial assessment. If the screening revealed the presence of behavioral health needs, a full behavioral assessment was performed in addition to the initial assessment. At this time the CM staff would assist the member with locating appropriate community resources or a behavioral health provider. If CM staff identified the presence of a behavioral health crisis during the assessment, appropriate MCO staff were contacted. P&P #HS QM PWE 1 indicated that CM staff were available to assist PCPs with behavioral health referrals when needed.

| | | | | |
|---|---|---|---|---|
| **23 CM central function** | | | 1.500 | 1.500 |
| EPSDT CM activities are a central function of the MCO, as evidenced by CM activities being integrated throughout the operations of the MCO. CM activities are individualized based on needs of the child and are not used only as a tool for prior authorizations. | ☑ Integrated throughout MCO | 0.750 | | |
| | ☑ Activities individualized | 0.750 | | |

*CD ¶ 70*

During interviews with the CM Manager and HFS Health Coach, it was evident that the MCO's CM activities crossed over to multiple areas within the organization. CM staff worked with members to develop a plan of care, which they followed up on at least every 30 days, and assisted the members in obtaining referrals for appropriate services. Such activities were conducted based on the needs of the member as identified through the initial CM assessment. They were not used as prior authorization tools. Medical and behavioral CM staff worked with one another to determine the most appropriate area of primary focus for the child. If the child was placed in behavioral CM, staff in that area consulted with medical CM staff as appropriate. The MCO provided an example of a case where the member's needs for additional therapy services were coordinated between medical and behavioral staff, and included input from the member's mother.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **24 Family involvement and accessible services** | | | 1.500 | 1.500 |
| Parents and family members are involved, to the greatest extent possible, in the determination of behavioral health services to be delivered to a particular child. The MCO provides a comprehensive and appropriate scope of geographically accessible child and adolescent behavioral health services in a range of treatment settings. | ☑ Parent/Family involvement | 0.375 | | |
| | ☑ Comprehensive/Appropriate scope | 0.375 | | |
| | ☑ Geographically accessible | 0.375 | | |
| | ☑ Range of treatment settings | 0.375 | | |

*CD ¶ 71(i and ii)*

The Manager of CM (Behavioral Health) provided examples of member cases which showed family member involvement in determining appropriate treatment of a child. CM notes indicated extensive efforts by the CM to work with families on obtaining the appropriate level of care. The CM also worked with facilities to assist each member's family in accessing the inpatient treatment required for the members. The MCO is contracted with all inpatient mental health facilities that provide services to children and adolescents in each region of the state. Services that were offered to families included inpatient options and therapeutic foster care. Family members were also offered assistance in coping with the children's behavioral health conditions.

| | | | | |
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| **25 Follow-up after inpatient or residential treatment** | | | 2.000 | 2.000 |
| The MCO ensures through coordination efforts with its contracted facilities that psychiatric hospital and residential treatment facility discharges do not occur without a discharge plan in which the member, his/her family, or other caregivers, clinicians and social worker(s) have participated. This discharge plan includes an outpatient visit scheduled before discharge, which ensures access to proper provider/medication follow-up. Also, an appropriate placement or housing site is secured prior to discharge. | ☑ Discharge plan completed | 0.500 | | |
| | ☑ Required persons participated | 0.500 | | |
| | ☑ Outpatient appointment scheduled | 0.500 | | |
| | ☑ Appropriate placement or housing secured | 0.500 | | |

*CD ¶ 71(iii); CRA § 2.9.6.3.2 (E/W and TCS); CRA § 2.9.9.3.2 (Middle)*

The CM Manager (Behavioral Health) provided an example of discharge planning conducted as a member was prepared for discharge from a residential treatment facility. The case notes indicated that the MCO CM, facility CM and family were involved in determining the course of care to be provided upon discharge. The MCO CM also coordinated with the facility CM to ensure member had appropriate access to a provider upon discharge for medication follow-up. The MCO CM also worked with the member's family to ensure a safe home environment for the member and member's family.

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **26 Screening components including follow-up** | | | 0.500 | 0.500 |
| The MCO has procedures in place for ensuring that all TENNderCare screens contain all required components, including follow-up components if all components of a screen cannot be completed in a single visit or whenever concerns or questions remain after the screening process. | ☑ Yes | 0.500 | | |
| | ☐ No | 0.000 | | |

*CD ¶ 41(a)-(l) and (n.v); CRA § 2.7.5.1.4 (E/W); CRA § 2.7.6.1.4 (Middle); CRA § 2.6.13.1.4 (TCS)*

The MCO used its Provider Manual to instruct providers that all parts of a TENNderCare screening should be documented in the medical record, and that in the event any part of a screening was not completed, a follow-up appointment should be scheduled. The MCO assessed provider compliance with this requirement during EPSDT medical record reviews. The TENNderCare Clinical Documentation Exit Summary Tool was used by MCO staff to discuss record review findings with providers/office staff. Providers were also given a handout at the time of the medical record review that included the excerpt from the Provider Manual with the TENNderCare documentation requirements.

| | | | | |
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| **27 Interperiodic screen** | | | 1.000 | 1.000 |
| The MCO demonstrates that any encounter with a health professional practicing within the scope of his/her practice is an interperiodic screen and that any person who suspects a problem may refer a child for an interperiodic screen. An interperiodic screen does not have to include any screening elements required for a periodic screen. | ☑ Any encounter is interperiodic screen | 0.500 | | |
| | ☑ No required screening elements | 0.500 | | |

*CD ¶ 42(a) and (b)*

The MCO's provider manual indicated that interperiodic screenings were available whenever anyone (e.g., parent, guardian or teacher) identifies the need for a screening. The Member Handbook also contained language informing parents/guardians that if someone else, like a teacher, was concerned about the child's health, a screening could be obtained. P&P HS QM PWE 1 defined interperiodic screenings as "any encounter with any provider practicing within the scope of his/her license that does not include the screening elements required for a periodic TENNderCare exam. Anyone such as an educator, parent, or health professional who suspects a problem may refer a child for an interperiodic screening."

| | | | | |
|---|---|---|---|---|
| **28 Prior authorization prohibited** | | | 0.500 | 0.500 |
| The MCO does not impose prior authorization requirements on interperiodic screens conducted by the PCP. | ☑ Yes | 0.500 | | |
| | ☐ No | 0.000 | | |

*CD ¶ 42(c); CRA § 2.7.5.1.7 (E/W); CRA § 2.7.6.1.7 (Middle); CRA § 2.6.13.1.7 (TCS)*

P&P HS QM PWE 1 stated that the MCO did not require prior authorization for interperiodic screenings. The MCO's Physician, Health Care Professional, Facility and Ancillary Administrative Guide informed providers that "Interperiodic screens are available whenever a person like a teacher or parent notices a change that might require a screening."

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| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **29 Screening standards met** | | | 1.500 | 1.500 |
| The MCO demonstrates that EPSDT screening standards are met or that all children who have not received complete screenings have been subject to outreach efforts reasonably calculated to ensure participation. In the event that screening rates do not meet compliance standards, the MCO may demonstrate compliance by showing that such failure to achieve standards was due to factors beyond the MCO's control. | ☑ Yes | 1.500 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.7.5.1.1 (E/W); CRA § 2.7.6.1.1 (Middle); CRA § 2.6.13.1.1 (TCS); CD ¶ 51*

The screening rate for 2009 was 103.4 percent. The MCO continued to conduct multiple forms of outreach for all TENNderCare-eligible members throughout 2009. This included numerous community events throughout the year.

| | | | | |
|---|---|---|---|---|
| **30 Transportation** | | | 2.000 | 2.000 |
| The MCO has protocols and procedures for ensuring access to non-emergency transportation services in accordance with state and federal laws. The MCO does not place blanket restrictions/requirements because of age or lack of parental accompaniment. Transportation assistance includes related travel expenses, meals, lodging, and cost of an attendant to accompany the child if necessary. The MCO has protocols/procedures for making referrals to TennCare transportation providers. | ☑ Protocols and procedures | 0.500 | | |
| | ☑ No blanket restrictions | 0.500 | | |
| | ☑ Assistance is inclusive of identified components | 0.500 | | |
| | ☑ Protocols for transportation referral | 0.500 | | |

*CD ¶ 74-77; CRA § 2.7.5.4.6 (E/W); CRA § 2.7.6.4.6 (Middle); CRA § 2.16.13.4.6 (TCS)*

P&P #GR NEMT A.4: Approving NEMT Services outlined the MCO's procedures for providing members access to transportation services as well as referring members to transportation providers. P&P #HS QM PWE 1 stated that "AmeriChoice provides TENNderCare transportation assistance, for a child to include related travel expenses, cost of meals, and lodging in route to and from care, and the cost of an attendant to accompany child if necessary." This same P&P also indicated that blanket restrictions were not used when determining a child's needs for transportation services.

# 2010 Annual Quality Survey - Quality Process Standards

## AmeriChoice-Middle

CONFIDENTIAL

| CRITERIA | | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | | |
| **31 Program coordination** | | | | 1.000 | 1.000 |
| The MCO coordinates TENNderCare outreach, screening, and treatment services with other children's health and education services and programs. | ☑ Yes | | 1.000 | | |
| | ☐ No | | 0.000 | | |

*CD ¶ 78; CRA § 2.7.5.1.3 (E/W); CRA § 2.7.6.1.3 (Middle); CRA § 2.6.13.1.3 (TCS)*

P&P #HS QM PWE 3: Health Education and Outreach Programs and Activities described the MCO's activities and efforts to coordinate TENNderCare services with other agencies and its efforts to engage members through outreach activities. Such activities were to include, but not be limited to the following: health fairs, baby showers, faith-based activities, school-based screenings and parent-teacher organizations.

STRENGTH: As part of the Emergency Department (ED) Diversion program, the MCO identified children with more than five ED visits in a seven- month period to determine if they had a medical home. During this process, several members were identified whose "troublesome patterns of service utilization" ultimately resulted in referrals and coordination with Department of Children Services.

# 2010 Annual Quality Survey - Quality Process Standards

AmeriChoice-Middle

CONFIDENTIAL

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **32 Individual education plans (IEPs)** | | | 1.000 | 1.000 |
| The MCO has a process to facilitate coordination of EPSDT services when TennCare-enrolled children have been identified as needing to receive medically related services in an educational setting, as listed in their IEPs. Annually, TennCare sends a letter to all School Directors and Special Education Directors requesting the IEPs on behalf of the MCOs. If the MCO becomes aware that a member has an IEP (for example, through the internal CM process), then the MCO is obligated to request a copy of the IEP from the school. | ☑ Requests IEPs | 0.200 | | |
| | ☑ Accepts problem or has tested | 0.200 | | |
| | ☑ Shares with PCP | 0.200 | | |
| | ☑ Notifies school contact of disposition of request | 0.200 | | |
| | ☑ Coordination calculated to reduce gaps and overlaps | 0.200 | | |

After receipt of the IEP, the MCO:

- either accepts the IEP as indication of a medical problem and treats the IEP as a request for service to which the MCO responds within 14 days or assists in making an appointment to have the child appropriately evaluated within the time frames specified in the TennCare Waiver Terms and Conditions for access to care;
- sends a copy of the IEP and related information to the PCP; and
- notifies the designated school contact of the ultimate disposition of the request.

Coordination by the MCO is calculated to reduce gaps and overlaps in services.

*CD ¶ 81; TENNderCARE Connection Policy; CRA § 2.9.11.5.1, 2.9.11.5.2 and 2.9.11.5.2.1-.3 (E/W); CRA § 2.9.14.8.1, 2.9.14.8.2 and 2.9.14.8.2.1-.3 (Middle); CRA § 2.9.12.6.1, 2.9.12.6.2 and 2.9.12.6.2.1-.3 (TCS)*

P&P #HS CM 11: Coordinating Services For a child With an Individualized Education Program (IEP) described the MCO's process for ensuring that members with IEPs receive the necessary services. All components listed above were identified in the P&P. Attachment B of the P&P, Individualized Education Program/IEP Workflow Process, also contained all components listed above. The CM Manager described the process in place by the MCO which mirrored that outlined in its P&P. She also provided an example of an IEP from the IEP Tracking Database. The database included a field that identified when the IEP was sent to the member's PCP. This process was effective in reducing gaps and overlaps in care.

# 2010 Annual Quality Survey - Quality Process Standards

AmeriChoice Middle

CONFIDENTIAL

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **33 Tracking system** | | | 2.000 | 2.000 |
| Tracking system data is used to take action to improve the EPSDT services. The tracking system information has been utilized to contact providers regarding the need to set appointments for the individual member. The tracking system information has been used to contact parents/ guardians/members regarding the need to make an appointment and receive EPSDT services. (For more detailed information refer to EPSDT Information System Tracking Review Tool). | ☑ Contact providers | 1.000 | | |
| | ☑ Contact parent/guardian/member | 1.000 | | |

*CD ¶ 94; CRA § 2.7.5.1.8 and 2.7.5.2.4 (E/W); CRA § 2.7.6.1.8 and 2.7.6.2.4 (Middle); CRA § 2.6.13.1.8 and 2.6.13.2.4 (TCS)*

The MCO's tracking system was reviewed during Performance Activity file review. Members who were noncompliant with TENNderCare screenings were referred to providers for outreach and appointment scheduling, and were subject to all appropriate outreach efforts by the MCO. The MCO used its online provider portal to supply PCPs with current lists of members not up-to-date on TENNderCare screenings. Providers were instructed to use this list to identify members who needed to be contacted for appointment scheduling. Provider newsletters and training conducted by the Provider Relations department informed PCPs of the list and how to access it. Hard copy lists were also made available upon request.

SUGGESTION: To further ensure that PCPs use the online list of TENNderCare members who are not up-to-date on their screenings, the MCO could include more specific instructions in newsletters and training materials that direct providers to the health plan website.

| | | | | |
|---|---|---|---|---|
| **34 EPSDT language in contracts** | | | 1.750 | 1.750 |
| All contracts with appropriate providers contain language requiring the EPSDT elements:<br>● comprehensive health history<br>● comprehensive physical exam<br>● laboratory testing<br>● vision and hearing testing<br>● dental screening<br>● health education<br>● immunizations | ☑ Comprehensive health history | 0.250 | | |
| | ☑ Comprehensive physical exam | 0.250 | | |
| | ☑ Laboratory testing | 0.250 | | |
| | ☑ Vision and hearing testing | 0.250 | | |
| | ☑ Dental screening | 0.250 | | |
| | ☑ Health education | 0.250 | | |
| | ☑ Immunizations | 0.250 | | |

*CRA § 2.12.7.48 (E/W and TCS); CRA § 2.12.9.56 (Middle)*

Provider contracts informed providers that all requirements in the provider manual must be followed. Medical Records Standards for TENNderCARE (EPSDT) Examinations in the provider manual were specific to the required exam components.

# 2010 Annual Quality Survey - Quality Process Standards

## AmeriChoice Middle

CONFIDENTIAL

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **John B. Consent Decree (EPSDT)** | | | | |
| **35 EPSDT contract review** | | | 0.500 | 0.500 |
| Review of contracts ensures that there are no provisions which would encourage violations of EPSDT mandate. | ☑ Yes (no provisions) | 0.500 | | |
| | ☐ No | 0.000 | | |

*CD ¶ 102*

Provider agreements were reviewed, and no provisions were found that would encourage violations of the John B. CD.

**Total Score: 38.250 out of 39.500 = 96.8 % Compliance**

# 2010 Annual Quality Survey - Quality Process Standards

## AmeriChoice-Middle

CONFIDENTIAL

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Grier Revised Consent Decree** | | | | |
| **1 Appeals unit** | | | 0.750 | 0.750 |
| The MCO has sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting members. | ☑ Yes<br>☐ No | 0.750<br>0.000 | | |
| *Grier Revised CD; CRA § 2.19.2.3 (E/W and TCS); CRA § 2.19.3.3 (Middle)* | | | | |
| The Appeals Organization Chart indicated that the MCO had sufficient staff (one Manager, one nurse and nine Clinical Appeals Reviewers) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting members. | | | | |
| **2 Grier/Appeals procedures** | | | 0.500 | 0.500 |
| The MCO has internal appeal procedures for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees, or court orders governing the appeals process. | ☑ Yes<br>☐ No | 0.500<br>0.000 | | |
| *CRA § 2.19.1 (E/W, Middle and TCS)* | | | | |
| P&P #GR 12.2: Member Complaint and Appeal Process-(TennCare Only) describes the MCO's internal appeal procedure for members in accordance with the TennCare rules and regulations, the TennCare waiver, consent decrees or court orders governing the appeals process. | | | | |

**Total Score: 1.250 out of 1.250 = 100 % Compliance**

# 2010 Annual Quality Survey - Quality Process Standards

## AmeriChoice Middle

CONFIDENTIAL

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Non-Discrimination Compliance** | | | | |
| **1 Non-Discrimination Compliance Plan** | | | 0.250 | 0.250 |
| There is documentation of the MCO's annual submission of a Non-Discrimination Compliance Plan to TennCare, no later than 90 days after the end of the calendar year. | ☑ Yes | 0.250 | | |
| | ☐ No | 0.000 | | |
| *CRA § 2.30.20.5 (E/W and TCS); CRA § 2.30.21.5 (Middle)* | | | | |
| An e-mail from MCO to TennCare indicated the submission of Non-Discrimination Compliance for 2008 on 03/31/09. | | | | |
| **2 Assurance of Non-Discrimination** | | | 0.250 | 0.250 |
| There is documentation of the MCO's annual submission of its Assurance of Non-Discrimination Certification, which has been signed and dated by the MCO's Chief Executive Officer (CEO) or his/her authorized agent. The annual date of the Assurance coordinates with the annual date of the Non-Discrimination Compliance Plan as documented in Element #1 above. (The certification is the MCO's assurance of compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981, the Church Amendments, Public Health Service Act Sec. 245 and the Weldon Amendments.) | ☑ Documented submission of signed and dated Assurance | 0.125 | | |
| | ☑ Date of Assurance coordinates with Non-Discrimination Compliance Plan | 0.125 | | |
| *CRA § 2.30.20.5 (E/W and TCS); CRA § 2.30.21.5 (Middle)* | | | | |
| An e-mail from MCO to TennCare indicated the submission of Annual Non-Discrimination Title VI Compliance & Assurance Plans for 2008 on 3/31/09.The MCO's Assurance of Non-Discrimination certification was signed and dated by the MCO's CEO on 3/31/09.The annual date of the Assurance coordinates with the annual date of the Non-Discrimination Compliance Plan as documented in Element #1 above. | | | | |

# 2010 Annual Quality Survey - Quality Process Standards

## AmeriChoice Middle

CONFIDENTIAL

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Non-Discrimination Compliance** | | | | |
| **3 Display of non-discrimination posters** | | | 0.250 | 0.000 |
| Posters informing MCO employees of their rights and obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 are displayed in conspicuous places, such as breakrooms, lunchrooms, human resource offices and near elevators. | ☐ Yes<br>☑ No | 0.250<br>0.000 | | |

*CRA § 4.32.3 (E/W and Middle); CRA § 5.21 (TCS)*

Posters located in the breakroom did not have information on the Omnibus Budget Reconciliation Act of 1981.

AREA OF NONCOMPLIANCE: The MCO should include the information on the posters located in their breakrooms informing their employees regarding the Omnibus Budget Reconciliation Act of 1981. The MCO should continue to include the current information like employees rights and obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990 and the Age Discrimination Act of 1975.

# 2010 Annual Quality Survey - Quality Process Standards

AmeriChoice Middle

CONFIDENTIAL

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Non-Discrimination Compliance** | | | | |
| **4 Non-discrimination written materials** | | | 0.500 | 0.500 |
| All vital MCO documents and member materials are made available to members in compliance with the LEP requirements of Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act of 1990. | ☑ Documents are translated as described | 0.250 | | |
| | ☑ Written materials made available in alternate formats at no cost | 0.250 | | |

There is evidence that they are being provided as noted below:

- All vital MCO documents and member materials are translated and available in Spanish. Within 90 calendar days of notification from TennCare, all vital MCO documents are translated and available to each LEP group identified by TennCare that constitutes five percent of the TennCare population or 1,000 members, whichever is less;
- All written materials are made available in alternative formats for persons with special needs, or appropriate interpretation/translation services are provided by the health plan at no cost to the member; and
- The MCO can show proof of its capability to provide vital documents to members with impaired sensory skills (visually impaired) who require communication assistance in alternative formats.

*CRA § 1 and 2.17.2.5-.7 (E/W and Middle); CRA § 1.3 and 2.17.2.5-.7 (TCS)*

P&P #GR 24.1.1: stated that all vital MCO documents and member materials are being translated into Spanish. Also, if any LEP group is identified the MCO would translate the documents and make them available to the members within 90 days of notification from TennCare. There were no LEP groups identified in 2009, and hence no vital documents were needed to be translated. The policy also stated that all written materials are made available in an alternative format at no cost to persons with special needs. The Manager of TennCare Compliance mentioned that all vital documents would be available to members with impaired sensory skills in alternative formats such as live interpretation service.

# 2010 Annual Quality Survey - Quality Process Standards

CONFIDENTIAL

## AmeriChoice-Middle

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Non-Discrimination Compliance** | | | | |
| **5 Written policy and procedure** | | | 1.000 | 1.000 |
| The MCO has a written policy and procedure on file for the provision of language interpretation and translation services for any member with LEP. The policy and procedure also addresses the provision of language assistance for members who require communication assistance in alternative formats (e.g., members who are visually impaired, deaf and/or deaf/blind). It has been approved by TennCare. | ☑ Language interpretation and translation services addressed; | 0.200 | | |
| | ☑ Communication assistance in alternative formats addressed; | 0.200 | | |
| | ☑ Staff, providers and direct service subcontractors instructed; | 0.200 | | |
| The MCO shows that it:<br>● instructs its staff, including but not limited to all providers and direct service subcontractors, regarding the policy and procedure; and<br>● has available language/communication help-lines with specific numbers that are made known to its members and subcontractors for the provision of member translation services and communication assistance in alternative formats. | ☑ Proof of available help-lines demonstrated; and | 0.200 | | |
| | ☑ Phone numbers made known to members and subcontractors. | 0.200 | | |

*CRA § 2.18.1.3, 2.28.2-.3 and 2.30.20.4 (E/W and TCS);*
*CRA § 2.18.1.3, 2.28.2-.3 and 2.30.21.4 (Middle)*

P&P #GR 24.1.1 stated that all vital MCO documents and member materials are being translated into Spanish. Also, if any LEP group is identified the MCO would translate the documents and make them available to the members within 90 days of notification from TennCare. There were no LEP groups identified in 2009, and hence no vital documents were needed to be translated. The policy also stated that all written materials are made available in an alternative format at no cost to persons with special needs. The Manager of TennCare Compliance mentioned that all vital documents would be available to members with impaired sensory skills in alternative formats such as live interpretation service.

SUGGESTION: The health plan's policy and procedure regarding language and interpretation services could more clearly state that assistance is available to visually impaired or blind members.

# 2010 Annual Quality Survey - Quality Process Standards

CONFIDENTIAL

## AmeriChoice-Middle

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Non-Discrimination Compliance** | | | | |
| **6 Complaint resolution and reporting** | | | 1.000 | 1.000 |
| The MCO has on file a written policy and procedure, approved by TennCare, for monitoring, investigating and resolving discrimination complaints. The MCO has written documentation that all discrimination complaints are investigated and resolved. The MCO submits a quarterly *Alleged Discrimination Report* to TennCare. The report lists all complaints of alleged discrimination filed against the MCO by employees, members, providers and subcontractors. | ☑ Policy and procedure | 0.200 | | |
| | ☑ Approved by TennCare | 0.200 | | |
| | ☑ Complaints documented, investigated and resolved, and are reported quarterly | 0.300 | | |
| | ☑ Quarterly report submitted with required information | 0.300 | | |

*CRA § 2.28.7 and 2.30.20.3 (E/W and TCS); CRA § 2.28.7 and 2.30.21.3 (Middle)*

P&P #AD CL 4: Non-discrimination Complaint Resolution addressed the process for monitoring, investigating and resolving discrimination complaints. The Desk Audit Tool provided the proof of approval of the policy. The Quarterly Non-Discrimination Compliance Report for all four quarters indicated that all discrimination complaints were investigated and resolved. An email from TennCare to the MCO indicated that the quarterly Alleged Discrimination Reports were received by TennCare. The report list included all complaints of alleged discrimination filed by employees, members, providers and subcontractors.

| | | | | |
|---|---|---|---|---|
| **7 Member Handbook notification and Complaint Form** | | | 0.500 | 0.500 |
| The MCO has included a notice of the right to file a discrimination complaint and a copy of a Discrimination Complaint Form in its English and Spanish Member Handbooks. | ☑ Notice of right placed in Member Handbooks | 0.250 | | |
| | ☑ Copy of form placed in English and Spanish Member Handbooks | 0.250 | | |

*CRA § 2.17.4.5.11 (E/W and TCS); CRA § 2.17.4.7.19 (Middle)*

The MCO included a notice of the right to file a discrimination complaint and a copy of a Discrimination Complaint Form in its English and Spanish Member Handbook.

# 2010 Annual Quality Survey - Quality Process Standards

## AmeriChoice Middle

CONFIDENTIAL

| CRITERIA | CRITERIA MET | CRITERIA VALUE | ELEMENT VALUE | SCORE |
|---|---|---|---|---|
| **Non-Discrimination Compliance** | | | | |
| **8 Quarterly newsletter notification** | | | 0.500 | 0.500 |
| Each quarterly newsletter sent by the MCO to members includes a notice of the right to file a complaint and a contractor phone number for doing so, as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981. The notice is in English and Spanish. | ☑ Notice of right and a phone number for making complaint | 0.250 | | |
| | ☑ Notice is in English and Spanish | 0.250 | | |

*CRA § 2.17.5.3.3 (E/W and TCS); CRA § 2.17.5.3.5 (Middle)*

Each quarterly newsletter sent by the MCO to members include a notice of the right to file a complaint and a contractor phone number for doing so. The notice was in English and Spanish.

| | | | | |
|---|---|---|---|---|
| **9 Subcontractor compliance education** | | | 0.250 | 0.250 |
| The MCO can document that its subcontractors have been made aware of their obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981. | ☑ Yes | 0.250 | | |
| | ☐ No | 0.000 | | |

*CRA § 2.26.5 (E/W and TCS); CRA § 2.26.7 (Middle)*

Physician, Health Care Professional, Facility and Ancillary Administrative Guide provided by the MCO to its subcontractors made them aware of their obligations under the necessary federal laws.

**Total Score: 4.250 out of 4.500 = 94.4 % Compliance**

# APPENDIX B | *Performance Activity Review Tool Instructions*

*for **AmeriChoice-Middle***

This section contains the instructions for the Annual Quality Survey (AQS) Performance Activity (PA) Review Tools for Managed Care Organizations (MCOs), 2010 Edition.

# *MCC Utilization Management (UM) Denials* (age 20 and younger only)—File Review Tool Instructions

***Authority:*** *Contractor Risk Agreement (CRA) between TennCare and Dental Benefits Manager (DBM)—§A.8.3.2.1; CRA between TennCare and East, Middle and West Managed Care Organizations (MCOs)—§ 2.6, 2.7, 2.13 and 2.14; CRA between TennCare and TennCareSelect—§ 2.6 and 2.9; and 42 Code of Federal Regulations (CFR) § 438.210 and .214, and § 431.211 and .213.*

## Time Standard

Review the MCC's policy and procedure regarding UM denials and note the maximum hours/days allowable for: 1) a decision to be made and 2) the member and provider to be notified of the decision to deny/reduce requested service. Then, compare the MCC's standards to the 21 days allowed by the CRA and to the CFR time frames listed below. **The time standard used for this review is the shortest of the three (MCC, CRA and CFR).** Record this number in the tool database and indicate whether this standard is based on calendar or business days.

The time frames the federal government has listed in 42 CFR § 438.210 and .214, and § 431.211 and .213 are as follows:

- *Standard authorization decisions* "may not exceed **14 calendar days** following receipt of the request for service, with a possible extension of up to 14 additional calendar days" if certain conditions apply.
- *Expedited authorization decisions* must be provided "as expeditiously as the…[member's] health condition requires and no later than 3 working days after receipt of the request for service." The MCC "may extend the 3 working days time period by up to 14 calendar days if the…[member] requests an extension, or if the MCC justifies a need for additional information and how the extension is in the…[member's] interest."
- *Timing of notice*. The health plan must mail the notice "…**at least 10 days before** the date of action, except … The agency [MCC] may mail a notice not later than the date of action if":
  a. the plan has factual information confirming the death of a…[member];
  b. the plan receives written notice from…[member] that she/he – "1) …no longer wishes services; or 2) gives information that requires termination or reduction of services and indicates that [she/he] understands that this must be the result of supplying that information;
  c. the…[member] has been admitted to an institution where she/he is ineligible under the plan for further services;
  d. the …[member's] whereabouts are unknown;
  e. the plan establishes the fact that the …[member] has been accepted for Medicaid services elsewhere;
  f. a change in the level of medical care is prescribed by the…[member's] physician;
  g. the notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or

h. the date of action will occur in less than 10 days, in accordance with § 483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of § 483.12(a)(5)(i)."

## Tool Components

Record the name of the MCC and the date of the review in the spaces provided.

Review the previously selected UM denial files for members under the age of 21 to complete **columns 2 – 15** on the *MCC UM Denials – File Review Tool* until there is a denominator of 10 files, all of which are denials. If a file is not applicable (i.e., anything other than a denial, or member is 21 years or older), it may be necessary to review additional files from the oversample to reach a denominator of 10 denials.

- **Column 1–File #:** This column is pre-populated with 1 through 10 to identify the number of files required for review.
- **Column 2–Case ID:** The Case ID represents the order of the file taken from the file review list (comprised of those files randomly abstracted from the MCC's data). The Case ID and the File # may not always match. For example, the first file examined (File # 1) may be the third file from the file review list (Case ID 3). This occurs when a file from the review list does not contain the required data for proper analysis. Because the Case ID is based on the file review list, QSource and the MCC are able to determine which file was reviewed should that be needed at a later date.
- **Column 3–Request Rcvd. Date:** Enter the month, day and year (MM/DD/YY) the request for the service or procedure was received by the MCC.
- **Column 4–Decision Made Date:** Enter the month, day and year (MM/DD/YY) the decision to deny was made.
- **Column 5–Wait (days) on Decision:** Enter the number of days it took the MCC to make the decision. Calculate by subtracting **column 3** from **column 4**.
- **Column 6–Decision Time Std.:** Enter the most stringent number of days after comparing MCC, CRA and CFR standards (e.g., if the MCC allows 10 days for a decision while the CRA allows 21 and the CFR allows 14, enter 10 days as the standard).
- Column 7 – Met Decision Time Std.: If column 5 is ≤ column 6, mark the "Y" cell. If column 5 is > column 6, mark the "N" cell.
- **Column 8–Decision Review Criteria Apropos to Condition:** Mark the "Y" cell in each row if a condition-appropriate review criterion was used to make the decision and to take action either to deny or reduce the amount, duration, or scope of the requested service; otherwise, mark the "N" cell.
- **Column 9–Consulted Requesting Provider as Apropos:** Mark the "Y" cell if the requesting provider was consulted prior to making the denial decision. Mark the "N" cell if not consulted, but there is evidence that she/he should have been. Otherwise, mark the "NA" cell.
- **Column 10–Final Denial by Qualified Med. Prof.:** A licensed physician or Doctor of Dental Surgery (DDS) must make all final denial and reduction of service decisions regarding inpatient hospital services. All other decisions to deny or reduce a service should be made

by a qualified clinical professional. Mark the "Y" cell if an appropriate professional made the decision; otherwise mark the "N" cell.

- **Column 11–Decision Not Arbitrary = Yes:** MCCs may not arbitrarily deny or reduce the amount, duration, or scope of a requested service solely because of the type of illness, diagnosis, or condition of the member. Mark the "Y" cell if the decision was NOT arbitrary; otherwise mark the "N" cell.
- **Column 12–Initial Notification Date:** Enter the month, day and year (MM/DD/YY) the MCC notified the member and provider about the decision to deny.
- **Column 13–Wait (days) to be Initially Notified:** Enter the number of business days it took the MCC to make the notification. Calculate by subtracting **column 3 from 12**.
- **Column 14–Initial Notification Time Std.:** Enter the most stringent number of days used to notify members and providers about a denial/reduction in service decision after comparing the MCC, CRA and CFR time standards.
- **Column 15–Met Initial Notification Time Std.:** If **column 13** is ≤ **column 14** mark the "Y" cell; otherwise mark the "N" cell.

## Scoring Directions

- **Applicable Answers, column 9:** Enter the number of cells in this column (i.e., all of those with "Ys" and "Ns"). All other columns for **Applicable Answers** are pre-populated with the applicable points for the number of files reviewed.
- **Compliant Answers, columns 7–11 and 15:** Enter the total number of **Compliant Answers** for each column (i.e., the number of "Y" cells).
- **Total Compliant:** Enter the sum of the numbers from **Compliant Answers**, **columns 7–11** and **15**.
- **Total Applicable:** Enter the sum of the numbers from **Applicable Answers**, **columns 7–11** and **15**.
- **Percent Compliant:** Divide the **Total Compliant** by the **Total Applicable** and enter that number as a percentage (e.g., 1/4 = 0.25 = 25 percent).

# *EPSDT Information System Tracking*—File Review Tool Instructions

***Authority:*** *John B. Consent Decree (EPSDT) ¶ 94; Contractor Risk Agreement (CRA) between TennCare and East, West and Middle Managed Care Organizations (MCOs)—§ 2.7.5.1; and CRA between TennCare and TennCareSelect—§ 2.6.13.*

## Tool Components

Record the name of the MCO and the date of the review in the spaces provided.

Review the previously selected EPSDT files to complete **columns 2–9** on the *EPSDT Information System Tracking–Review Tool* until there is a denominator of 10 files, all of which are EPSDT. If a file is not applicable (i.e., anything other than an EPSDT file), it may be necessary to review additional files from the oversample in order to reach a denominator of 10 EPSDT files.

- **Column 1–File #:** This column is pre-populated with 1 through 10 to identify the number of files required for review.
- **Column 2–Case ID:** The Case ID represents the order of the file taken from the file review list (comprised of those files randomly abstracted from the MCC's data). The Case ID and the File # may not always match. For example, the first file examined (File # 1) may be the third file from the file review list (Case ID 3). This occurs when a file from the review list does not contain the required data for proper analysis. Because the Case ID is based on the file review list, QSource and the MCC are able to determine which file was reviewed should that be needed at a later date.
- **Column 3–Medical Record (MR) or Information System (IS):** There are two rows per file for **columns 3–7.** The **MR** row is used to document information found in the member's medical record; the **IS** row is used to document information found in the health plan's IS tracking program.
- **Column 4–Receipt of Screening:** Mark the "Y" cell in the **MR** row if the member's receipt is documented in the medical record; otherwise, mark the "N" cell. Mark the "Y" cell in the **IS** row if the member's receipt is documented in the health plan's IS tracking program; otherwise, mark the "N" cell.
- **Column 5–Diagnosis Documented:** Mark the "Y" cell in the appropriate row if the diagnosis for this encounter is documented; otherwise, mark the "N" cell. Complete this process in the **MR** and **IS** rows for each file.
- **Column 6–Treatment, Immunization, Lab Work Documented:** Mark the "Y" cell in the appropriate row if any treatment, immunization or laboratory work was *done, given to* or *prescribed* for the member. Mark the "N" cell if none was *done, given* or *prescribed* but there is evidence that treatment, immunization, or laboratory work was indicated; otherwise, mark the "NA" cell.
- **Column 7–Ability to Determine Screening Status:** Mark the "Y" cell in the appropriate row if the member's current screening status is documented; otherwise, mark the "N" cell. Complete this process in the **MR** and **IS** rows for each file.

- **Column 8–Actions Taken to Improve Member's Screenings by Contacting Provider:** Mark the "Y" cell if the PCP was contacted regarding the need to set appointments for the member as a direct result of the information in the MCO's tracking system; otherwise, mark "N" cell. Mark the "NA" cell if contacting the PCP was not indicated because the medical record and tracking system showed evidence that the member was up to date.
- **Column 9–Actions Taken to Improve Member's Screenings by Contacting Parent/ Guardian/Member:** Mark the "Y" cell if the parent/guardian/member was contacted regarding the need to make an appointment and receive EPSDT services as a direct result of the information in the MCO's tracking system; otherwise, mark the "N" cell. Mark the "NA" cell if contacting the parent/guardian/member was not indicated because the medical record and tracking system showed evidence that the member was up to date.

## Scoring Directions

- **Applicable Answers, columns 6, 8 and 9:** Enter the applicable number of cells for each column (i.e., all of those with "Ys" and "Ns"). All other columns for **Applicable Answers** are pre-populated with the applicable points for the number of files reviewed.
- **Compliant Answers, columns 4–9:** For **columns 4–7** enter the total number of rows where the "Ys" or "Ns" are the same for each member. For **columns 8** and **9** enter the total number of rows that are marked "Y."
- **Total Compliant:** Enter the sum of the numbers from **Compliant Answers**, **columns 4–9**.
- **Total Applicable:** Enter the sum of the numbers from **Applicable Answers**, **columns 4–9**.
- **Percent Compliant:** Divide the **Total Compliant** by the **Total Applicable** and enter that number as a percentage (e.g., 1/4 = 0.25 = 25 percent).

# *MCC Appeals (Grier)* —File Review Tool Instructions

***Authority:*** *Grier v. Wadley Revised Consent Decree (Grier Revised CD) § C.7 and C.16.b; Tennessee Code Annotated (TCA) § 4-5-202, 4-5-301, et seq., 71-5-105 and 71-5-109; Executive Order No. 23 of 1999 (Amendment filed February 1, 2001, and made effective April 17, 2001); 42 Code of Federal Regulations (CFR) § 438.406 and .408; Contractor Risk Agreement (CRA) between TennCare and East, Middle, West and TennCare*Select *Managed Care Organizations (MCOs)—§ 2.19; and CRA between TennCare and Dental Benefits Manager (DBM)—§ A.17.*

## Tool Components

Record the name of the Managed Care Contractor (MCC) and the date of the review in the spaces provided.

**MCC decision time standards:** Review the MCC's policy and procedure regarding *Grier Revised CD* (appeal) handling. Record in the tool database the maximum number of hours/days allowable (most stringent) for appeal decisions. The *Grier Revised CD* maximum lengths of time for decisions are five days if expedited and 14 days if routine.

**MCC notification time standards:** From the policy, record in the tool database the number of days the MCC has determined to be the maximum amount of time allowable to notify the member of the decision, with regard to the concurrent-routine TennCare and CFR regulations. Indicate whether this standard is based on calendar or business days.

**For concurrent-routine:** The *Grier Revised CD* states that notice must be given **10 days** prior to action taking effect. **Two days** notice is allowed ***only*** if the member's provider initiates a reduction, termination, or suspension in the following instances:

- Any behavioral health service for a severely and persistently mentally ill adult member or severely emotionally disturbed child member;
- Any inpatient psychiatric or residential service;
- Any service being provided to treat a member's chronic condition across a continuum of services when the next appropriate level of medical services is not immediately available; or
- Home health services.

The Rules of the Tennessee Department of Finance and Administration, Bureau of TennCare, Chapters 1200-13-13 and 1200-13-14 state that in the "instances of Managed Care Contractor-initiated reduction, termination, or suspension of inpatient hospital treatment, the notice must be…at least 2 business days in advance of the proposed action. Where applicable and not in conflict with this rule, the exceptions set out at 42 CFR 431.211-.214 permit or require reduction of the time frames within which advance notice must be given."

Review the previously selected appeal files completing **columns 2–18** on the *MCC Appeals (Grier) – File Review Tool*. If a file is not applicable (i.e., anything other than an appeal), it may be necessary to review additional files from the oversample to reach a denominator of 10 appeals.

- **Column 1–File #:** This column is pre-populated with 1 through 10 to identify the number of files required for review.
- **Column 2–Case ID:** The Case ID represents the order of the file taken from the file review list (comprised of those fi**les** randomly abstracted from the MCC's data). The Case ID and the File # may not always match. For example, the first file examined (File # 1) may be the third file from the file review list (Case ID 3). This occurs when a file from the review list does not contain the required data for proper analysis. Because the Case ID is based on the file review list, QSource and the MCC are able to determine which file was reviewed should that be needed at a later date.
- **Column 3–E/R and C/N:** Indicate the type of file under review by writing an "E" (expedited) or "R" (routine) **AND** "C" (concurrent) or "N" (non-concurrent).
- **Column 4–Appeal Rcvd. Date:** Enter the month, day and year (MM/DD/YY) on which the appeal request was received by the MCC from the TennCare Solutions Unit.
- **Column 5–Authorization Request with Named Provider:** Mark the "Y" cell if the practitioner/provider is listed by name. If the appeal is from a practitioner/provider, or if the member wants the practitioner/provider to be able to provide a service and the practitioner/provider's name is not listed, mark the "N" cell. If no practitioner/provider was involved in the case (e.g., member appeals on behalf of him/herself), mark the "NA" cell.
- **Column 6–Reviewed by Same Practitioner Type as Requester:** If the appealed denial is being upheld, the file is to be reviewed by a qualified professional, which is a practitioner with experience in the condition for which the request was made. Mark the "NA" cell if the denial is being overturned. Mark the "Y" cell if a qualified professional reviewed the file. Mark the "N" cell if not reviewed by a qualified professional.
- **Column 7–Appeal Investigation Documented:** Mark the "Y" cell if the appeal was appropriately investigated; otherwise, mark the "N" cell. A proper investigation includes the following steps:
  - Documentation of the substance of the appeal and the MCC's actions, including any aspects of medical care involved;
  - Investigation of the appeal, including a description of the medical assistance requested;
  - The MCC considered any additional information provided by the member and/or practitioner/provider and determined if additional information was available that was not considered when it made the first decision; and
  - The MCC gathered information to help understand the member's report of the situation and collected information from involved MCC departments, as well as the practitioner/provider's office, if applicable.
- **Column 8–Decision Made Date:** Enter the month, day and year (MM/DD/YY) the appeal decision was sent to the member and/or the practitioner/provider. This can be delivered by mail, phone, fax, or other method as appropriate.
- **Column 9–Wait (days) on Decision:** Enter the number of days it took the MCC to make the decision. The date of receipt is day zero. Exclude state holidays and weekends if the standard is business days.

- **Column 10–Decision Time Std.:** Enter the most stringent number of days after comparing the MCC and *Grier Revised CD* standards (e.g., for an Expedited file, if the MCC allows 3 days for a decision and the *Grier Revised CD* allows 5 days, enter 3 days as the standard).
- **Column 11–Met Decision Time Std.:** If **column 9** is ≤ **column 10**, mark the "Y" cell; otherwise mark the "N" cell.
- **Column 12–Member Notified Date:** Enter the month, day and year (MM/DD/YY) on which the MCO notified the member of the resolution.
- **Column 13–Wait (days) to be Notified:** Enter the number of days it took the MCC to contact the member. The date of decision is day zero.
- **Column 14–Notification time standard (most stringent):** Enter the number of hours/days listed for the type of file after comparing the MCO and *Grier Revised CD* standards.
- **Column 15–Met Notification Time Std.:** If **column 13** is ≤ **column 14**, mark the "Y" cell; otherwise mark the "N" cell.
- **Column 16–Used State Letter Template and 6th Grade Level:** Mark the "Y" cell if the letter sent to the member met these requirements. The letter must include a statement of reasons for the decision (such as state rule or health plan provision). If the letter was not the appropriate template from the Bureau of TennCare, mark the "N" cell.
- **Column 17–Instructions on contesting:** For cases where the denial was upheld, mark the "Y" cell if the letter contains instructions on how to contest decisions at the MCO level **and** if those instructions include all three of the following components:
  - Information about the opportunity to contest the decision;
  - Instructions on how to contest the decision, including the right to an expedited process concerning urgent care; and
  - An explanation of the circumstances under which on-going medical services will be continued if a hearing is requested.

  Mark the "N" cell if the denial was upheld but not all components were included. Mark the "NA" cell if the denial was overturned by the MCC based on this appeal.
- **Column 18–For Delayed Decision, Notification <21 days:** Mark the "Y" cell if it took more than 14 days to make a decision but the MCC notified the member of the delay by day 21 and made the services available. Mark the "N" cell if it took more than 14 days **AND** the member was **NOT** notified by day 21 **OR** if the member was notified of the delay, but the services were not offered. Mark "NA" cell if notification of the decision occurred prior to day 14.

## Scoring Directions

- **Applicable Answers, columns 5, 6, 17 and 18:** Enter the applicable number of cells in each column (i.e., all of those with "Ys" and "Ns"). All other columns for **Applicable Answers** are pre-populated with the applicable points for the number of files reviewed.
- **Compliant Answers, columns 5–7, 11, and 15–18:** Enter the total number of compliant answers for each column (i.e., the number of "Y" cells marked in each).

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- **Total Compliant:** Enter the sum of the numbers from **Compliant Answers**, **columns 5–7**, **11**, and **15–18**.
- **Total Applicable:** Enter the sum of the numbers from **Applicable Answers**, **columns 5–7**, **11**, and **15–18**.
- **Percent Compliant:** Divide the **Total Compliant** by the **Total Applicable,** and enter that number as a percentage (e.g., 1/4 = 0.25 = 25 percent).

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# APPENDIX C | *Performance Activity Review Tools*

*for **AmeriChoice-Middle***

This section contains the completed Annual Quality Survey (AQS) Performance Activity (PA) Review Tools for Managed Care Organizations (MCOs), 2010 Edition.

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## MCC UM Denials – File Review Tool

MCC: AmeriChoice-Middle | Time Standard Calculation: Calendar Days | Date: 4/20/10

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | | 8 | | 9 | | | 10 | | 11 | | 12 | 13 | 14 | 15 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| File # | Case ID* | Request Rcvd. Date | Decision Made Date | Wait (days) on Deci-sion | Deci-sion Time Std. | Met Decision Time Std. | | Decision Review Criteria Apropos to Condition | | Consulted Requesting Provider as Apropos | | | Final Denial by Qualified Med. Prof. | | Decision Not Arbitrary = Yes | | Initial Notifica-tion Date | Wait (days) to be Initially Notified | Initial Notifica-tion Time Std. | Met Initial Notification Time Std. | |
| | | | | | | Y | N | Y | N | Y | N | NA | Y | N | Y | N | | | | Y | N |
| 1 | 1 | 09/22/09 | 09/22/09 | 0 | 14 | X | | X | | | | X | X | | X | | 09/22/09 | 0 | 14 | X | |
| 2 | 2 | 01/12/09 | 01/14/09 | 2 | 14 | X | | X | | | | X | X | | X | | 01/14/09 | 2 | 14 | X | |
| 3 | 11 | 11/25/09 | 11/30/09 | 5 | 14 | X | | X | | | | X | X | | X | | 11/30/09 | 5 | 14 | X | |
| 4 | 4 | 10/09/09 | 10/14/09 | 5 | 14 | X | | X | | | | X | X | | X | | 10/16/09 | 7 | 14 | X | |
| 5 | 5 | 02/04/09 | 02/11/09 | 7 | 14 | X | | X | | | | X | X | | X | | 02/12/09 | 8 | 14 | X | |
| 6 | 6 | 03/30/09 | 04/09/09 | 10 | 14 | X | | X | | | | X | X | | X | | 04/09/09 | 10 | 14 | X | |
| 7 | 7 | 06/24/09 | 07/01/09 | 7 | 14 | X | | X | | | | X | X | | X | | 07/01/09 | 7 | 14 | X | |
| 8 | 8 | 11/19/09 | 11/19/09 | 0 | 14 | X | | X | | | | X | X | | X | | 11/19/09 | 0 | 14 | X | |
| 9 | 9 | 10/09/09 | 10/13/09 | 4 | 14 | X | | X | | | | X | X | | X | | 10/28/09 | 19 | 14 | | X |
| 10 | 10 | 11/10/09 | 11/10/09 | 0 | 14 | X | | X | | | | X | X | | X | | 11/18/09 | 8 | 14 | X | |
| Applicable Answers | | | | | | 10 | | 10 | | 0 | | | 10 | | 10 | | | | | 10 | |
| Compliant Answers | | | | | | 10 | | 10 | | 0 | | | 10 | | 10 | | | | | 9 | |

*Case IDs have been altered to protect patient information.*

| | |
|---|---|
| Total Compliant | 49 |
| Total Applicable | 50 |
| Percent Compliant | 98.0% |

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## EPSDT Information System Tracking – Review Tool

| MCO: AmeriChoice-Middle | | | Time Standard Calculation: NA | | | | | | | | | | | | | | Date: 4/20/10 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | | 5 | | 6 | | | 7 | | 8 | | | 9 | | |
| File # | Case ID* | Medical Record (MR) / Information System (IS) | Receipt of Screening | | Diagnosis Documented | | Treatment, Immunization, Lab Work Documented | | | Ability to Determine Screening Status | | Actions Taken to Improve Member's Screenings by Contacting Provider | | | Actions Taken to Improve Member's Screenings by Contacting Parent/Guardian/Member | | |
| | | | Y | N | Y | N | Y | N | NA | Y | N | Y | N | NA | Y | N | N/A |
| 1 | 1 | MR | X | | X | | X | | | X | | | | X | | | X |
| | | IS | X | | X | | X | | | X | | | | | | | |
| 2 | 2 | MR | X | | X | | X | | | X | | | | X | | | X |
| | | IS | X | | X | | X | | | X | | | | | | | |
| 3 | 3 | MR | X | | X | | X | | | X | | | | X | | | X |
| | | IS | X | | X | | X | | | X | | | | | | | |
| 4 | 4 | MR | X | | X | | X | | | X | | | | X | | | X |
| | | IS | X | | X | | X | | | X | | | | | | | |
| 5 | 5 | MR | X | | X | | X | | | X | | | | X | | | X |
| | | IS | X | | X | | X | | | X | | | | | | | |
| 6 | 6 | MR | | X | X | | X | | | X | | X | | | X | | |
| | | IS | | X | X | | X | | | X | | | | | | | |
| 7 | 7 | MR | X | | X | | X | | | X | | | | X | | | X |
| | | IS | X | | X | | X | | | X | | | | | | | |
| 8 | 8 | MR | X | | X | | X | | | X | | | | X | | | X |
| | | IS | X | | X | | X | | | X | | | | | | | |
| 9 | 9 | MR | X | | X | | X | | | X | | | | X | | | X |
| | | IS | X | | X | | X | | | X | | | | | | | |
| 10 | 10 | MR | X | | X | | X | | | X | | | | X | | | X |
| | | IS | X | | X | | X | | | X | | | | | | | |
| Applicable Answers | | | 10 | | 10 | | 10 | | | 10 | | 1 | | | 1 | | |
| Compliant Answers | | | 10 | | 10 | | 10 | | | 10 | | 1 | | | 1 | | |

| | |
|---|---|
| Total Compliant | 42 |
| Total Applicable | 42 |
| **Percent Compliant** | **100%** |

**Case IDs have been altered to protect patient information.*

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## MCC Appeals (*Grier*) – File Review Tool

**MCC: AmeriChoice-Middle** | **Time Standard Calculation: Calendar Days** | **Date: 4/20/10**

| 1 | 2 | 3 | 4 | 5 | | | 6 | | | 7 | | 8 | 9 | 10 | 11 | | 12 | 13 | 14 | 15 | | 16 | | 17 | | | 18 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| File # | Case ID* | E/R and C/N** | Appeal Rcvd. Date | Authorization Request with Named Provider | | | Reviewed by Same Practitioner Type as Requester | | | Appeal Investigation Documented | | Decision Made Date | Wait (days) on Decision | Decision Time Std. | Met Decision Time Std. | | Member Notified Date | Wait (days) to be Notified | Notification Time Std. | Met Notification Time Std. | | Used State Letter Template & 6th Grade Level | | Contesting Instructions in Letter | | | For Delayed Decision, Notification <21 days | | |
| | | | | Y | N | NA | Y | N | NA | Y | N | | | | Y | N | | | | Y | N | Y | N | Y | N | NA | Y | N | NA |
| 1 | 1 | RC | 05/28/09 | | | X | | | X | X | | 06/03/09 | 6 | 14 | X | | 06/05/09 | 8 | 14 | X | | X | | X | | | | | X |
| 2 | 2 | EN | 12/14/09 | X | | | X | | | X | | 12/22/09 | 8† | 5 | X | | 12/28/09 | 14† | 5 | X | | X | | X | | | | | X |
| 3 | 3 | RC | 05/28/09 | | | X | | | X | X | | 06/05/09 | 8 | 14 | X | | 06/10/09 | 13 | 14 | X | | X | | X | | | | | X |
| 4 | 4 | RC | 04/17/09 | | | X | | | X | X | | 05/01/09 | 14 | 14 | X | | 05/01/09 | 14 | 14 | X | | X | | X | | | | | X |
| 5 | 5 | RC | 03/23/09 | X | | | X | | | X | | 04/03/09 | 11 | 14 | X | | 04/06/09 | 14 | 14 | X | | X | | X | | | | | X |
| 6 | 6 | RN | 05/14/09 | X | | | X | | | X | | 05/19/09 | 5 | 14 | X | | 05/22/09 | 8 | 14 | X | | X | | | | X | | | X |
| 7 | 8 | EC | 02/27/09 | | | X | | | X | X | | 03/04/09 | 5† | 5 | X | | 03/09/09 | 10† | 5 | X | | X | | X | | | | | X |
| 8 | 9 | EC | 09/16/09 | | | X | | | X | X | | 09/25/09 | 9† | 5 | X | | 09/30/09 | 14† | 5 | X | | X | | X | | | | | X |
| 9 | 10 | RN | 06/19/09 | | | X | | | X | X | | 06/26/09 | 7 | 14 | X | | 06/29/09 | 10 | 14 | X | | X | | X | | | | | X |
| 10 | 11 | EN | 02/03/09 | X | | | X | | | X | | 02/05/09 | 2 | 5 | X | | 02/09/09 | 6†† | 5 | X | | X | | X | | | | | X |
| **Applicable Answers** | | | | 4 | | | 4 | | | 10 | | | | | 10 | | | | | 10 | | 10 | | 9 | | | 0 | | |
| **Compliant Answers** | | | | 4 | | | 4 | | | 10 | | | | | 10 | | | | | 10 | | 10 | | 9 | | | 0 | | |

| | |
|---|---|
| **Total Compliant:** | **57** |
| **Total Applicable:** | **57** |
| **Percent Compliant:** | **100%** |

**Case IDs have been altered to protect patient information.*

***Expedited or routine and concurrent or non-concurrent.*

*†Extension granted by TennCare to 14 days.*

*††Date fell on a Sunday. Notification sent on Monday.*

# APPENDIX D | *Response to AQS Findings*

*for **AmeriChoice-Middle***

**AmeriChoice-Middle** had the opportunity to respond to the draft of this report. No comments were received.

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| AmeriChoice-Middle's Responses to QP Standard Areas of Noncompliance and Suggestions | | | |
|---|---|---|---|
| **Report Finding** | **Health Plan Comment** | **QSource Response** | **Additional Comments** |
| | None | | |

| AmeriChoice-Middle's Responses to PA Areas of Noncompliance and Suggestions | | | |
|---|---|---|---|
| **Report Finding** | **Health Plan Comment** | **QSource Response** | **Additional Comments** |
| | None | | |

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AmeriChoice **Middle** 2010 AQS Plan Of Correction

| 2010 Annual Quality Survey<br>Corrective Action Plan | | | |
|---|---|---|---|
| **Areas of Noncompliance** | **Action Steps/Progress** | **Intended Completion Date** | **Responsible Person/Titles** |
| **Clinical Criteria for UM Decisions: Denial File Review** One record did not meet the initial notification time standard | 1. Complete UM documentation audits every month for timely turn around time<br><br>2. Re-educate on Medical Necessity Policy (HS UM 1)<br><br>3. Initiated a new Denial Letter tasking process | 1. Ongoing monthly process<br><br>2. Completed<br><br>3. Completed - Implemented new tasking process 6/28/2010 to identify a request for denial letter to be completed. Ongoing monitoring and tracking will take place during month UM documentation audits. | Associate Director Medical Clinical Operations |
| **Notification of changes to written materials**<br>The MCO had updates to the policy regarding co-pay changes effective 1/1/2010, but the members were not provided the written 30 days in advance. | As benefit changes are identified, Americhoice will contact the state and request template changes at least 90 days prior to the effective date of the change. If the state does not intend to provide a template for the member communication, AmeriChoice will develop the communication and submit for approval no later than 60 days prior to the effective date of the change. AmeriChoice will communicate with the approved language no later than 30 days prior to the effective date of the change. If AmeriChoice is given less than 60 days notice, then AmeriChoice will request that the state clarify contract expectations around member notification for that benefit change event. The Health Plan will update the member communication policy to reflect the notification requirements around benefit change communications. | September 1, 2010 | Compliance Officer and Vice President of Marketing Outreach and Communication |

| | | | |
|---|---|---|---|
| **Undeliverable Mail (EPSDT)**<br>The MCO should ensure that, when mail is returned as undeliverable, both attempts to find family occur within the required time frames. | In 2010, the Health Plan initiated a new process for EPSDT returned mail by adding a bar code to all EPSDT mail so that when mail is returned, it is scanned electronically and a list generated for automated calls. The 1st attempt process did not change and continues to meet the 30 day timeframe. The bar code scanning process was completed and the first 2010 monthly "Returned Mail Call Campaign" was conducted March 12, 2010. Returned Mail Call Campaigns continue monthly to meet the 90 day 2nd attempt timeline. | Completed | Manager, Prevention and Wellness Education TENNderCare/EPSDT |
| **Community contacts approved (EPSDT)**<br>The MCO should ensure that all community events involving member outreach/interaction receive appropriate approval from TennCare. The MCO should also ensure that events are documented accurately in quarterly EPSDT reports. | AMC will strengthen quality controls around EPSDT community outreach to ensure a) prior approval of 100% of events and b) 100% reporting compliance for all completed EPSDT community outreach events.<br><br>Step 1: Revise tracking mechanism to include all events for approval.<br><br>Step 2: Update Policy & Procedure to reflect new database process and quality controls<br><br>Step 3: Update Policy & Procedure to reflect quarterly report process including increased quality controls<br><br>Step 4: Implement new P&Ps | <br><br><br><br>Step 1: July 1, 2010<br><br>Step 2: July 15, 2010<br><br>Step 3: July 15, 2010<br><br>Step 4: August 1, 2010 | Compliance Officer and Vice President of Marketing Outreach and Communication |

| | | | |
|---|---|---|---|
| **Display of non-discrimination posters** The MCO should include the information on the posters located in their break rooms informing their employees regarding the Omnibus Budget Reconciliation Act of 1981. The MCO should continue to include the current information like employees' rights and obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990 and the Age Discrimination Act of 1975. | Order new posters which include required non-discrimination language and display in the employee break rooms. | Completed | Compliance Officer |