NCQA News

TENNESSEE – Quarter 2 – 2015 TNPEC-1051-15

Working together to achieve better health outcomes while meeting HEDIS® measures

We know you've heard of HEDIS, which was established by the National Committee for Quality Assurance (NCQA). We send you report cards, letters and reminders about members overdue for services related to HEDIS measures. You might even be eligible for incentive payments when you help members get these important services.

Our Quality Improvement (QI) Program
When it comes to quality, we're guided by:

- Results-based studies conducted by our QI program team
- Sound advice from internal and external experts
- National standards set by the Bureau of TennCare and the NCQA
- Current research that informs the criteria we use
- First-hand experience of case managers who know our members' needs

Our comprehensive program:

- Adheres to HEDIS standards and measures our progress to meet annual goals
- Objectively monitors and evaluates the care and services our members receive
- Plans studies across the continuum of care and service to ensure ongoing, proactive evaluation and refinement of our program
- Reflects the demographic and epidemiological needs of each population we serve
- Encourages both members and providers to recommend improvements
- Identifies ways we can promote and improve patient safety

Our Benchmarks for Clinical Performance and Service Satisfaction
HEDIS, Healthcare Effectiveness Data and Information Set; a program developed by the NCQA to measure performance on important dimensions of care and service. Altogether, HEDIS consists of several measures across five domains of care.

CAHPS — Consumer Assessment of Healthcare Providers and Systems; a survey evaluating member satisfaction with care and services received over the past six months by questioning a random sample of plan members about their doctors and the health plan.

Provider Satisfaction Survey — An annual survey to find out what you, our providers, think we're doing well and what we can do better in several capacities, including communication and technology, claims processing and customer service.

HEDIS, CAHPS and the Provider Satisfaction Survey results help us identify areas of strength and areas where we need to focus our improvement efforts. We use the results to:

- Measure our performance against our goals
- Determine the effectiveness of actions we implemented to improve our results

To review the 2014 Quality Improvement Program Summary, call Patricia Kirkpatrick, Director II of Quality Management at 615-316-2400. We'll be glad to send you a copy.

Quality Improvement Resources for You
We're here to support you in delivering timely, quality care to our members. Here are some tools you can take advantage of as a valued provider in our network.

Access to Case Management
Did you know, as a component of our population health programs, we offer complex case management for our high-risk members? Using claims and utilization data, we identify members at risk for or susceptible to certain diseases. Then, we:

- Use evidence-based guidelines to coordinate care with the member, his or her family, physicians and other health care providers
- Work with everyone involved in the member's care to help implement a case management plan based on the member's needs
- Provide education and support to our members and their families to help our members improve their health and quality of life
- Use a collaborative process of assessment, planning, facilitation and advocacy for options and services for our members

The goal is to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes. Where indicated, we coordinate and integrate case management services for those members with co-occurring behavioral health and physical health disorders.
If you have a high-risk member you'd like to refer to this program, call our Provider Services team for help.

Clinical Practice and Preventive Health Guidelines
On our provider self-service site, we offer clinical care and preventive health guidelines based on current research and national standards, and known to be effective in improving health outcomes. Effectiveness of guidelines is determined by scientific evidence, professional standards or expert opinion. The guidelines are based on current research and national standards, and are available on our website at providers.amerigroup.com.

- ADHD
- Adult Hypertension
- Adult Preventive Health
- Asthma
- Behavioral Health Screening, Assessment and Treatment
- Bipolar Disorder – Adolescents
- Bipolar Disorder - Adults
- Child Preventive Health
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Diabetes
- Family Planning Preventive
- High-Risk OB Guidelines
- Immunizations
- Major Depression
- Obesity – Adult
- Obesity – Child and Adolescent
- Postpartum Care
- Routine Antepartum Care
- Schizophrenia

Need a paper copy of a guideline? Call our Provider Services team.

Utilization Management Criteria
If one of our medical directors denies your service request, we'll send you and the member a notice of action letter, including the reason for denial, the criteria/guidelines used for the decision and an explanation of your appeal process and rights. To speak with a medical director about the service request denial, call the number on your letter. To request a copy of the specific criteria/guidelines used for the decision, call our Provider Services team or write to:

Medical Management
Amerigroup Community Care
22 Century Blvd., Suite 210
Nashville, TN 37214

Our Utilization Management Team
Our team members, including the clinical professionals who coordinate our members' care, are governed by the following statements:

- Utilization Management (UM) decision-making is based only on appropriateness of care and service, and existence of coverage.
- We do not specifically reward practitioners or other individuals for issuing denial of coverage or care.
- Financial incentives for UM decision-makers don't encourage decisions that result in underutilization.

We're available 24 hours a day, 7 days a week to accept precertification requests. Submit requests:

- By phone: 1-800-454-3730
- By fax: 1-800-964-3627
- Online: providers.amerigroup.com/TN

Have questions about utilization decisions or the utilization management process in general? Ask to speak to a clinical team member when you call our Provider Services line: 1-800-454-3730.

Pharmacy Tools
Need up-to-date pharmacy information? Log in to our provider self-service site to access TennCare's Preferred Drug List, our medical injectables, prior authorization forms and clinical criteria for prior authorizations.

Have questions about the formulary or need a paper copy? Ask to speak to a Pharmacy team member when you call our Provider Services line**.** Pharmacists and pharmacy technicians are available Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 10 a.m. to 2 p.m. Central time.

Our Members' Rights and Responsibilities
Our members' defined rights and responsibilities are in your provider manual on our provider self-service site. If you'd like us to mail you a copy, call our Provider Services team.
Our Member Services representatives serve as advocates for our members. To reach Member Services, please call 1-800-600-4441 (TTY 1-800-855-2880).