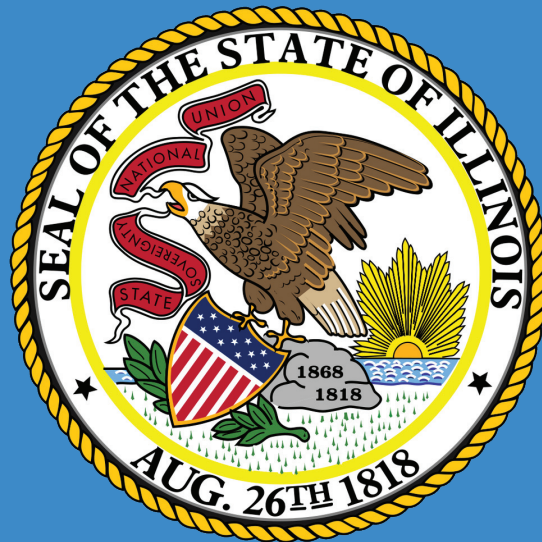


Illinois Department of Healthcare and Family Services  
Division of Medical Programs



# External Quality Review Annual Report

## State Fiscal Year 2010–2011

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### Introduction

Since June 2002, Health Services Advisory Group, Inc. (HSAG) has served as the external quality review organization (EQRO) for the Illinois Department of Healthcare and Family Services (HFS), formerly known as the Illinois Department of Public Aid (IDPA). The State fiscal year (SFY) 2010–2011 Illinois External Quality Review (EQR) Technical Report describes the manner in which data from EQR activities conducted in accordance with the Code of Federal Regulations (CFR), at 42 CFR 438.358, were aggregated and analyzed. The report also describes how conclusions were drawn as to the quality and timeliness of, and access to, care furnished to participants of the Illinois Medical Assistance Program. These beneficiaries were enrolled in Illinois' one managed care community network (MCCN), **Family Health Network, Inc. (FHN)**, or in one of four contracted Managed Care Organizations (MCOs): **Harmony Health Plan of Illinois, Inc. (Harmony)**; **Meridian Health Plan, Inc. (Meridian)**; **Aetna Better Health (Aetna)**; and **IlliniCare Health Plan (IlliniCare)**. Medicaid managed care is currently delivered through three models: Voluntary Managed Care (VMC), Primary Care Case Management (PCCM) and the Integrated Care Program (ICP). This executive summary outlines the mandatory and optional EQR activities performed by HSAG in SFY 2010–2011.

### Purpose of Report

The SFY 2010–2011 EQR Technical Report provides an evaluation of the data sources reviewed by HSAG. As the EQRO, HSAG assessed the progress made in fulfilling HFS' goals for the quality and timeliness of, and access to, care furnished to Illinois Medical Assistance Program recipients for HFS-contracted MCOs for the SFY 2010–2011 evaluation period. A goal of this report is to ascertain whether health plans have met the intent of the BBA and State requirements.

The BBA requires that states contract with an EQRO to conduct an annual evaluation of MCOs that serve Medicaid recipients. The purpose of this annual evaluation is to determine each MCO's compliance with federal quality assessment and performance improvement standards. The Centers for Medicare & Medicaid Services (CMS) regulates requirements and procedures for the EQRO.

Pursuant to the Balanced Budget Act (BBA), 42 CFR 438.364 calls for the production by each state of a detailed technical report on EQR results. In accordance with 42 CFR 438.358, the EQR technical report describes the manner in which the data from EQR activities were aggregated and analyzed. The report also describes how conclusions were drawn as to the quality and timeliness of, and access to, care furnished to Illinois Medical Assistance Program recipients by Department-

contracted MCOs. Information released in this technical report does not disclose the identity of any recipient, in accordance with 438.350(f) and 438.364(a)(b). This report specifically addresses the following for each EQR activity conducted:

- ◆ Objectives
- ◆ Technical methods of data collection and analysis
- ◆ Description of data obtained
- ◆ Conclusions drawn from the data

In addition, this report includes an assessment of each MCO's strengths and weaknesses with respect to the quality and timeliness of, and access to, health care services furnished to HFS beneficiaries. The report also offers recommendations for improving the quality of health care services furnished by each MCO, makes comparisons of MCO performance, and describes performance improvement efforts.

## Overview of the 2010–2011 External Quality Review

### *Mandatory EQR Activities*

The SFY 2010–2011 EQR Technical Report focuses on the three federally-mandated EQR activities that HSAG performed for the MCOs over a 12-month period (June 1, 2010, to May 31, 2011). As set forth in 42 CFR 438.352, these mandatory activities were:

- ◆ Review, within the previous three-year period, to determine MCO compliance with State standards for access to care, structure and operations, and quality measurement and improvement. During SFY 2010–2011, HSAG conducted a focused review of the Voluntary Managed Care MCOs (VMCOs) to review standards not met during the SFY 2009–2010 compliance review (VMCO compliance with the Quality Assurance Plan standards). An additional focus was a review of each MCO's case management and care coordination systems and programs. In addition, HSAG conducted readiness reviews for the health plans participating in the new Integrated Care Program.
- ◆ Validation of performance measures. The State contracted with HSAG to conduct a HEDIS<sup>®</sup> 1-1 (Healthcare Effectiveness Data and Information Set) compliance audit of 2010 data for the MCOs. The process of validating performance measures includes two elements: (1) validation of an MCO's data collection process, and (2) a review of performance measure results compared with other MCOs and national benchmarks. This report presents the performance measure results for the VMCOs. The ICPs did not begin accepting membership until May 2011; therefore, performance measure rates will not be reported by the ICPs until 2013.

<sup>1-1</sup> HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance (NCQA).

- ◆ Validation of performance improvement projects (PIPs). As part of the SFY 2010–2011 review, HSAG validated PIPs conducted by the MCOs regarding compliance with requirements set forth in 42 CFR 438.240(b)(1). In SFY 2010–2011, the MCOs continued their PIPs on the topics of Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screening, perinatal care and depression screening, and improving ambulatory follow-up and primary care physician (PCP) communication.

### Optional EQR Activities

Other EQR activities conducted by HSAG included:

- ◆ Assessment of consumer satisfaction surveys. Each year, the MCOs are required to independently administer a consumer satisfaction survey. As part of its SFY 2010–2011 review, HSAG evaluated the results of adult and child CAHPS<sup>®</sup> (Consumer Assessment of Healthcare Providers and Systems) surveys conducted in 2010 by The Meyers Group to identify trends, strengths, and opportunities for improvement. **Meridian** was allowed to conduct its own survey due to insufficient enrollment to meet the CAHPS eligibility criteria.
- ◆ Collaborative PIPs. Health plans are required to initiate a new quality improvement project each year, and projects typically have a cycle of two to four years. HSAG provides support and assistance to the MCOs in developing, implementing, and evaluating each of the improvement initiatives.
- ◆ Provision of technical assistance. HSAG has provided ongoing technical assistance to the MCOs at the request of HFS.

## Findings, Conclusions, and Recommendations

As set forth in 42 CFR 438.364(a)(3), this section of the technical report includes recommendations for improving quality of health care services furnished by each MCO.

The Centers for Medicare & Medicaid Services (CMS) chose the domains of quality, access, and timeliness as keys to evaluating the performance of Medicaid managed care plans. HSAG provides overall findings, conclusions, and recommendations regarding the health plans serving Illinois Medicaid beneficiaries during the review period for each domain of care and presents them in the annual EQR technical report.

The findings, conclusions, and recommendations presented in this section are gathered from a variety of assessment sources, including:

- ◆ Performance measure audits using NCQA’s standardized audit methodology (as described in Section 6 of this report).
- ◆ Performance improvement project (PIPs) results (as described in Section 7 of this report).
- ◆ Member satisfaction survey results (as described in Section 8 of this report).

- ◆ Compliance review findings (as described in Section 5 of this report).

### **Performance Measures—Voluntary Managed Care**

For ease of review, this report organizes performance reporting by classifying performance measures into the following categories. These categories align with those included in the State Quality Strategy. Measures in these categories provide information on the quality, timeliness of, and access to health care services furnished to HFS beneficiaries.

- ◆ Child and Adolescent Care
- ◆ Access to Care
- ◆ Maternity-Related Care
- ◆ Preventive Screening for Women
- ◆ Chronic Conditions/Disease Management
- ◆ Behavioral Health

#### **Child and Adolescent Care**

The Child and Adolescent Care measures identified below fall into the Effectiveness of Care, Access/Availability of Care, and Utilization and Relative Resource HEDIS domains. Measures in the Effectiveness of Care domain provide information about the quality of clinical care, use of preventive practices, and recommended screening for common diseases. The Access/Availability measures provide information about member services, ease of members' access to health care providers, and timeliness of care. Utilization and Relative Resource measures provide information on resource management and how the VMCO uses available health services and resources to manage chronic diseases. The following table presents HEDIS measures regarding care for children and adolescents.

**Table 1.1—HEDIS Measures for Child and Adolescent Care**

<b>Category</b>	<b>HEDIS 2011 Measure</b>
<b>Child and Adolescent Care</b>	<i>Childhood Immunization Status (Combinations 2 and 3)</i>
	<i>Lead Screening in Children</i>
	<i>Well-Child Visits in the First 15 Months of Life (0 Visits and 6+ Visits)</i>
	<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>
	<i>Adolescent Well-Care Visits</i>
	<i>Immunizations for Adolescents (Combined Rate)</i>

Of the eight measures in the Child and Adolescent Care category, **FHN**'s rates exceeded the 2010 HEDIS Medicaid 50th percentiles on only one measure—*Lead Screening in Children*—improving 11.5 percentage points since HEDIS 2008.

**Harmony** reported two measures with rates at or above the Medicaid 2010 HEDIS 50th percentiles. For *Lead Screening in Children*, **Harmony** improved 12.2 percentage points while increasing its rates for *Well-Child Visits (3–6 Years)* by 14.4 percentage points.

Though neither plan met the National HEDIS 2009 Medicaid 50th percentile for the *Well-Child Visits During the First 15 Months of Life—Zero Visits* measure, both **FHN** and **Harmony** have demonstrated an overall trend of improvement since HEDIS 2008. The results for this measure indicate that approximately 95.0 percent of the eligible children receive at least one well-child visit in their first 15 months of life.

Though demonstrating trended improvement, the rates for both **FHN** and **Harmony** VMCOs were well below the National Medicaid HEDIS 2010 50th percentile for *Well-Child Visits in the First 15 Months of Life—Six or More Visits*.

## Access to Care

The Access to Care measures identified below fall into the HEDIS Access/Availability of Care domain. These measures look at how members access health care services offered by the VMCO. The measures look at preventive and ambulatory services for adult, children, and adolescent members. The following table presents HEDIS measures regarding access to care.

**Table 1.2—HEDIS Measures for Access to Care**

Category	HEDIS Measure
Access to Care	<i>Children's and Adolescents' Access to Primary Care Practitioners (12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years)</i>
	<i>Adults' Access to Preventive/Ambulatory Care (Ages 20–44 and Ages 45–64)</i>

The low rates for *Children's Access to Primary Care Practitioners* and *Adults' Access to Preventive/Ambulatory Care* services indicate that both **FHN** and **Harmony** need to improve access to care. The rates continued to improve but still remain low and well below the national 50th percentiles. Both **FHN** and **Harmony** should examine their network provider coverage along with potential access-to-care barriers and evaluate internal policies regarding member and provider education. The VMCOs and the State should also consider conducting a PIP around these measures.

For most measures in this category, when looking at trended performance since the HEDIS 2008 baseline rate, **Harmony** has consistently outperformed **FHN** each year.



## Maternity-Related Care

The Maternity-Related Care measures fall into the Access/Availability of Care and Utilization and Relative Resource Use HEDIS domains. The measures look at how well the VMCO provides timely prenatal care and care provided to women following delivery. In addition, measuring the frequency of prenatal care provides information about how the stage of a woman's pregnancy when she enrolls in the VMCO impacts the VMCO's ability to provide effective pregnancy-related care. The following table presents HEDIS measures related to maternity care.

**Table 1.3—HEDIS Measures for Maternity Care**

Category	HEDIS 2011 Measure
Maternity-Related Care	<i>Frequency of Ongoing Prenatal Care (0–21 Percent of Visits and 81–100 Percent of Visits)</i>
	<i>Timeliness of Prenatal Care</i>
	<i>Postpartum Care</i>

Both **FHN** and **Harmony** continue to report rates well below the HEDIS Medicaid 50th percentile for maternity-related measures. In response to these low rates, the State and the VMCOs began a collaborative perinatal depression screening PIP in 2006–2007.

The interventions **FHN** and **Harmony** have implemented were expected to result in higher rates for these HEDIS measures. For most of these measures, the rates improved. **FHN** improved on every measure except *Frequency of Ongoing Prenatal Care (0–21 Percent of Visits)*. However, **Harmony** had only limited success, improving less than 1.5 percentage points for *Frequency of Ongoing Prenatal Care (0–21 Percent of Visits and 81–100 Percent of Visits)*.

In prior years, there were several potential issues identified as probable causes for the poor rates for these measures: the encounter data may be incomplete, **FHN** and **Harmony** may have had difficulty identifying pregnant members, there may be a network adequacy issue, there may be issues with member compliance, or any combination of these factors. **FHN** and **Harmony** should include additional encounter data as a way to improve data completeness; conduct a root-cause analysis to determine the reason for low compliance; and assess interventions to improve the rates for maternity-related measures, particularly in regards to those measures that assess access to care. Both plans have implemented or expanded prenatal incentives and/or educational programs for women.

## Preventive Screening for Women

The Preventive Screening for Women measures fall into the Effectiveness of Care HEDIS domain. The measures look at whether female members are screened for breast and cervical cancer and chlamydia. The following table presents HEDIS measures regarding preventive screenings for women.

**Table 1.4—HEDIS Measures for Preventative Screening for Women**

Category	HEDIS 2011 Measure
Preventive Screening for Women	<i>Breast Cancer Screening</i>
	<i>Cervical Cancer Screening</i>
	<i>Chlamydia Screening in Women (Combined Rate)</i>

Both **FHN** and **Harmony** rates for *Cervical Cancer Screening* exceeded the National HEDIS Medicaid 50th percentile.

**FHN**'s rate of 66.3 percent for *Chlamydia Screening in Women* exceeded the National Medicaid 50th percentile and demonstrated an improvement of 18.6 percentage points from HEDIS 2008.

**Harmony**'s rate has remained fairly constant each year and remains below the 50th percentile.

**Harmony** has also struggled to improve its rate for *Breast Cancer Screening*, demonstrating a continued decrease each year, with an overall decline of 4.8 percentage points since HEDIS 2008. In contrast, the rate for **FHN** improved 19.9 percentage points since HEDIS 2008.

### Chronic Conditions/Disease Management

The Chronic Conditions/Disease Management measures fall into the Effectiveness of Care HEDIS domain. The measures look at how well care is delivered to members with chronic disease and how well the VMCOs' health care delivery system helps members cope with their illness. The following table presents HEDIS measures regarding chronic conditions/disease management.

**Table 1.5—HEDIS Measures for Chronic Conditions/Disease Management**

Category	HEDIS 2011 Measure
Chronic Conditions/Disease Management	<i>Controlling High Blood Pressure (Combined Rate)</i>
	<i>Comprehensive Diabetes Care (HbA1c Testing, Good HbA1c Control, Poor HbA1c Control, Eye Exam, LDL-C Screening, LDL-C Level &lt;100 mg/dL, Nephropathy Monitoring, Blood Pressure &lt;140/90, and Blood Pressure &lt;140/80)</i>
	<i>Use of Appropriate Medications for People With Asthma (Combined Rate)</i>
	<i>Follow-up After Hospitalization for Mental Illness (7-Days and 30-Days)</i>

**FHN** had two measures with rates that exceeded the 2010 HEDIS Medicaid 50th percentile in the Chronic Conditions/Disease Management category: *Diabetes Care (Nephropathy Monitoring)* and *Appropriate Medications for Asthma (Combined Rate)*.

Although **FHN**'s rates on many of the diabetes care measures have consistently improved, rates for all but one of those measures remained below the National Medicaid HEDIS 50th percentiles. Diabetes care measures were one of **Harmony**'s generally lowest-performing areas when comparing to the 50th percentiles and looking at improvement, though the plan did improve rates on some measures.

Both VMCOs continue to struggle to improve performance for the *Diabetes Care—Eye Exam* measure. One barrier to consider is that Illinois law allows eye examinations for retinopathy to be performed by an optometrist. Optometry services are carved out of the MCO agreement as a covered service and therefore the MCO's do not receive the encounter data. However, **FHN** and **Harmony** need to conduct an analysis to determine the reason the rate continues to be so low. The VMCOs and the State might also consider conducting a PIP around this measure.

Due to **Meridian's** low population size, **Meridian** did not have more than 30 eligible members for many of the reported HEDIS measures for HEDIS 2011, and trending rates across years was not possible. In accordance with NCQA requirements, the rates for these measures are not applicable (NA). However, all of **Meridian's** reported rates for HEDIS 2011 were above the 50th percentiles.

The HEDIS 2011 compliance audit indicated that **Meridian, Harmony,** and **FHN** were in compliance with the *HEDIS 2011 Technical Specifications*. Membership data supported all necessary HEDIS calculations, medical data were fully or partially compliant with the audit standards, and measure calculations resulted in rates that were not significantly biased. Furthermore, all selected HEDIS performance measures attained a Report (R) designation.

## Behavioral Health

The Behavioral Health measures fall into the Effectiveness of Care HEDIS domain. The measures look at continuity of care for mental illness. The following table presents HEDIS measures regarding behavioral health.

**Table 1.6—HEDIS Measure for Behavioral Health**

Category	HEDIS 2011 Measure
Behavioral Health	<i>Follow-up After Hospitalization for Mental Illness (7-Days and 30-Days)</i>

**FHN** had two measures with rates that exceeded the 2010 HEDIS Medicaid 50th in the Behavioral Health category: *Follow-up After Hospitalization for Mental Illness—7 Days* and *Follow-up After Hospitalization for Mental Illness—30 Days*.

The two measures related to mental health continue to represent an area of strength for **FHN**, with the 7-day rate exceeding the 90th percentile and the 30-day rate exceeding the 75th percentile. **Harmony's** rates for these two measures improved significantly between HEDIS 2008 and HEDIS 2009, and its 7-day rate exceeded the National Medicaid HEDIS 50th percentile last year. However, **Harmony's** 7-day rate declined from 49.2 percent last year to 42.7 percent for HEDIS 2011, and its 30-day rate has been fairly constant over the last three years with little to no improvement.

Section 6 and Appendices A-C of this report provide detailed information on VMC performance for all of the performance measures.

### ***Encounter Data Completeness—Voluntary Managed Care***

Overall, the results show that **FHN** did not receive all of its encounter data. Twelve measures had less than a 50.0 percent encounter data completeness rate, and none of the measures had a data completion rate at or above 90.0 percent. These results indicate that **FHN** continues to have difficulty obtaining complete encounter data and is strongly encouraged to focus efforts on improving encounter data submission.

The rates indicate that **Harmony** has reasonably good encounter data completeness. Two measures had more than a 90.0 percent data completion rate, two were above 80.0 percent, seven were above 70.0 percent, and one measure was above 60.0 percent. However, five of the measures had less than 50.0 percent data completion rate. **Harmony** should continue to reinforce efforts to improve submission of encounter data, concentrating efforts toward obtaining complete lab data.

A detailed analysis on encounter data completeness for FHN and Harmony can be found in Section 6 of this report.

### ***Performance Improvement Projects (PIPs)***

The purpose of performance improvement projects (PIPs) is to assess and improve processes to improve care outcomes. It typically consists of a baseline, intervention period(s), and remeasurement(s). The PIP process provides an opportunity to identify and measure a targeted area, analyze the results, and implement interventions for improvement. PIPs must be designed, conducted, and reported in a methodologically sound manner. In accordance with federal regulations, HFS' EQRO validates PIPs to determine if they are designed to achieve improvement in clinical and nonclinical care, and if the PIPs will have a favorable effect on health outcomes and enrollee satisfaction. The EQRO validates the study's findings on the likely validity and reliability of the results.

HFS required each VMCO delivering Voluntary Managed Care services to participate in a mandatory statewide PIP focused on the following three topics:

- ◆ Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
- ◆ Perinatal Care and Depression Screening
- ◆ Improving Ambulatory Follow-Up and PCP Communication

To conduct an effective PIP, study indicators are chosen for each topic. Indicators are quantitative or qualitative characteristics (variables) reflecting a discrete event that is to be measured. For example, one indicator for the *EPSDT* PIP is *Total number of members with a physical exam performed on every EPSDT visit*.

During SFY 2010–2011, HSAG conducted a validation and analysis of the three above-mentioned PIPs to evaluate the VMCOs' performance on the PIP study indicators. The following summarizes the results of that analysis.

### Voluntary Managed Care PIPs

Ten study indicators were validated for the *EPSDT* PIP which focused on improving performance related to *EPSDT* screenings and visits. **FHN** demonstrated statistically significant improvement for seven of the 10 indicators and achieved sustained improvement for one indicator. **Harmony** outperformed **FHN** with nine of the 10 indicators demonstrating statistically significant improvement and achieving sustained improvement for four of the ten indicators. **Meridian** reported baseline rates only and could not be assessed for improvement or sustained improvement.

The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve PIP outcomes. For the *EPSDT* PIP, all three VMCOs identified that lack of provider documentation was a key barrier and subsequently implemented a collaborative intervention of developing a standardized form to be used by the providers.

The primary purpose of the *Perinatal Care and Depression Screening* PIP was to determine if VMCO interventions have helped to improve rates for the perinatal HEDIS measures. **FHN** showed statistically significant improvement for four of the 13 indicators; however, five indicators declined. **FHN** achieved sustained improvement for six indicators. **Harmony** demonstrated statistically significant improvement in six of the 15 indicators and achieved sustained improvement for seven indicators. **Meridian** reported baseline rates only and could not be assessed for improvement or sustained improvement.

**FHN, Harmony, and Meridian** reported baseline rates for the *Improving Ambulatory Follow-Up* and *PCP Communication* PIP and could not be assessed for improvement or sustained improvement. The goals of this PIP are to improve follow-up treatment after a mental illness and reduce or eliminate the barriers to effective communications between medical and behavioral health care providers.

Overall recommendations for PIPs include:

- ◆ Build upon the existing momentum for study indicators with improving rates and implement new and/or enhanced quality improvement interventions for these PIPs.
- ◆ Implement a method to study the efficacy of the interventions to determine which interventions are most successful and which ones have not produced the desired effect.
- ◆ Identify study outcome barriers specific to the interventions already implemented.
- ◆ Conduct a “drill-down” type of analysis before and after the implementation of any intervention.
- ◆ Perform interim evaluations of the results in addition to the formal annual evaluation.

### **Integrated Care Program (ICP) PIPs**

The health plans participating in the ICP, through input from HFS, identified the PIP topic, Community Based Care Coordination, which will be designed to focus on medically high-risk members with a recent hospital discharge who are actively receiving care coordination with linkage to community resources. During the third quarter of 2011, the ICPs began developing the study question and indicators and identifying data sources. Development of the PIP will continue in SFY 2012, and the ICPs are scheduled to report baseline rates for the PIP in SFY 2013.

Section 7 of this report details the validation process for PIPs and the results of the Voluntary Managed Care PIPs conducted during the report period.

### **Member Satisfaction Surveys—Voluntary Managed Care**

Member satisfaction surveys are designed to capture accurate and reliable information from consumers about their experiences with health care. Consumer Assessment of Healthcare Providers and Systems (CAHPS<sup>®</sup>) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ) and refers to collection of standardized healthcare-related surveys.

CAHPS measures fall into the Experience of Care HEDIS domain. The surveys ask adult Medicaid members and parents of Medicaid children to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. The survey questions are categorized into nine measures, four global ratings, and five composite scores of satisfaction. The global ratings reflect the overall satisfaction of adult members and parents of children with their personal doctor, specialist, health plan, and all health care. The composition scores reflect the overall satisfaction of adult members and parents with different aspects of care: getting needed care, getting care quickly, how well doctors communicate, and shared decision making.

The following table presents CAHPS measures regarding member satisfaction.

Table 1.7—CAHPS Measures for Member Satisfaction

Category	CAHPS 2011 Measure
Member Satisfaction—Composite Measures	<i>Getting Needed Care</i>
	<i>Getting Care Quickly</i>
	<i>How Well Doctors Communicate</i>
	<i>Customer Service</i>
	<i>Shared Decision Making</i>
	<i>Getting Needed Care</i>
Member Satisfaction—Global Measures	<i>Rating of All Health Care</i>
	<i>Rating of Personal Doctor</i>
	<i>Rating of Specialist Seen Most Often</i>
	<i>Rating of Health Plan</i>
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as NA.	

A comparison of **FHN**'s 2010 results to its 2011 results revealed that **FHN**'s rates for adult CAHPS measures decreased for all four reportable measures: *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. However, **FHN** scored above the 2011 NCQA CAHPS top-box national average on one measure, *How Well Doctors Communicate*.

For the child Medicaid surveys, **FHN**'s rate decreased for all five reportable measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. The rate for *Rating of Health Plan* was the only statistically significant decrease for both the adult and child populations.

**Harmony** showed an increase in rates from its 2010 results to 2011 results for all seven reportable adult measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*.

**Harmony** scored above the 2011 NCQA CAHPS top-box national averages on two measures: *How Well Doctors Communicate* and *Shared Decision Making*.

**Harmony** showed an increase in rates for four child measures: *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. **Harmony**'s rates decreased from 2010 to 2011 for two measures: *Getting Care Quickly* and *Shared Decision Making*; however, these decreases were not substantial.

Overall recommendations for **FHN** and **Harmony** to improving CAHPS results include:

- ◆ Identify potential barriers for patients receiving appropriate access to care.
- ◆ Identify and eliminate patient challenges when receiving health care.

- ◆ Consider creating patient and family advisory councils composed of the patients and families who represent the population(s) they serve.
- ◆ Encourage physician-patient communication to improve patient satisfaction and outcomes.
- ◆ Request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit.
- ◆ Consider establishing an online patient portal or integrating online tools and services into current Web-based systems that focus on patient-centered care.
- ◆ Create an environment that promotes quality improvement (QI) in all aspects of care to encourage organization-wide participation in QI efforts.
- ◆ Encourage patients to take a more active role in the management of their health care by providing them with the tools necessary to effectively communicate with their physicians.
- ◆ Revise existing and create new print materials that are easy to understand based on patients' needs and preferences, and provide training for health care workers on how to use these materials.
- ◆ Consider an open access scheduling model to match the demand for appointments with physician supply.
- ◆ Conduct a patient flow analysis.
- ◆ Establish a nurse advice help line to direct members to the most appropriate level of care for their health problem(s).
- ◆ Enhance provider directories.
- ◆ Ensure physicians are properly trained to facilitate the shared decision making process with patients.

Due to its size, **Meridian** was allowed to create and administer its own consumer satisfaction survey and therefore cannot be compared with the other health plans. A comparison of **Meridian**'s 2009 results to its 2010 results (not including the percentage of identified smokers) reveal that **Meridian** improved on seven of the 11 measures: *Doctor's office wait time, Doctors who listen and explain things in an understandable way, Courteous and helpful office staff, Doctors who show respect for what patients say, Doctors who spend enough time with patients, Rating of doctor, and Rating of Meridian.*

Rates decreased from 2009 to 2010 on the *Getting in to see a doctor as soon as needed* measure as well as all three smoking cessation measures.

Overall recommendations for **Meridian** to improve member satisfaction include:

- ◆ Provide physicians with educational materials that they can use to become more informed about the smoking cessation programs and explore the option of creating similar smoking cessation educational materials for members.



- ◆ Improve in the area of office wait time and encourage physicians to monitor patient flow by conducting a patient flow analysis.
- ◆ Encourage physicians to explore open access scheduling to improve in the area of patients getting a physician appointment as soon as needed.

Section 8 of this report presents the detailed results of the CAHPS surveys and other member satisfaction surveys conducted by the VMCOs during the report period.

### ***Focused Reviews—Voluntary Managed Care***

In SFY 2010–2011, HSAG conducted focused on-site reviews of **FHN**, **Harmony**, and **Meridian**. The focused review areas included measurement and improvement standards for all areas related to quality assessment and process improvement; access standards for continuity of care and case management; and structure and operations standards for delegation oversight, credentialing, and recredentialing.

Many of **FHN**'s policies and procedures for continuity of care and case management were found deficient and not in compliance with federal Medicaid managed care regulations, State rules, and the associated Illinois contract requirements for access standards. In October 2010, **FHN** implemented new case management software and case management processes; therefore, its focused review was followed by additional corrective actions related to Case Management and Care Coordination requirements. In April 2011, a focused review of **FHN** resulted in a recommendation to continue to improve its case management and oversight and monitoring activities. **FHN** responded with a comprehensive plan implemented in May 2011 to build a robust care management program and boost QI improvements that were approved by HFS.

Review of **FHN**'s measurement and improvement standards included in the focused review identified that **FHN** did not have a system established for tracking and trending of health care utilization data. In addition, **FHN**'s oversight and monitoring of QA activities lacked development of corrective action recommendations for correcting noncompliance with delegation oversight activities. **FHN** will need to continue to evaluate the effectiveness of its quality improvement interventions and work with network providers to create, implement, and sustain quality improvement initiatives.

Review of the structure and operations standards included in the review identified that **FHN** failed to monitor the performance of its delegated entities through routine reporting and follow-up, ongoing monitoring, and evaluation to determine whether the delegated activities were being carried out according to BBA, HFS, and **FHN** requirements.

Throughout SFY 2010–2011, **Harmony** worked to strengthen its case management and care coordination program by evaluating the process for member referrals to case management through case and disease management claims/encounters algorithm. **Harmony** reported that as a result of

this evaluation, the number of cases identified and referred to case management almost doubled between 2010 and 2011. Review of medical and behavioral case management files identified the need for continued focus on improved communication with members in case management.

Review of **Harmony**'s measurement and improvement standards included a review of the annual Quality Improvement Program (QIP) Evaluation which revealed that the plan will need to continue to strengthen its annual review process through continued evaluation of the barriers to quality improvement and the development of innovative interventions that will address the barriers identified.

Review of the structure and operations standards identified that **Harmony**'s case management delegation oversight tool lacked all the required components necessary to ensure compliance with contract requirements. In addition, **Harmony** did not have a vendor oversight process in place to ensure coordination and continuity of care and involvement of the PCP in aftercare for members with behavioral health conditions. **Harmony** was in compliance with the credentialing and recredentialing policies and procedures and implemented changes to its grievance system.

A review of the case management and care coordination program identified that **Meridian** used the Managed Care Information System (MCS), its internally developed proprietary software system, for documentation of case management activities. A review of medical and behavioral case management files found that while the files provided documentation of timely development of care treatment plans, **Meridian** will need to ensure that the member and the member's primary care physician/specialist are consistently informed that the member has been enrolled into case management services and that the PCP receives a copy of the care treatment plan. **Meridian** must also continue its efforts to facilitate and coordinate communication between service providers and the member/member's family.

**Meridian** was a Chief Information Officer (CIO) 100 Award winner in 2010 for its innovative capabilities of integrating health care data. Review of **Meridian**'s measurement and improvement standards revealed that as the plan continues to expand into additional counties and grow its membership, **Meridian** will need to include an evaluation of the effectiveness of its cultural competency and case and disease management programs in the Quality Improvement Program Plan.

A review of structure and operations standards found **Meridian** in compliance with the majority of the delegation and credentialing and recredentialing requirements.

### **Readiness Reviews—Integrated Care Program**

HSAG was contracted by HFS to conduct a pre- and post-implementation operational readiness review for the health plans contracted to implement HFS' Integrated Care Program, **Aetna** and

**IlliniCare.** The pre-implementation readiness review activities conducted in SFY 2010–2011 consisted of a comprehensive desk document review. The documents requiring review were determined based on HFS contractual and federal requirements. The ICPs were required to comply with all elements identified as mandatory or critical components prior to the May 1, 2011, program implementation date. HFS, with assistance from HSAG, reviewed and approved all mandatory documentation prior to implementation of the program. Both **Aetna** and **IlliniCare** met the State requirements for document approval prior to the implementation date.

Assessment of the ICPs' readiness and compliance will continue throughout SFY 2012 and SFY 2013 as HSAG conducts an on-site review to further monitor compliance to ensure the ICPs are meeting the State's standards for program implementation, and HSAG completes post-implementation activities described above.

Section 5 details the procedures and findings of the focused reviews and readiness reviews conducted in SFY 2010–2011.

## Report Organization

The EQR technical report is organized as follows:

- ◆ **Section 1—Executive Summary** describes the purpose of this report, the scope of the report (mandatory and optional EQR activities), and a summary of overall conclusions and recommendations.
- ◆ **Section 2—Introduction** outlines the organization of the report, Section 2 also provides the history of State Medicaid and describes its eligibility requirements, enrollment, and programs.
- ◆ **Section 3—HFS Managed Care Program Quality Strategy** describes the goals of the quality strategy, the State’s monitoring and compliance efforts to assess progress toward meeting quality strategy goals, and describes HFS’ process for updating its quality strategy.
- ◆ **Section 4—HFS Managed Care Program Initiatives** highlights initiatives that support the improvement of quality of care and services for Medicaid beneficiaries as well as activities that support plan improvement efforts.
- ◆ **Section 5—Annual Administrative Assessment** describes the EQR activities conducted for each MCO. For each of the activities, the report presents the objectives, technical methods of data collection and analysis, description of data obtained, findings for each plan, and conclusions drawn from the data.
- ◆ **Section 6—Performance Measures** describes the evaluation of the MCOs’ ability to collect and accurately report on the performance measures and performance measure results for HEDIS 2011 and trended HEDIS measures from 2008–2011.
- ◆ **Section 7—Performance Improvement Projects [PIPs]** describes the validation process for PIPs and presents the results of the PIPs conducted by MCOs during the report period.
- ◆ **Section 8—Member Satisfaction Survey** presents the results of the CAHPS surveys and other member satisfaction surveys conducted by MCOs during the report period.
- ◆ **Section 9—Overall Findings, Conclusions, and Recommendations** provides overall findings, conclusions, and recommendations regarding the health plans serving Illinois Medicaid beneficiaries during the review period.
- ◆ **Section 10—Technical Assistance to HFS and the HFS Managed Care Plans** describes technical assistance provided by HSAG in SFY 2010–2011.
- ◆ **Appendix A**—displays the Illinois HEDIS 2011 Medicaid rates for Child and Adolescent Care and Adults’ Access to Preventive/Ambulatory Health Services measures, and Chronic Conditions and Disease Management measures for voluntary managed care.

- ◆ **Appendix B**—displays trending graphs for HEDIS 2008–HEDIS 2011 for all measures for voluntary managed care.
- ◆ **Appendix C**—displays the HEDIS 2008–2011 measures for **FHN** and **Harmony** in a trended table.
- ◆ **Appendix D**—displays the Medicaid HEDIS 2010 means and percentiles.

## Illinois Medicaid Overview

The Department of Healthcare and Family Services (HFS), Division of Medical Programs, administers and, in conjunction with the federal government, funds medical services provided to about 20 percent of the State’s population. HFS was formerly the Illinois Department of Public Aid.

HFS is responsible for administering the State of Illinois' Medical Assistance Programs under the provisions of the Illinois Public Aid Code (305 ILCS 5/5 et seq.), the Illinois Children's Health Insurance Program Act (CHIPRA) (215 ILCS 106/1 et seq.), Covering All Kids Health Insurance Act (215 ILCS 170/1 et seq.), and Titles XIX and XXI of the federal Social Security Act. Through its role as the designated Medicaid single State agency, HFS works with several other agencies that manage important portions of the program—the Department of Human Services (DHS); Department of Public Health (DPH); Department of Children and Family Services (DCF); the Department on Aging (DoA); the University of Illinois at Chicago, Cook County; and other local units of government, including hundreds of local school districts.

In 2011, HFS began implementing both the Illinois Medicaid reform legislation (P.A. 096-1501) and the federal Patient Protection and Affordable Care Act (Pub. L. 111-148), with emphasis on service delivery reforms (access to care), cost containment strategies (structure and operations), program integrity enhancements, and agency efficiencies (quality measurement improvement).

### Eligibility

HFS medical programs pay for a wide range of health services provided by thousands of medical providers throughout Illinois. The primary medical programs are:

- ◆ Medical Assistance, as authorized under the Illinois Public Aid Code (305 ILCS 5/5 et seq.) and Title XIX of the Social Security Act, Medicaid.
- ◆ Children’s Health Insurance Program (CHIP), as authorized under the Illinois Insurance Code (215 ILCS 106/1 et seq.) and Title XXI of the Social Security Act.

Necessary medical benefits, as well as preventive care for children, are covered for eligible persons when provided by a health care provider enrolled with HFS. Eligibility requirements vary by

program. Most people who enroll are covered for comprehensive services, including, but not limited to, doctor visits, well-child care, immunizations for children, mental health and substance abuse services, hospital care, emergency services, prescription drugs, and medical equipment and supplies. Some programs, however, cover a limited set of services.

### **Medical Assistance Programs**

To be entitled for the medical assistance programs, a person must fit into an eligibility category. Broadly, the categories are (1) families, children, or pregnant women, and (2) aged, blind, or disabled persons. Medical coverage is provided to children, parents, or relatives caring for children, pregnant women, veterans, seniors, persons who are blind, and persons with disabilities. To be eligible, adults must also be Illinois residents and U.S. citizens or qualified immigrants. (Immigrants who are not permanent legal residents may be covered for emergency medical care only and are not eligible for transplantation services.) Children are eligible regardless of immigration status. Individuals must also meet income and asset requirements. If an applicant is categorically eligible but has excess income and/or resources, then he or she can qualify for medical assistance under the spend-down program.

The following lists eligibility requirements for medical assistance programs:

1. FamilyCare/All Kids covers children through 18 years of age. Adults must be either a parent or caretaker relative with a child under 19 years of age living in their home, or be a pregnant woman. For all plans, non-pregnant adults must live in Illinois and be U.S. citizens or legal permanent immigrants in the country for a minimum of five years. Children and pregnant women must live in Illinois and are eligible regardless of citizenship or immigration status.
2. Aid to Aged Blind and Disabled (AABD) covers seniors 65 or older, persons who are blind, and persons with disabilities with income up to 100 percent of the federal poverty level (FPL) and no more than \$2,000 of non-exempt resources (one person). Individuals who receive Supplemental Security Income (SSI) or are ineligible for SSI due to income or are ineligible for SSI due to expiration of federal time limit on assistance to certain immigrants who have not yet become U.S. citizens may be eligible.

### **Primary Care Case Management (PCCM)**

Illinois' PCCM program, called Illinois Health Connect (IHC), is a statewide health plan available to most persons covered by an HFS medical program. IHC is based on the American Academy of Pediatrics' initiative to create medical homes to encourage delivery of health care services in the most appropriate setting and ensure access to preventive health care services.

Under IHC, recipients can choose their own medical home/PCP while receiving the advantages of care coordination and case management. The program is mandatory statewide for most recipients

with the exception of those who choose to enroll in the VMC program or those who are required to enroll in the Integrated Care program.

IHC has over 5,600 medical homes with total available panel capacity to serve over 5.3 million HFS medical assistance program-eligible recipients statewide.

### **Children's Health Insurance Program (CHIP)**

HFS also operates the Children's Health Insurance Program (CHIP) designed to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. Most enrollees in the CHIP program are served in the Illinois Health Connect program described above, but some are enrolled in managed care. The following lists eligibility requirements for CHIP:

The following lists eligibility requirements for CHIP:

1. All Kids Share provides a full range of health benefits to eligible children. To be eligible children must have countable family income over 133 percent and at or below 150 percent of the FPL.
2. All Kids Premium Level 1 provides a full range of health benefits to eligible children. For children to be eligible, families must have countable income over 150 percent and at or below 200 percent of the FPL.
3. All Kids Premium Level 2 provides a full range of health benefits to eligible children in families with income above 200 percent and at or below 300 percent of the FPL.
4. All Kids Rebate provides families with full or partial reimbursement of premium costs, up to \$75 per person per month, for private or employer-sponsored health insurance coverage of eligible children. To be eligible, families must have countable family income over 133 percent and at or below 200 percent of the FPL. To qualify, they must have health insurance that covers physician and inpatient hospital care.
5. Moms and Babies provides a full range of health benefits to eligible pregnant women and their babies up to one year of age. To be eligible, pregnant women living in Illinois must have countable family income at or below 200 percent of the FPL. Babies under one year of age are eligible at any income as long as Medicaid covered their mother at the time of the child's birth.

### **Illinois Medicaid Managed Care**

The State's overall goal in using managed care and other care coordination services is to improve the lives of participants by purchasing quality health services through an integrated and coordinated delivery system that promotes and focuses on health outcomes, cost controls, accessibility to providers, accountability, and customer satisfaction. HFS, in conjunction with its vendors, seeks to improve the overall quality of care through better access to primary and

preventive care, specialty referrals, enhanced care coordination, utilization management, and outreach programs leading to measurable quality improvement initiatives in all areas of managed care contracting and service delivery.

Managed care is a voluntary program in Illinois and has been a health care option for medical assistance participants since 1976. Voluntary managed care (VMC) continues to be a choice even with the implementation of newer managed care models. The State contracts with MCOs to manage the provision of health care for HFS beneficiaries. MCOs include health maintenance organizations (HMOs) and managed care community networks (MCCNs). The State's contracts require the MCOs to offer the same comprehensive set of services to HFS beneficiaries that are available to the fee-for-service population, except certain services which are carved out and available through fee-for-service. Except for financial solvency and licensing requirements, HMOs and MCCNs have the same contractual requirements. The Department of Insurance licenses HMOs, which contract on an at-risk basis to provide medical services to their HFS beneficiaries. MCCNs are provider-sponsored organizations within Illinois certified by the Department as meeting its requirements for such organizations.

Illinois has been studying better ways to coordinate or manage care for many years. In 2004, the Illinois Legislature created the Managed Care Task Force to study expanded use of MCOs. The Primary Care Case Management (PCCM) program became fully operational in November 2007. This program creates medical homes for its enrollees to make sure that primary and preventive care is provided in the best setting. Some CHIP recipients are enrolled under the VMC program, though the majority of recipients receive benefits under the PCCM program.

Illinois has continued to work to develop comprehensive approaches to target the wider Medicaid population through new coordinated/managed care models that would augment Illinois' managed care delivery programs. In 2009, the Medicaid Reform Committee was created in the House and the Deficit Reduction Committee was created in the Senate, both of which urged for more use of MCOs. The administration recognized some flaws in the fragmented fee-for-service Medicaid system and set in process a new model for integrated care for Medicaid enrollees. After many months of development and involvement from multiple stakeholder groups, HFS implemented the State's first integrated health care program for seniors and adults with disabilities on May 1, 2011. The Integrated Care Program (ICP) provides integration of all of the individual's physical, behavioral, and social needs to improve enrollees' health outcomes and enhance their quality of life by providing individuals the support necessary to live more independently in the community.

More detailed descriptions of Illinois' three Medicaid managed care delivery systems are provided below.



### ***Voluntary Managed Care (VMC)***

All Kids, Moms and Babies, and FamilyCare recipients living in certain counties can voluntarily enroll in an MCO. Recipients living in Illinois counties with a VMC option choose a primary care physician (PCP) in the MCO's network for their medical home. Recipients who enroll in an MCO receive most of their services from doctors and hospitals that are part of the VMC network unless they are granted approval to obtain outside services. Recipients can receive their health care and may receive additional benefits by enrolling in an MCO.

All Kids offers health insurance coverage to income-eligible children and pregnant women in Illinois. The All Kids program offers many Illinois children comprehensive health care that includes doctors' visits, hospital stays, prescription drugs, vision care, dental care, and medical devices like eyeglasses and asthma inhalers. FamilyCare broadens coverage to eligible parents or caretaker relatives, as well as children. Moms and Babies covers health care for women while they are pregnant and for 60 days after the baby is born. This program covers outpatient health care and inpatient hospital care, including delivery.

During the report period, HFS contracted with three MCOs—**FHN**, **Harmony**, and **Meridian**—to provide health care services to Medicaid managed care beneficiaries.

**Harmony** is an HMO and **FHN** is a not-for-profit, provider-sponsored organization that operates as an MCCN. Both health plans operated in Cook County in SFY 2010–2011. **Harmony** also operated in the southern counties of Madison, Perry, Randolph, St. Clair, Washington, Jackson, Williamson and Kane a collar county in northern Illinois in SFY 2010–2011. **Meridian** is a physician-owned and operated MCO that began providing services to HFS beneficiaries in Adams, Brown, Henry, Mercer, Pike, Rock Island, and Scott counties in January 2009.<sup>2-1</sup> In SFY 2010–2011, **Meridian** was approved to expand into Cook County.<sup>2-2</sup>

### ***Integrated Care Program (ICP)***

The ICP is a managed care program built on a foundation of well-resourced medical homes with an emphasis on wellness, preventive care, effective evidence-based management of chronic health conditions, and coordination and continuity of care. It is a program for older adults and adults with disabilities who are eligible for Medicaid but not Medicare. ICP is a mandatory managed care program that operates in select counties.

The ICP brings together local PCPs, specialists, hospitals, nursing homes, and other providers to organize and coordinate care around a patient's needs. It aims to keep enrollees healthy through more coordinated and better medical care while helping to prevent unnecessary health care costs.

<sup>2-1</sup> [http://www.hfs.illinois.gov/managedcare/managedcare\\_enrollment.html](http://www.hfs.illinois.gov/managedcare/managedcare_enrollment.html)

<sup>2-2</sup> <http://www.hfs.illinois.gov/annualreport/>

With integrated care, members have:

- ◆ Choices of doctors, specialists, and hospitals.
- ◆ Better coordination of care working with a team of people to help them live an independent and healthy life.
- ◆ Control of managing their health care needs.
- ◆ Additional programs and services to help them live a healthy life.

Participants in the ICP previously received covered services through the Medicaid fee-for-service system. Most of these participants were enrolled in the PCCM program. The ICPs are responsible for all covered services currently funded by Medicaid through the State plan or waivers. However, covered services will be phased in as three service packages as follows.

**Service Package I:** The ICP is implemented in the Illinois areas of suburban Cook (all zip codes that do not begin with 606), DuPage, Kane, Kankakee, Lake, and Will counties. The State implemented the managed care delivery system under the State plan authority (Section 1932[a]), approved effective May 1, 2011. Select long-term care services, including several 1915 (c) Home and Community Based Services (HCBS) waivers, are being added under Service Package II of the ICP. Once Service Package II is in effect, all ICP enrollees in these areas will have their waiver services administered through their plan to more effectively coordinate and meet the total needs of the participant. The plans will have specific quality improvement responsibilities to identify and resolve issues.

Beginning the first year, Service Package I covers all non-long-term care services and mental health and alcohol and substance abuse services. Short-term post-acute rehabilitative stays in nursing facilities are not considered long-term care services in the ICP and will be the responsibility of the contractor. In Illinois, the rate for nursing facilities does not cover pharmacy, physicians, hospital, or other acute care services. The ICP will be responsible for the medical care services of nursing facility residents in Service Package I and also to all waiver participants otherwise eligible for the ICP.

**Service Package II:** Service Package II of the ICP is scheduled to be implemented in 2012. It will deliver care coordination and waiver services through a mandatory managed care delivery system for participants in several 1915 (c) HCBS waivers who are enrolled in the ICP. Service Package II includes all long-term care services and the care provided through HCBS waivers, excluding waivers designed for individuals with developmental disabilities, including skilled nursing facilities (SNFs) and intermediate care facilities (ICFs).

**Service Package III:** Service Package III, scheduled for implementation in 2013 or 2014, includes long-term care services and/or HCBS waiver services for enrollees with developmental disabilities and children who are Medically Fragile and Technology-Dependent (MFTD).

ICP participants in Illinois must choose between two health plans: **Aetna** and **IlliniCare**. The contracts with these health plans contain 30 performance measures. These measures create an incentive for the health plans to direct money toward care that produces valued outcomes. The plans are rewarded for meeting pre-established targets for delivering quality health care services that result in:

- ◆ Better health for the member.
- ◆ Better quality of life for the member.
- ◆ Reduction in the cost of the service over time.

## Enrollment

In State Fiscal Year (SFY) 2011, Medicaid, and the means-tested medical programs associated with it, provided comprehensive health care coverage to approximately 2.74 million Illinoisans and partial benefits to over 300,000.

On average, each month HFS' programs cover nearly 1.7 million children; 168,000 seniors; 260,000 persons with disabilities; 636,000 non-disabled, non-senior adults; and approximately 297,000 additional enrollees with partial benefit packages (such as Illinois Healthy Women). Enrollment figures for SFY 2011 are displayed in Table 2.1 below.

**Table 2.1—Illinois Medicaid Enrollment SFY 2011**

Type of Benefits	Enrollment
<b>Comprehensive Benefits</b>	
Children	1,677,575
Adults with Disabilities	260,228
Other Adults	636,531
Seniors	168,943
Total Comprehensive	2,743,277
<b>Partial Benefits</b>	
Enrollees with Partial Benefits	309,387
<b>Total Enrollees</b>	
Total Enrollees	3,052,664

For additional information about Medicaid programs, eligibility, and HFS, visit the following Web site: <http://www2.illinois.gov/hfs/agency/Pages/default.aspx>.

## HFS Managed Care Program Quality Strategy

Federal regulations at 42 CFR §438.200 and §438.202 require that state Medicaid agencies develop and implement a written quality strategy for assessing and improving the quality of health care services offered to their members. The written strategy must describe the standards the State and its contracted plans must meet. The State must conduct periodic reviews to examine the scope and content of its quality strategy, evaluate its effectiveness, and update this strategy as needed.

In furtherance of HFS' mission to improve the health of Illinois families by providing access to quality health care, in consideration of the health needs of the participants served, and in compliance with federal and State regulations, HFS originally developed a strategy for the quality assurance component of the managed care program in 2006. After drafting the Quality Strategy with MCOs' involvement, it was reviewed by a diverse set of stakeholders, including providers and advocates; and their input was incorporated.

During the review period, HFS continued revisions to the original State Quality Strategy to incorporate the following comments and recommendations from the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS):

- ◆ The overall program goal could be enhanced by adding a short list of objectives that references baseline performance data, measureable targets, and planned initiatives.
- ◆ HFS should clarify what constitutes satisfactory progress for an MCO unable to meet each of the established goals, and the actions HFS will take if progress is not achieved.
- ◆ HFS should include targets the MCOs must meet for each HEDIS measure. This should include MCO outcomes and trends, baseline, benchmarks, and targets.
- ◆ HFS should identify successes that may be considered best practices.
- ◆ The State should identify ongoing challenges to improving the quality of care to beneficiaries.
- ◆ The State should recommend ongoing quality improvement activities—e.g., performance improvement projects, withholds/pay-for-performance incentives, value-based purchasing incentives or disincentives, telemedicine, and health information technology changes.

The Quality Strategy has evolved over time based on community concerns and feedback, participant health needs, federal and State law, industry standards, lessons learned, and best practices, and in collaboration with the MCOs to establish objectives, priorities, and achievable timelines. The Quality Strategy is viewed as a “work in progress” as the state of health care quality

(e.g., clinical practice and improved methods for quality measurement and monitoring accountability) is continuously evolving.

The process HFS uses to refine the Quality Strategy includes stakeholder involvement, including collaboration between the MCOs and HFS through ongoing monthly telephonic and quarterly face-to-face meetings. In addition, HFS has created a Medical Advisory Committee (MAC), which consists of up to 15 members. At least five members of MAC must be consumers or advocates. The remaining 10 members are usually health care providers. The Departments of Children and Family Services, Human Services, and Public Health each have one ex officio member.

This committee advises HFS about health and medical care services under the Medical Assistance Program pursuant to the requirements of 42 CFR 431.12 with respect to policy and planning involved in the provision of medical assistance. It meets six times per year and currently has four subcommittees: Care Coordination, Long Term Care, Public Education, and Pharmacy.

HFS uses feedback from MAC members and other stakeholders to make necessary revisions to the Quality Strategy. The purpose of the Quality Strategy, to be achieved through consistent application, is to ensure that quality health care services are delivered with timely access to appropriate covered services; coordination and continuity of care; prevention and early intervention, including risk assessment and health education; improved health outcomes; and ongoing quality improvement.

Throughout SFY 2010–2011, HFS has continued to focus on measuring progress and outcomes, and establishing thresholds for improved performance. In addition, HFS began implementing both the Illinois Medicaid reform legislation (P.A. 096-1501) and the federal Patient Protection and Affordable Care Act (Pub. L. 111-148), with emphasis on service delivery reforms (access to care), cost containment strategies (structure and operations), program integrity enhancements, and agency efficiencies (quality measurement improvement). Specific program changes and enhancements include continued enrollment in the Primary Care Case Management (PCCM) program to encourage delivery of health care services in the most appropriate setting and ensure access to preventive health care services and the creation of the Integrated Care Program, which aims to keep enrollees healthy through more coordinated and better medical care while helping to prevent unnecessary health care costs. HFS is working on revisions to the State Quality Strategy to address these and other legislative and programmatic changes.

The fully revised State Quality Strategy is expected to be published in November 2012.

## Quality Strategy Objectives

During SFY 2010–2011, HFS worked with stakeholders to begin drafting the revised Quality Strategy and identified the following overarching goals for quality improvement.

Goal 1: Ensure adequate access to care and services for Illinois Medicaid recipients that is appropriate, cost effective, safe, and timely.

Goal 2: Ensure the quality of care and services delivered to Illinois Medicaid recipients.

Goal 3: Improve Care Coordination—the right care, right time, right setting, and right provider.

Goal 4: Ensure consumer satisfaction with access to, and the quality of, care and services delivered by Illinois Medicaid managed care programs.

Goal 5: Ensure efficient and effective administration of Illinois Medicaid managed care programs.

To focus continuous quality improvement efforts toward the aims of the Quality Strategy, HFS is identifying priority measures to align with the revised Quality Strategy goals. The measures will help MCOs focus their quality improvement efforts. It is HFS' expectation that by targeting specific priorities, more consistent improvement in these areas can be achieved. Minimum performance goals (benchmarks) for many of these measures will be established using the Quality Improvement System for Managed Care (QISMC) hybrid method. The hybrid QISMC methodology takes into consideration high performance levels (HPLs) and minimum performance levels (MPLs) and is used when HEDIS scores are above the established goals.

## Quality Performance Withhold

HFS offered quality performance payments to encourage the improvement of certain quality-of-care indicators. The HEDIS measures used to determine the quality performance payments for voluntary managed care were:

- ◆ *Childhood Immunization Status—Combo 3*
- ◆ *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- ◆ *Cervical Cancer Screening*
- ◆ *Timeliness of Prenatal Care*
- ◆ *Postpartum Care*
- ◆ *Use of Appropriate Medications for People With Asthma—Combined Rate*
- ◆ *Comprehensive Diabetes Care—HbA1C Testing*

During SFY 2010–2011, HFS worked collaboratively with HSAG and the ICPs to identify and develop performance measures specific to ICP members. Through this collaboration, 30 performance measures were identified and data specifications were developed for each of the performance measures. The 30 ICP performance measures that were developed by HFS and the ICPs are a mix of HEDIS, HEDIS-like, and State-defined measures. Of the measures, 12 are P4P measures, as displayed below.

- ◆ *Follow-up with any Provider within 30 Days After an Initial Behavioral Health Diagnosis*
- ◆ *Follow-up with a Mental Health Provider within 30 Days of Discharge for Mental Illness*
- ◆ *Antidepressant Medication Management*
- ◆ *Annual Dental Visit—DD Only*
- ◆ *Comprehensive Diabetes Care*
- ◆ *Congestive Heart Failure*
- ◆ *Coronary Artery Disease*
- ◆ *Pharmacotherapy Management of COPD Exacerbation*
- ◆ *Ambulatory Care—Emergency Department (ED) Visits per 1,000 Enrollees*
- ◆ *Ambulatory Care Follow-up with a Provider within 14 days of ED Visit*
- ◆ *Ambulatory Care Follow-up with a Provider within 14 Days of Inpatient Discharge*
- ◆ *Access to Member's Assigned PCP*

## Technical Reporting to Assess Progress in Meeting Quality Goals and Objectives

HFS monitors and evaluates compliance with access to care, structure and operations, quality measurement and improvement, and consumer satisfaction to monitor progress toward the goals of the Quality Strategy. In addition to HFS' Bureau of Managed Care, the State's Bureau of Information Systems (Medicaid Management Information System [MMIS] and Client Information System (SIS) maintains functional areas, including without limitation: client information—eligibility, demographics, provider enrollment, MCO enrollment, claims and encounter data, payment information, third-party liability, and reporting. HFS' data warehouse and its executive information system (EIS) track key indicators for comparison (state, county, fee-for-service, and MCO [specific and aggregate]) for tracking and trending of utilization and health outcomes. Data matches with other data systems to determine utilization (e.g., immunization tracking systems and lead poisoning prevention programs) are performed on an ongoing basis, providing child-specific enrollee information to the respective MCO, as well as aggregate findings, for improvement in MCO outreach, patient compliance, and encounter data submission.

The areas described below are reviewed on an ongoing basis.

- ◆ Assuring the MCO (HMO) has a certificate of authority (license), an approved certificate of coverage from the Illinois Department of Insurance, and an approval from the Illinois Department of Public Health to provide managed care services to enrollees.
- ◆ Assuring the MCO (MCCN) meets HFS' regulatory requirements.
- ◆ Coordinating monitoring of the fiscal components of the contract that are performed by HFS' Office of Health Finance.
- ◆ Performing the initial, comprehensive readiness review and prior approval of the MCO's products and plans to comply with each aspect of the contract.
- ◆ Providing prior approval on all enrollee and potential enrollee written materials, including marketing materials.
- ◆ Ensuring that an information management system exists with sufficient resources to support MCO operations.
- ◆ Reviewing and providing approval (or requiring revision) on the MCO's submission of required reports or documentation on the following schedule, as appropriate: initially, as each event occurs; as revised; and monthly, quarterly, and/or annually.
- ◆ Performing on-site compliance monitoring visits, such as attendance at MCO meetings for performance reviews of quality assurance, or compliance checks, such as calling to assess after-hours availability.
- ◆ Maintaining a historical registry of marketing representatives, tracking marketing meeting schedules, handling marketing complaints, and addressing marketing concerns.
- ◆ Performing network adequacy reviews, including prior approval of primary care providers to assure that they are enrolled in, and in good standing with, the Medical Assistance Program in one of the five primary care specialties allowed in the contract.
- ◆ Monitoring physician terminations and site closures to assure appropriate transfers and network adequacy.
- ◆ Performing compliance reviews, including encounter data monitoring and utilization reporting to each MCO based on HFS' analyses of administrative data.
- ◆ Maintaining ongoing dialogue with, and providing technical assistance to, each MCO by conducting monthly conference calls and quarterly face-to-face meetings with the medical directors and quality assurance staff in a collaborative forum to coordinate quality assurance activities, identify/resolve issues and barriers, and share best practices.



- ◆ Assessing customer satisfaction through MCO customer satisfaction surveys, problem and complaint resolution through HFS' hotline, and interaction with the enrollee and the MCO's member services or key MCO administrative staff members.
- ◆ Monitoring the MCO's progress toward achieving the performance goals detailed in the contract and its focus on improving health outcomes.
- ◆ Requiring quality improvement projects, corrective action plans, and sanctions for contract noncompliance when the "cure" does not occur sufficiently and/or timely, as defined by HFS.
- ◆ Monitoring the MCO's compliance with its operation of a grievance and appeals process.
- ◆ Communicating recommendations to the MCOs.
- ◆ Providing oversight for the quality improvement plan.
- ◆ Contracting with and monitoring the EQRO for the provision of external oversight and monitoring of the quality assurance component of managed care.

To facilitate accurate and timely technical reporting, HFS' EQRO developed and currently maintains the performance tracking tool (PTT). The PTT initially was designed to be used by each MCO as a mechanism for monitoring and trending the results of each performance measure identified in the tool. The tool was used to record the baseline and remeasurement results for each performance measure and identify how the MCO was performing in comparison to national benchmarks and the calculated goals for the subsequent reporting period.

HFS, its EQRO, and the MCOs have continued to provide technical enhancements to the PTT's design and functionality. The PTT is a functional tool that has evolved into the mechanism the State and the MCOs use to track and monitor all of the activities the MCOs perform during the year. Specifically, the PTT includes:

- ◆ Compliance monitoring activities, including areas for targeted improvement for the MCOs.
- ◆ Benchmarks for performance measures.
- ◆ HEDIS tables for MCOs to automatically trend, graph, determine HEDIS percentile rankings, and determine next goals.
- ◆ PIP summary tables to determine the validation status and improvements for individual PIP quality indicators.
- ◆ Chi-square and *p* value calculator to facilitate the VMCOs' ability to determine if changes are statistically significant.

HFS uses the PTT to enhance reporting to CMS and the State Legislature, as well as to enhance interdepartmental reporting. The PTT is also used to determine areas that need focused attention.

## Quality Strategy Review

To promote continuous quality improvement, HFS has developed a strategy to ensure that review of the Quality Strategy's objectives is ongoing throughout the year. HFS holds quarterly Quality Improvement Committee meetings with its EQRO, staff from the MCOs, and health plan medical directors and quality program staff. The meetings include discussion of compliance with the State's quality strategy, ongoing monitoring of performance of the MCO and ICP programs, program changes or additions, and future initiatives. As new programs and initiatives are implemented, such as the Integrated Care Program, HFS incorporates initiatives of those programs into the Quality Strategy to ensure continuous quality improvement.

HFS also conducts monthly Quality Assessment and Performance Improvement (QAPI) committee meetings to evaluate MCO performance and whether the goals and objectives of the Quality Strategy are being met, as well as to establish goals and objectives. The monthly conference calls and quarterly face-to-face meetings ensure frequent review of the Quality Strategy objectives and regular evaluation of plan performance.

HFS implemented the performance tracking tool (PTT) which allows plans to track their performance and P4P measures and provides calculation of the performance goals using the QISMC methodology. Formulas for determining improvement in the measures are programmed in the PTT, allowing for immediate evaluation of statistical significance. Once the most current results are populated, the PTT will also calculate an MCO's QISMC goals for the following years.

The EQRO evaluates the MCOs' annual evaluation of their QAPI programs, and results of this evaluation are used to help develop the strategic direction for HFS and the MCOs. The results of this review are used in annual meetings between HFS and the MCOs to review the results of the EQR activities such as compliance reviews, validation of performance measures, and validation of non-collaborative and collaborative PIPs. In addition, HFS convenes an annual quality assurance meeting to review the Quality Strategy with stakeholders, providers, and MCOs.

Each year, HFS requires its EQRO to provide a written review of the State's Quality Strategy for compliance with the requirements of 42 CFR 438.204 and for its effectiveness for managed care. This review is to include specific recommendations regarding any compliance deficits that may exist, as well as any revisions that might help the MCOs improve the health outcomes of the State's Medicaid recipients. The results and recommendations of this review will be included in the annual EQR report. The Quality Strategy review process includes the following elements:

1. Review of annual results
2. Calculation of performance goals (QISMC)
3. Identification of compliance with strategic goals
4. Establishment of new/revise existing performance targets
5. Consultation with HFS on P4P measures

HFS will update the Quality Strategy as necessary based on MCO performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Illinois Medicaid program. HFS will update the Quality Strategy to ensure its effectiveness at least annually to incorporate new goals and objectives for the following year.

The purpose of these reviews is to determine if improvement in the quality of services provided to recipients, providers, and integrated stakeholders was accomplished; determine the need for revision; and ensure that MCOs are in contract compliance and commit adequate resources to perform internal monitoring and ongoing quality improvement toward the Quality Strategy goals.

The annual evaluation includes an assessment of the following:

- ◆ Access to care and network adequacy.
- ◆ Organizational structure and operations.
- ◆ Quality assurance processes, including peer review and utilization review.
- ◆ Recipient complaints, grievances, and appeals, as well as provider complaints and issues.
- ◆ Nonclinical and clinical quality measure results.
- ◆ Performance improvement project findings.
- ◆ Success in improving health outcomes.
- ◆ The effectiveness of quality interventions and remediation strategies during the previous year (demonstrated by improvement in care and services) and trending indicator data.
- ◆ Identification of program barriers and limitations.
- ◆ Feedback obtained from HFS leadership, MCOs, the provider community, advocacy groups, Medicaid recipients, and other internal and external stakeholders that can impact recipient access to high-quality and timely care and services.
- ◆ Recommendations for the upcoming year.

Prior to each annual update, HFS solicits stakeholder input on the goals and objectives of the Quality Strategy. The revised Quality Strategy will be shared with all pertinent stakeholders, posted on the HFS Web site for public view, and forwarded to CMS.

### ***Documenting Challenges, Successes, and Quality Strategy Changes***

HFS will use two methods to continuously track the progress toward achieving the goals and objectives outlined in this Quality Strategy. The first is the performance tracking tool (PTT). The PTT lists each of the performance measures, including the priority measures and progress toward

achievement of those goals. In addition, the EQR work plan outlines all EQR activities anticipated during the contract period. This includes a timeline for review of the Quality Strategy, meetings with stakeholders for diverse feedback, and the Quality Strategy revision process.

Annually, HFS and its EQRO will update the Quality Strategy goals and the PTT. In addition to sharing the revised PTT and Quality Strategy with the MCOs and other stakeholders, the EQRO will include the PTT as part of the annual Quality Strategy evaluation, which is included as a section in the annual EQR technical report.

### HFS Managed Care Program Initiatives Driving Improvement

This section highlights initiatives that support the improvement of quality of care and services for Medicaid beneficiaries as well as activities that support plan improvement efforts. All initiatives and activities were in alignment with the State's quality strategy.

### Statewide Collaboratives/Initiatives

#### *Integrated Care Program (ICP)*

HFS implemented the State's first integrated health care program on May 1, 2011. Two health maintenance organizations (HMOs), **Aetna** and **IlliniCare**, were selected to administer the program. The ICP is built on a foundation of well-resourced medical homes with an emphasis on wellness, preventive care, effective evidence-based management of chronic health conditions, and coordination and continuity of care. It is a program for older adults and adults with disabilities who are eligible for Medicaid but not Medicare. Effective May 2011, the ICP became a mandatory program that operates in select counties.

The ICP brings together local PCPs, specialists, hospitals, nursing homes, and other providers to organize and coordinate care around a patient's needs. It aims to keep enrollees healthy through more coordinated and better medical care while helping to prevent unnecessary health care costs.

With integrated care, members will have:

- ◆ Choices of doctors, specialists, and hospitals.
- ◆ Better coordination of care with a team of people working with members to help them live an independent and healthy life.
- ◆ Control of managing their health care needs.
- ◆ Additional programs and services to help them live a healthy life.

The participants in the ICP previously received covered services through the Medicaid fee-for-service system. Most of these participants were enrolled in the PCCM program. The MCOs that participate in the ICP will be responsible for all covered services currently funded by Medicaid through the State plan or waivers. However, covered services will be phased in as three service packages.

The savings/cost avoidance over the five-year contract period are estimated at nearly \$200 million as a result of:

- ◆ Automatic savings every year due to rates set for the companies at 3.9 percent below what is otherwise estimated to be spent on care for these Medicaid recipients.
- ◆ Lower growth rates (or estimated cost inflation) over time because of requirements for enhanced coordination of services and focus on prevention, especially as more services are added in Service Package II and Service Package III.

### **Performance Tracking Tool (PTT)**

The PTT initially was designed to be used by each VMCO as a mechanism for monitoring and trending the results of each performance measure identified in the tool. The tool was used to record the baseline and remeasurement results for each performance measure and identify how the MCO was performing in comparison to national benchmarks and the calculated goals for the subsequent reporting period.

HFS, its EQRO, and the MCOs have continued to provide technical enhancements to the PTT design and functionality. The PTT is a functional tool that has evolved into the mechanism the State and the MCOs use to track and monitor all of the activities the MCOs perform during the year. Specifically, the PTT includes:

- ◆ Compliance monitoring activities, including areas for targeted improvement for the VMCOs.
- ◆ Benchmarks for performance measures.
- ◆ HEDIS tables for VMCOs to automatically trend, graph, determine HEDIS percentile rankings, and determine next goals.
- ◆ PIP summary tables to determine the validation status and improvements for individual PIP quality indicators.
- ◆ Chi-square and *p* value calculator to facilitate the VMCOs' ability to determine if changes are statistically significant.

HFS uses the PTT to enhance reporting to CMS and the State Legislature, as well as enhance interdepartmental reporting. The PTT is also used to determine areas that need focused attention.

## Pay-for-Performance (P4P)

### ***Voluntary Managed Care Program***

In its contracts with VMCOs, HFS has established a process for health plans to earn incentive payments for performance. This quality performance program consists of two components—a withhold program and an opportunity to earn additional payments through a bonus/incentive program. HFS may withhold up to 1 percent of each capitation payment. These funds will be used to make quality performance payments based on each HEDIS measure listed below where the VMCO meets criteria established by HFS. The VMCO may also be eligible to receive a bonus/incentive payment based on performance, not to exceed one-half of 1 percent (0.5 percent) of the capitation revenue paid to the MCO during the measurement year, for the HEDIS quality performance measures that meet or exceed the most recent 75th HEDIS percentile as defined in Section 7.8 (e) of the VMCO contract.

Performance calculations are based on the hybrid Quality Improvement System for Managed Care (QISMC) methodology. The previous year's score is the baseline for each year. For measures that decline from the prior year, the original hybrid QISMC goal will remain the basis for the MCO in meeting the goals. Rates that receive a Not Report (NR) designation for either a baseline year or a remeasurement year will result in the withhold amount for the measurement year being retained by HFS.

The HEDIS measures used to determine the quality performance payments were:

1. *Childhood Immunization Status—Combo 3*
2. *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
3. *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
4. *Cervical Cancer Screening*
5. *Timeliness of Prenatal Care*
6. *Postpartum Care*
7. *Use of Appropriate Medications for People With Asthma—Combined Rate*
8. *Comprehensive Diabetes Care—HbA1C Testing*

### ***Integrated Care Program***

In its ICP contracts, HFS has established a process for health plans to earn incentive payments for performance. Collection of data and calculation of ICPs' performance against the P4P metrics will be in accordance with national HEDIS timelines and specifications. If an ICP reaches the target

goal on a P4P metric, it will earn the percentage of the incentive pool assigned to that P4P metric. HFS has created the incentive pool by withholding a portion of the contractual capitation rate, which will be combined with an additional bonus amount funded by HFS so that total funding of the incentive pool shall be equal to 5 percent of the capitation rate. An equal portion of the incentive pool is allocated to each P4P metric.

ICPs are not eligible to receive any incentive payments if they fail to meet a minimum performance standard. The minimum performance standard will require ICPs' measurement year performance to be no lower than 1 percent below that year's baseline on all P4P measures, except that ICPs may regress more than 1 percent in three P4P measures in the first measurement year. Of the measures, 12 are P4P measures, as displayed in Appendix B.

Calendar year 2010 is considered the initial baseline year, meaning 2010 baseline data will be used to set the baseline for 2012. In consultation with the ICPs, HFS will use the rates reported for members who were previously enrolled in the fee-for-service program but who are now enrolled in an ICP to derive a baseline rate. These rates represent the performance on these measures while these members were participating in the fee-for-service program. This baseline rate was then used to calculate a QISMC goal for 2013. By developing a QISMC goal via this method, the State was able to establish a baseline for performance for the new program. For the first two years, the target goal will be set as a percentage above the baseline equal to 10 percent of the difference between the baseline score and 100 percent. For example, if the baseline is 50 percent, 10 percent of the difference between 50 percent and 100 percent is 5 percent; therefore, the goal will be set at 55 percent. When the ICPs report actual baseline rates in 2013, these will be used to calculate future QISMC target goals.

P4P metrics, baselines, and goals for future years will be negotiated and established through countersigned letters. If any coding or data specifications are modified, and HFS or ICP has a reasonable basis to believe that the modification will have an impact on an incentive pool payment, then the two entities will negotiate; and the resolution will be established through countersigned letters.

## **MCO Collaboratives/Initiatives**

### ***EPSDT Screening Performance Improvement Project (PIP)***

HFS required each VMCO to participate in a mandatory statewide PIP focused on improving performance related to EPSDT screenings and visits, including the content of care for children younger than 3 years of age. EPSDT is designed to detect and treat health problems early through three methods: (1) regular medical, dental, vision, and hearing screening and blood lead testing; (2) immunizations; and (3) education. EPSDT provides a comprehensive child health program to help



ensure that health problems are identified, diagnosed, and treated early, before they become more complex and treatment becomes more costly. The goals of the PIP are as follows:

- ◆ Provide baseline results of EPSDT screening indicators for targeting interventions and improving rates.
- ◆ Improve the quantity and quality of EPSDT examinations through a collaborative process.
- ◆ Enhance the MCOs' knowledge and expertise in conducting PIPs while meeting both State and CMS requirements for PIPs.

The EPSDT Screening PIP will be continued until the indicators demonstrate sustained improvement. In addition, the following quality improvement initiatives were continued, revised, or implemented by the VMCOs in an effort to improve EPSDT screening rates.

## Family Health Network

### Member Initiatives

- ◆ Mailings
  - Developed a partnership with Wyeth/Pfizer to send immunization reminders. Each month, **FHN** sends Pfizer a list of members aged 8–9 months and 16–17 months who are missing encounters for Prevnar, the pneumococcal vaccine. Pfizer has partnered with Televox, who makes immunization reminder calls to **FHN**'s members on the list. **FHN**'s performance on the Combo 3 immunization rate has steadily increased over the last few years.

### Provider Initiatives

- ◆ Held extensive meetings with medical groups' executive and quality staffs to discuss documentation requirements, coding, EPSDT compliance, and the use of standardized charting forms or electronic medical records. Information from the sessions was reinforced by visits from the **FHN** quality specialist and medical director.

## Harmony

### Member Initiatives

- ◆ Telephonic Outreach
  - Implemented a centralized telephonic outreach to parents/caregivers of children regarding the importance of scheduling well-child visits and childhood immunizations. In addition, **Harmony** made maternity discharge planning calls to assist mothers with scheduling of newborn well-care visits for ages 0–15 months.
- ◆ Mailings
  - Provided newborn packets that contained information on the recommended well-child visits, immunizations, and lab testing schedule.

- Sent preventive care booklets to new members which listed the recommended well-child visits and immunization schedule, and highlighted the importance of preventive health care services.
- ◆ Incentive Programs
  - Awarded a \$50 gift card for completion of recommended well-child visits in the first 15 months of life (6+ Visits). The card can be used at one of several retail stores.

### **Provider Initiatives**

- ◆ Implemented outreach visits to medical groups and providers. During these visits, Provider Services representatives provided education and encouraged compliance with encounter submission of immunizations.

## **Meridian**

### **Member Initiatives**

- ◆ Mailings
  - Revised member outreach materials to include a clear reminder to parents/guardians on the necessary elements of well-child visits and immunizations, as well as continuation of incentive mailings for members who are in need of HEDIS services (well-child visits).
- ◆ Telephonic Outreach
  - Added automated dialing software (TouchStar) which allows a dedicated staff member to place weekly calls to members to remind them of outstanding HEDIS requirements. In addition, **Meridian** continued telephonic outreach reminders to parents/guardians on the need for well-child visits.

### **Provider Initiatives**

- ◆ Provider Education
  - Revised provider educational materials to include information about EPSDT screenings and coding/billing for EPSDT services.
- ◆ Incentive Programs
  - Continued the existing provider incentives for completion of EPSDT visits.

## **Illinois Project LAUNCH**

During this reporting period, the VMCOs joined the Project LAUNCH collaborative, which is a cross-agency initiative that supports the EPSDT PIP interventions. The focus of Illinois Project LAUNCH is to promote mental health wellness, to link families with community-based programs, and to encourage families and providers to regularly access and use services that promote family wellness. The VMCOs joined the partnership with Illinois Project LAUNCH to connect with hard-to-reach enrollees who reside in a targeted low-income, high-violence geographic area in

Chicago. The extraordinary social issues in this area cause significant barriers for enrollees in prioritizing health care and accessing their medical home for preventive health care, including well-child screening services. Barriers to accessing health care identified for residents in this area included lack of transportation to medical appointments, lack of awareness of benefits available through the VMCOs, and lack of knowledge or relationship with their primary care provider or medical home.

The VMCOs began developing a member resource card that will describe for the primary care provider, community workers, and the enrollee how to determine which health plan an enrollee is assigned to and how to contact the VMCO for assistance such as member services, medical transportation, and the on-call nurse advise line. In addition, the VMCOs plan to develop a provider resource card that describes the concepts and responsibilities of the medical home provider. As part of this initiative, the VMCOs, Illinois Project LAUNCH, HFS, Illinois Health Connect, and the Illinois Chapter, American Academy of Pediatrics are providing subject matter expert input regarding the content of the resource cards. The resource cards will be available to Illinois Project LAUNCH staff members and providers in the community in English and Spanish.

### ***Perinatal Care and Depression Screening PIP***

HFS identified improving birth outcomes as one of its health care priorities. The risks from untreated major depression during pregnancy may include decreased prenatal care, decreased nutritional quality, increased use of addictive substances, and increased risk of becoming a victim of violence. Improving participation in prenatal and postpartum care, as well as ensuring that perinatal depression screening occurs, are key components of HFS' program.

The PIPs were based on the *Timeliness of Prenatal Care* and *Postpartum Care* HEDIS measures to identify the eligible population and to improve rates for these two measures. In addition to the HEDIS measures, the State and the VMCOs chose to determine the percentage of women who were enrolled in an Illinois Medicaid VMC and who were screened for depression during the prenatal and/or postpartum period. The primary purpose of this collaborative PIP was to determine if VMCO interventions have helped to improve the rates for the perinatal HEDIS measures, along with depression screening for these women. A secondary goal was to determine potential opportunities to improve the rate of objective depression screening, along with appropriate treatment when depression is identified through screening and assessment.

The *Perinatal Care and Depression Screening* PIP will be continued until the indicators demonstrate sustained improvement.

In addition, the following quality improvement initiatives were continued, revised, or implemented by the VMCOs in an effort to improve perinatal care and depression screening rates.

## Family Health Network

### Member Initiatives

- ◆ Incentive Programs
  - Continued Brighter Beginnings, an incentive program for pregnant members and their babies, throughout the reporting period. Beginning in July 2010, the postpartum incentive was increased and a depression screening requirement was added to the program. This additional benefit resulted in a 35 percent increase in participation in depression screenings, with 70 percent of women willing to accept a behavioral health referral.
  - Implemented the Baby Photo Program, in which a coupon for a free baby photo from Sears is mailed to members who qualify for the program. The first coupon is mailed to moms who meet the criteria for the \$25 postpartum incentive. Subsequent coupons are mailed annually near the baby's birthday for each child that was continuously enrolled for the year. This annual coupon continues up to age 5 as long as the child is continuously enrolled and immunizations are up to date.
  - Implemented an immunization incentive in July 2010 consisting of mailing a monthly coupon for one free package of Osco brand diapers to parents of children under 3 years of age who are enrolled in the program and whose immunizations are up to date.
- ◆ Member Education/Support
  - Began a partnership with "Text4Baby" in March, 2011. Information about the program is included in member newsletters and in the prenatal information packet mailed to all known pregnant members. The program provides support for members throughout their pregnancy and up to the first year of their babies' life with free messages on topics such as prenatal care, baby health, and parenting. The messages are pertinent to the gestational age and age of the baby.

### Provider Initiatives

- ◆ Incentive Programs
  - Instituted a new provider incentive for early notification of pregnant members in February 2011. Providers receive \$25 for notifying **FHN** of members who were pregnant. Details of the incentive program were communicated to the providers through the provider newsletter and through office visits by the **FHN** maternity case manager.

## Harmony

### Member Initiatives

- ◆ **Harmony** Hugs Program
  - Initiated in January 2011, all pregnant **Harmony** members receive an initial Hugs enrollment call. The call is designed to educate pregnant members about the benefits of the Hugs program, services provided, and incentives provided. Members are also given the option of

opting out of the Hugs program. Members are enrolled according to low-, medium-, and high-risk groups. **Harmony** contracted with Care Net to complete telephonic outreach to pregnant members to encourage participation in the **Harmony** Hugs Program. As of January 2011, this outreach had resulted in enrollment of 377 members in the Hugs Program.

- ◆ Referred high-risk cases for Centering and Doula programs to focus on pregnant members who fall into the age group and/or zip codes with the highest rates of noncompliance.
- ◆ Mailings
  - Continued distribution of maternity booklets which provided prenatal, postpartum, and newborn care education to all known pregnant members whether they are enrolled in the **Harmony** Hugs program or not.
- ◆ Incentive Programs
  - Implemented the OB Prenatal Reward Program which provided strollers to members who completed program requirements. The OB Prenatal Reward Program was revised in 2011 with removal of the postpartum visit requirement to qualify for the incentive.
  - Provided pediatric preventive health information through the Maternity Education and Reward Program (MERP). (In 2011, 778 MERP booklets were mailed and 33 strollers were distributed to members).

### **Provider Initiatives**

- ◆ Incentive Programs
  - Continued the provider incentive program, which provides a monetary bonus for each compliant first prenatal visit, as confirmed by submission of a notification form. This initiative focuses on lower-performing provider groups.

## **Meridian**

### **Member Initiatives**

- ◆ Women and Children's Services (WCS) Program
  - All members identified as pregnant are enrolled in the WCS program. These members are risk stratified based on a high-risk prenatal assessment tool used with every pregnant member reached telephonically and through provider office contact. The WCS Program assists members by working collaboratively with their physician and community agencies to:
    - Educate members and coordinate prenatal care.
    - Encourage pregnant members to attend prenatal appointments.
    - Refer members to the Family Case Management (FCM) Program.
    - Remind members to complete postpartum care through member and provider outreach.

- ◆ Screenings
  - Completed 203 high-risk prenatal screenings for referral and intervention by high-risk prenatal nurses, and postpartum depression screening of 85 percent of the current eligible population using the Edinburgh Postnatal Depression Screening Tool.
- ◆ Mailings
  - Distributed prenatal and postpartum educational materials to members.
- ◆ Telephonic Outreach
  - Conducted outreach and education of members following delivery to remind them of the need for a postpartum care follow-up visit.

### ***Improving Ambulatory Follow-Up and PCP Communication PIP***

HFS required that each VMCO participate in a statewide PIP on improving ambulatory follow-up and PCP communication. This is a two-part collaborative study between the State, EQRO, and VMCOs that began in 2009. The study was developed based on the HEDIS 2010 Technical Specifications for the *Follow-up After Hospitalization for Mental Illness* measure. Appropriate follow-up care reduces the risk of repeat hospitalization and identifies those in need of further hospitalization before the member reaches the point of crisis. Communication and coordination of care between medical and behavioral health providers is a best practice principle essential to ensure consumer safety and optimal clinical outcomes. The goals of this PIP were to improve follow-up treatment after a mental illness and reduce or eliminate the barriers to effective communications between medical and behavioral health care providers.

In addition, the following quality improvement initiatives were continued, revised, or implemented by the VMCOs in an effort to improve ambulatory follow-up and PCP communication rates.

## **Family Health Network**

### **Provider Initiatives**

- ◆ **FHN** and PsycHealth (**FHN**'s behavioral health provider) implemented the medical follow-up after acute hospitalization program, a pilot program in 2010. This initiative promoted medical care follow-up, integrative care coordination, and increased communication between service providers while reducing barriers to medical follow-up visits. All members admitted for mental health inpatient level of care are routinely assessed for knowledge of their PCP's name and contact information and whether they have had a medical exam within the past six months. The program demonstrated significant success during its implementation phase and was awarded a URAC Best Practice Bronze Award.

## Harmony

### Member Initiatives

- ◆ Implemented the Hospital to Home (H2H) Initiative and Bridge Appointments. **Harmony** and Magellan (**Harmony's** behavioral health provider) implemented the H2H initiative, which targeted members who had an inpatient admission. This initiative offered members an opportunity to be evaluated in their home within seven days of discharge, and assessment of members' needs identified ongoing services needed to support their recovery. Members were also given a \$10.00 gift card incentive to Walgreens following completion of an outpatient appointment.

## Meridian

### Telephonic Outreach

- ◆ Developed a post-discharge follow-up call program for members recently discharged from an acute care hospital or nursing facility to prevent hospital readmissions. The focused intervention included case manager telephonic outreach within seven days of discharge to assess and address member needs.

### Internal Initiatives

- ◆ Established an in-house behavioral health program, including the hiring of a social worker and a director for the behavioral health department.

## Care Coordination PIP—Integrated Care Program

Integral to care coordination is the linkage of the member to community resources. Research demonstrates that high-risk members who have increased access to community resources that provide education, physician assessments, and pharmacological interventions will demonstrate improved health outcomes by lower readmission rates.

The ICPs, through input from HFS, identified the PIP topic, Community Based Care Coordination, which will be designed to focus on medically high-risk members with a recent hospital discharge who are actively receiving care coordination with linkage to community resources. The PIP will focus on measuring the effectiveness of care coordination for medically high-risk members with a recent hospital discharge. The goal of the PIP will be to increase access to community resources that provide education, physician assessments, and pharmacological interventions to decrease hospital readmissions and improve health outcomes.

The EQRO facilitated monthly and quarterly conference calls with HFS and the ICPs throughout SFY 2010–2011. With technical assistance from the EQRO and through a collaborative effort, the ICPs began to develop the study question and indicators, and to identify data sources. It is projected that baseline measurement data for this PIP will be collected in SFY 2013.

### Introduction

HFS contracts with HSAG to perform external oversight, monitoring, and evaluation of the quality assurance component of managed care. In accordance with 42 CFR 438.356, HFS contracts with an EQRO to conduct the mandatory and optional EQR activities as set forth in 42 CFR 438.358.

As set forth in 42 CFR 438.352, a mandatory EQR activity is to conduct a review, within the previous three-year period, to determine MCO compliance with State standards for access to care, structure and operations, and quality measurement and improvement. HFS has an annual monitoring process in place to ensure the CFR and BBA requirements are met over a three year period. HSAG reviews MCO compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. In accordance with 42 CFR 438.204(g), these standards are as stringent as the federal Medicaid managed care standards described in 42 CFR 438, which address requirements related to access, structure and operations, and measurement and improvement. Compliance is also determined through review of individual files to evaluate implementation of standards.

During SFY 2010–2011, HSAG conducted a focused review of the VMCOs to review standards not met during the SFY 2009–2010 compliance review (MCO compliance with the Quality Assurance Plan standards). An additional focus was a review of each MCOs' case management and care coordination systems and programs. In addition, HSAG conducted readiness reviews for the health plans participating in the new Integrated Care Program.

For each of the activities, this section of the report presents the objectives, technical methods of data collection and analysis, description of data obtained, findings for each plan, and conclusions drawn from the data. Additional details about the results of the EQR activities are included in the individual and aggregate MCO reports prepared by HSAG.

### Compliance Monitoring

Private accreditation organizations, state licensing and Medicaid agencies, and the federal Medicare program all recognize that having standards is only the first step in promoting safe and effective health care. Making sure that the standards are followed is the second step. According to 42 CFR 438.358, a state or its EQRO must conduct a review within a three-year period to determine health plan compliance with QAP standards. Compliance monitoring is designed to determine an



MCO's compliance with its contract, State and federal regulations, and various compliance monitoring standards.

In SFY 2010–2011, HSAG conducted focused on-site reviews of the three voluntary managed care organizations (VMCOs): **FHN**, **Harmony**, and **Meridian**. The focused review areas included Measurement and Improvement Standards for all areas related to quality assessment and process improvement; Access Standards for continuity of care and case management; and Structure and Operations Standards for delegation oversight, credentialing, and recredentialing if the score received by the VMCO in the prior comprehensive review warranted re-review. In addition, HSAG completed a review of the VMCOs annual quality improvement program (QIP) evaluation reports. The findings of the evaluation were discussed with each VMCO and included in a Focused Review Report prepared for HFS and the VMCO.

In SFY 2010–2011, the State of Illinois awarded Medicaid managed care contracts to **Aetna** and **IlliniCare** to administer services to Illinois Medicaid beneficiaries enrolled in the State's new Integrated Care Program (ICP) for seniors and adults with disabilities who are eligible for Medicaid but not Medicare. HSAG conducted pre-implementation readiness review activities with **Aetna** and **IlliniCare**. The pre-implementation activities included weekly conference calls with **Aetna** and **IlliniCare**, during which HFS and HSAG reviewed the integrated care plans' (ICPs) preparation for implementation of the Integrated Care Program as well as a comprehensive desk document review. These activities were conducted in July and August 2011 to validate that the ICPs implemented the required policies and procedures as directed in the pre-implementation stage of the readiness review.

The State and the individual ICPs used the information and findings from the readiness reviews to:

- ◆ Evaluate the quality and timeliness of, and access to, health care furnished by the ICP to medical assistance program participants.
- ◆ Identify, implement, and monitor system interventions to improve quality.
- ◆ Evaluate current performance processes.
- ◆ Plan and initiate activities to sustain and enhance current performance processes.

## VMCO Focused Reviews

### **Objective**

The primary objective of HSAG's focused reviews were to provide meaningful information to HFS and the health plans regarding VMCO compliance with federal managed care regulations and

contract requirements specified in the October 1, 2009, *State of Illinois Department of Healthcare and Family Services Contract for Furnishing Health Services by a Managed Care Organization*. A particular focus of this review was to determine how each VMCO maintained compliance in the areas identified in the prior comprehensive review findings as warranting re-review. The focused review also emphasized review of the VMCOs' case management and care coordination systems and programs.

### **Procedure**

Throughout preparation for the focused review and performance of the activities during the on-site review, HSAG worked closely with HFS and the VMCOs to ensure a coordinated and supportive approach. To complete the focused review, HSAG assembled a team to:

- ◆ Collaborate with HFS to determine the scope of the review and scoring methodology, data collection methods, schedules for the desk review and on-site review activities, and the agenda for the on-site review.
- ◆ Collect and review data and documents before and during the on-site review.
- ◆ Aggregate and analyze the data and information collected.
- ◆ Prepare a report of review findings.

HSAG followed the guidelines in the February 11, 2003, CMS protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance With Medicaid Managed Care Proposed Regulations at 42 CFR, Parts 400, 430, et al.* The following list describes the focused review activities in chronological order.

- ◆ Established the review schedule.
- ◆ Prepared the data collection tool for reviewing the standards and submitted it to HFS for approval.
- ◆ Prepared and submitted the pre-assessment form and agenda to the VMCOs.
- ◆ Forwarded the focused review tool and file review tools to the VMCOs.
- ◆ Participated in pre-on-site conference calls with HFS and each VMCO.
- ◆ Responded to VMCOs' questions related to the review and provided additional information needed before the review.
- ◆ Received data files from the VMCOs, then selected and posted samples to HSAG's FTP site prepared for each VMCO.
- ◆ Conducted a file review of selected sample files.
- ◆ Received VMCOs' documents for HSAG's desk review and evaluated the information before conducting the on-site review.

- ◆ Conducted the on-site portion of the review.
- ◆ Calculated the individual scores and determined the overall compliance score for performance.
- ◆ Prepared a report of findings and required corrective actions.

### **Data Collection and Analysis**

HSAG developed the SFY 2010–2011 Focused Review Administrative Tool and file review tools consistent with State and federal requirements and protocols. To select standards for inclusion in the focused review tool, HSAG used the requirements specified in the *State of Illinois Contract for Furnishing Health Services by a Managed Care Organization*, effective October 1, 2009; the *Illinois Compiled Statutes*; and the Balanced Budget Act of 1997 (BBA), including revisions issued June 14, 2002, and effective August 13, 2002.

The focused review areas selected included Measurement and Improvement Standards for all areas related to quality assessment and process improvement, Access Standards for continuity of care and case management, and Structure and Operations Standards for delegation oversight, credentialing, and recredentialing (if the score received by the VMCO in the prior comprehensive review warranted re-review).

For the file review portion of the review, HSAG generated unique record review samples based on data files supplied by the VMCOs and HFS. A random sample of 10 unduplicated records was selected from each of the data files, and an additional 5 unduplicated records were selected for the oversample. For case management, HSAG reviewed 5 additional cases with a medical diagnosis that were not shared with the MCO prior to the site visit (unannounced sample). In addition to the sample file reviews, HSAG conducted a delegation oversight file review of the VMCOs' delegated vendors.

During the on-site review, HSAG conducted interviews, reviewed systems demonstrations, and reviewed files designated for the file reviews with VMCO staff to obtain further information to determine the VMCO's compliance with contract requirements. Throughout the desk review and on-site review process, reviewers documented within the standardized monitoring tools.

HSAG analyzed the review information to determine the organization's performance for each of the elements within the standards. HSAG used the designations *Met*, *Partially Met*, and *Not Met* to document the degree to which the VMCOs complied with the requirements. HSAG used a designation of *Not Evaluated* if an individual element was not evaluated for the VMCO during the period covered by the review. HSAG also used the standardized monitoring tool to document follow-up on any elements that required corrective action.

## Plan Comparisons

The following table compares plan performance on the applicable standards assessed in the focused reviews.

**Table 5.1—Summary of Scores for the Standards**

		Total Compliance Score	Total Compliance Score	Total Compliance Score
Standard #	Standard	FHN	Harmony	Meridian
<b>Access Standards</b>				
VI	Continuity of Care and Case Management	40%	70%	75%
XI	Access and Availability—Service Delivery	92%	Not Evaluated	85%
<b>Measurement and Improvement Standards</b>				
I	Quality Assurance Program (Combined QAP, Written QAP, and QAP Written Guidelines)	88%	88%	100%
II	Systematic Process of Quality Assessment and Performance Improvement	58%	71%	87%
III	QAP Structure (Combined QAP, Governing Body, and Designated Senior Executive)	75%	85%	95%
VII	Coordination of QAP Activity With Other Management Activity	60%	100%	100%
<b>Structure and Operations Standards</b>				
IV	Monitoring of Delegated Activities (Combined Delegation With Monitoring BH Subcontractors)	66%	73%	93%
V	Credentialing and Recredentialing	88%	98%	100%
IX	Enrollee Information, Rights, and Protections—Including Grievances	Not Evaluated	99%	Not Evaluated
<b>Totals</b>		<b>73%</b>	<b>88%</b>	<b>92%</b>

## Plan-Specific Findings

### Family Health Network

#### Access Standards

**Case Management and Care Coordination Program**—Many of the policies and procedures for continuity of care and case management were found deficient and not in compliance with federal Medicaid managed care regulations, State rules, and the associated Illinois contract requirements for access standards. Between October 2009 and October 2010, **FHN** did not have a process in place to complete chronic care action plans; to identify, assess, or develop care treatment plans for children with special health care needs; or to complete health risk assessments (HRAs) for new

enrollees as required. In October 2010, **FHN** implemented the case management software and processes which had been under development throughout 2009–2010. Therefore, **FHN**'s focused review was followed by additional corrective actions related to case management and care coordination requirements. HSAG provided extensive technical assistance throughout SFY 2010–2011 to assure **FHN**'s newly implemented case management software and processes were in compliance with State contract and BBA requirements. In May 2011, **FHN** implemented an immediate corrective action plan (CAP) to correct the deficiencies identified in the case management program. The CAP included allocation of additional resources to eliminate the backlog of **FHN** members needing a health risk assessment and the development and implementation of care plans for members requiring case management services. **Measurement and Improvement Standards**—Review of the measurement and improvement standards included in the focused review identified that **FHN** did not have a system established for tracking and trending of health care utilization data. In addition, **FHN**'s oversight and monitoring of quality assurance (QA) activities lacked development of corrective action recommendations for correcting noncompliance with delegation oversight activities, as well as ensuring timely implementation of the case management system and including implementation of an interim system to ensure members were provided case and disease management services during the case management software implementation.

**FHN** will need to continue to evaluate the effectiveness of its quality improvement (QI) interventions and work with network providers to create, implement, and sustain quality improvement initiatives within clinical areas that support children, pregnant women, adults, and members with chronic conditions, as specified by HFS and outlined in the QA Program Description. In addition, the VMCOs were required to participate in three performance improvement projects (PIPs). **FHN** reported the status of each PIP to HFS as required each year; however, **FHN** will need to continue to evaluate the effectiveness of its interventions for each of the PIPs and continue to implement QI efforts for increasing and sustaining improvement for each of the PIPs.

**Structure and Operations Standards**—Review of the Structure and Operations Standards identified that **FHN** failed to monitor the performance of its delegated entities through routine reporting and follow-up, ongoing monitoring, and evaluation to determine whether the delegated activities were being carried out according to BBA, HFS, and **FHN** requirements.

## Harmony Health Plan

### Access Standards

**Case Management and Care Coordination Program**—Throughout SFY 2010–2011, **Harmony** worked to strengthen its case management and care coordination program by evaluating the process for member referrals to case management through a case and disease management claims/encounters algorithm. The algorithm evaluated and scored members on three

primary drivers: severity, utilization, and cost. Through data mining, members were flagged if identified as having certain chronic care conditions and evaluated for case management services. **Harmony** reported that as a result of this evaluation, the number of cases identified and referred to case management almost doubled between 2010 and 2011. As additional improvements, **Harmony** (1) implemented a telephonic transitional care management hospital-to-home program that focused on members with complex discharge needs, (2) refined the referral process for 24-hour Nurse Advice Line cases and follow-up by case management, (3) revised the process for assessing children and youth with special health care needs, and (4) increased focus on patient self-management education and skills building through motivational interviewing techniques.

Review of medical and behavioral case management files identified the need for continued focus on improved communication with members in case management including involving the member in the care planning process, completion of assessments and action plans for members with chronic conditions, consistent review and updates to the care plans, and improving communication with providers by sharing the member's care plan and soliciting the provider's input and thereby taking an active role in ensuring successful outcomes for the member.

**Measurement and Improvement Standards**—A review of **Harmony's** annual QIP evaluation identified that the plan will need to continue to strengthen its annual review process through continued evaluation of the barriers to quality improvement and the development of innovative interventions that will address the barriers identified. In addition, **Harmony** will need to include an evaluation of the effectiveness of its cultural competency program.

**Harmony's** QIP will require revision to include provisions for enrollee participation in the grievance committee; include methods for development, implementation, and review of the Health Education program; and provide a description of the Fraud, Waste and Abuse program and the Privacy and Security program.

**Structure and Operation Standards**—Review of the Structure and Operations Standards included review of provider selection, subcontractual relationships and delegation, credentialing and recredentialing, enrollee information, and grievance systems. A review of the delegation requirements identified that **Harmony** had entered into a delegated agreement with Magellan Behavioral Health as a provider of behavioral health services beginning in September 2010. Review of the behavioral health case management files identified that the case management delegation oversight tool lacked all the required components necessary to ensure compliance with contract requirements. In addition, **Harmony** did not have a vendor oversight process in place to ensure coordination and continuity of care and involvement of the primary care physician (PCP) in aftercare for members with behavioral health conditions.

**Harmony** was in compliance with the credentialing and recredentialing policies and procedures; however, **Harmony** did not have provisions in a policy or in the QI Program Description for an annual review of peer review procedures.

During the review period, **Harmony** implemented changes to its grievance system including (1) updating the grievance category listing, (2) developing step-by-step instructions for **Harmony** associates' grievance training, (3) establishing a dedicated quality review team that reviewed 100 percent of grievances, and (4) working with the Provider Relations department to drill down on root cause and key grievance drivers. The information system Paradigm was used to document and track grievances. **Harmony** identified transportation issues as the leading cause for grievances in 2010.

## **Meridian**

### **Access Standards**

**Case Management and Care Coordination Program**—A review of the program identified that **Meridian** used the Managed Care Information System (MCS), its internally developed proprietary software system, for documentation of case management activities. MCS was used to track, support, and monitor the case management process including assessment forms, care treatment plans, and case manager contact logs. **Meridian** offered several case management programs including Primary, Complex, High-Risk Pregnancy and Behavioral Health. The Complex Case Management Program was designed to address the needs of members with complex health care needs (i.e., members with multiple conditions, complicated medication regimes, and unique needs). The goal of the Behavioral Health Case Management Program was to identify members requiring behavioral health and alcohol and substance abuse services and to provide a continuum of care through collaboration and referral assistance with mental health, substance abuse, prevention and/or other services to support the member in self-sufficiency.

A review of medical and behavioral case management files found that while the files provided documentation of timely development of care treatment plans, **Meridian** will need to ensure that the member and the member's PCP/specialist are consistently informed that the member has been enrolled into case management services and that the PCP receives a copy of the care treatment plan. **Meridian** must also continue its efforts to facilitate and coordinate communication between service providers and the member/member's family.

**Measurement and Improvement Standards**—A review of the QIP Plan found that **Meridian** described the organizational arrangements and responsibilities for quality improvement. The program description outlined the authority for the QIP, purpose of the program, goals and objectives, scope of activities, committee structures and reporting, and responsibilities of the quality management department. As **Meridian** continues to expand into additional counties and

grow its membership, the plan will need to include an evaluation of the effectiveness of its cultural competency program, and its case and disease management programs.

Claims, credentialing, provider, member, preventive services, authorizations, case and disease management data are all housed in MCS allowing the programs to function together to simplify and streamline member and provider interactions with **Meridian** staff. Meridian was a Chief Information Officer (CIO) 100 Award winner in 2007, 2008, and 2010 for its innovative capabilities of integrating health care data.

**Structure and Operation Standards**—A review of delegation and credentialing and recredentialing requirements found **Meridian** in compliance with the majority of the requirements. During the review period, **Meridian** ended its delegation agreement for behavioral health and utilization management functions with CompCare and developed an in-house behavioral health program.

## ICP Readiness Reviews

### Objectives

HSAG was contracted by HFS to conduct a pre- and post-implementation operational readiness review for the health plans contracted to implement HFS' Integrated Care Program, **Aetna** and **IlliniCare**. The primary objectives of HSAG's pre-implementation reviews were, prior to member enrollment in the new Integrated Care Program, to provide information that would allow HFS and the ICPs to assess access and availability of services, facilitate revisions to policies and procedures, and ensure compliance with federal managed care regulations and contract requirements specified in the May 1, 2011, *State of Illinois Department of Healthcare and Family Services Contract for Furnishing Health Services in an Integrated Care Program by a Managed Care Organization*. The purpose of the review was to determine the ICPs' capacity to participate in the new Illinois Medicaid program. The operational readiness review was designed to consist of four phases: pre-implementation activities, an on-site readiness review, post-readiness review activities, and post-implementation monitoring. During SFY 2010–2011, HSAG conducted the pre-implementation activities. The on-site and post-readiness review activities will occur in SFY 2012 and SFY 2013.

### Procedure

During the pre-implementation phase, HFS and HSAG conducted weekly conference calls with the ICPs to monitor implementation status. Prior to the on-site readiness review, the ICPs were required to submit frequent network adequacy reports to HFS to monitor the ICPs' efforts to establish their provider networks.



The pre-implementation readiness review activities conducted in SFY 2010–2011 consisted of a comprehensive desk document review. HSAG worked with HFS to prepare a list of documents requiring mandatory review and approval prior to the membership enrollment in May 1, 2011. The documents requiring review were determined based on HFS' contractual requirements and federal requirements. The ICPs were provided a list of these mandatory documents for review. After initial submission, the content of the documents were reviewed for compliance with federal and State regulatory requirements and HFS contractual requirements. The ICPs were required to revise any documents not meeting the requirements and resubmit them for approval. HSAG developed a *Health Plan Documents for Prior Approval* document to track the receipt of initial and revised mandatory documents from the ICPs and track the review and approval of mandatory documents by HFS and HSAG.

The ICPs were required to comply with all elements identified as mandatory or critical components prior to the May 1, 2011, program implementation date. HFS, with assistance from HSAG, reviewed and approved all mandatory documentation prior to implementation of the program.

Both **Aetna** and **IlliniCare** met the State requirements for document approval prior to the implementation date. Documents included for mandatory approval were in the following categories:

- ◆ Enrollee Information and Enrollee Rights
- ◆ Care Coordination
- ◆ Disease Management
- ◆ Provider Information
- ◆ Enrollee Handbook
- ◆ GeoAccess Reporting (HFS monitored)
- ◆ Quality Management Program Description and Work Plan
- ◆ Utilization Management Program Description and Work Plan

Assessment of the Integrated Care Plans' readiness and compliance will continue throughout SFY 2012 and SFY 2013. HSAG will conduct an on-site review to further monitor compliance to ensure the ICPs are meeting the State's standards for program implementation and will complete post-implementation activities described above.

### Performance Measure Validation

#### Objectives

This section describes the evaluation of the MCOs' ability to collect and accurately report on the performance measures. HEDIS performance measures are a nationally recognized set of performance measures developed by NCQA. Health care purchasers use these measures to assess the quality and timeliness of care and service delivery to members of managed care delivery systems.

A key element of improving health care services is the ability to provide easily understood, comparable information on the performance of the MCOs. Systematically measuring performance provides a common language based on numeric values and allows the establishment of benchmarks, or points of reference, for performance. Performance measure results allow the MCO to make informed judgments about the effectiveness of existing processes and procedures, identify opportunities for improvement, and determine if interventions or redesigned processes are meeting objectives.

The Department requires the MCOs to monitor and evaluate the quality of care through the use of HEDIS and Department-defined performance measures. The MCOs must establish methods by which to determine if the administrative data are accurate for each measure. In addition, the MCOs are required by contract to track and monitor each performance measure and applicable performance goal on an ongoing basis, and to implement a quality improvement initiative addressing compliance until the MCOs meet the performance goal.

NCQA licenses organizations and certifies selected employees of licensed organizations to conduct performance measure audits using NCQA's standardized audit methodology. The NCQA HEDIS Compliance Audit<sup>™ 6-1</sup> indicates the extent to which MCOs have adequate and sound capabilities for processing medical, member, and provider information for accurate and automated performance measurement, including HEDIS reporting. The validation addresses the technical aspects of producing HEDIS data, including:

- ◆ Information practices and control procedures
- ◆ Sampling methods and procedures

<sup>6-1</sup> NCQA HEDIS Compliance Audit<sup>™</sup> is a trademark of the National Committee for Quality Assurance (NCQA).

- ◆ Data integrity
- ◆ Compliance with HEDIS specifications
- ◆ Analytic file production

## Conducting the Review

### *Technical Methods of Data Collection and Analysis*

The Department required that an NCQA-licensed audit organization conduct an independent audit of each MCO's measurement year (MY) 2010 data. The State contracted with HSAG to audit **FHN**, **Harmony**, and **Meridian**. The audits were conducted in a manner consistent with the 2011 NCQA *HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. The audit incorporated two main components:

- ◆ A detailed assessment of the MCO's IS capabilities for collecting, analyzing, and reporting HEDIS information.
- ◆ A review of the specific reporting methods used for HEDIS measures, including computer programming and query logic used to access and manipulate data and to calculate measures; databases and files used to store HEDIS information; medical record abstraction tools and abstraction procedures used; and any manual processes employed for 2011 HEDIS data production and reporting. The audit extends to include any data collection and reporting processes supplied by vendors, contractors, or third parties, as well as the MCO's oversight of these outsourced functions.

For each MCO, a specific set of performance measures was selected. This selection was based on factors such as Department-required measures, a full year of data, previously audited measures, and past performance. The measures selected for validation through the HEDIS compliance audits were the following:

- ◆ *Childhood Immunization Status*
- ◆ *Well-Child Visits in the First 15 Months of Life (0 Visits and 6 or More Visits)*
- ◆ *Prenatal and Postpartum Care*

The MCOs also reported on other HEDIS measures that were not validated during the audit, although the processes for collecting and calculating each measure were validated. The rates for these HEDIS measures are included in this report and consist of the following performance measures:

- ◆ *Lead Screening in Children*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life*

- ◆ *Adolescent Well-Care Visits*
- ◆ *Immunizations for Adolescents (Combined Rate)*
- ◆ *Children's and Adolescents' Access to Primary Care Practitioners (PCPs)*
- ◆ *Adults' Access to Preventive/Ambulatory Care*
- ◆ *Breast Cancer Screening*
- ◆ *Cervical Cancer Screening*
- ◆ *Chlamydia Screening in Women*
- ◆ *Frequency of Ongoing Prenatal Care (0–21 Percent of Visits and 81–100 Percent of Visits)*
- ◆ *Controlling High Blood Pressure*
- ◆ *Comprehensive Diabetes Care*
- ◆ *Use of Appropriate Medications for People With Asthma*
- ◆ *Follow-up After Hospitalization for Mental Illness (7-Days and 30-Days)*

HSAG used a number of different methods and information sources to conduct the audits, including:

- ◆ Teleconference calls with MCO personnel and vendor representatives, as necessary.
- ◆ Detailed review of each MCO's completed responses to the HEDIS Record of Administration, Data Management and Processes (HEDIS Roadmap) published by NCQA as Appendix 2 to HEDIS Volume 5, and updated information communicated by NCQA to the audit team directly.
- ◆ On-site meetings in the MCOs' offices, including: staff interviews, live system and procedure documentation, documentation review and requests for additional information, primary HEDIS data source verification, programming logic review and inspection of dated job logs, computer database and file structure review, and discussion and feedback sessions.
- ◆ Detailed evaluation of computer programming used to access administrative data sets and calculate HEDIS measures.
- ◆ If the hybrid method was used, abstraction of a sample of medical records selected by the auditors, with a comparison of the results to the MCO's review determinations for the same records.
- ◆ Requests for corrective actions and modifications to the MCO's HEDIS data collection and reporting processes and data samples, as necessary, and verification that actions were taken.
- ◆ Accuracy checks of the final HEDIS rates completed by the MCO.
- ◆ Interviews of a variety of individuals whose department or responsibilities played a role in the production of HEDIS data. Typically, such individuals included the HEDIS manager, IS director, quality management director, enrollment and provider data manager, medical records

staff, claims processing staff, programmers, analysts, and others involved in the HEDIS preparation process. Representatives of vendors that provided or processed HEDIS 2011 (and earlier historical) data may also have been interviewed and asked to provide documentation of their work.

Each of the audited measures reviewed by the audit team received a final audit result consistent with the NCQA categories listed below. Table 6.1 provides the audit finding results that are applicable to the HEDIS measures.

**Table 6.1—HEDIS Measure Audit Findings**

Rate/Result	Comment
0–XXX	Reportable rate or numeric result for HEDIS measures.
NR	Not Reported: 1. Plan chose not to report 2. Calculated rate was materially biased 3. Plan not required to report
NA	Small Denominator: The organization followed the specifications but the denominator was too small to report a valid rate
NB	No Benefit: The organization did not offer the health benefits required by the measure (e.g., mental health or chemical dependency)

For measures reported as percentages, NCQA has defined significant bias as a deviation of more than 5 percentage points from the true percentage.

For some measures, more than one rate is required for HEDIS reporting (for example, *Childhood Immunization Status* and *Well-Child Visits in the First 15 Months of Life*). It is possible that the MCO prepared some of the rates required by the measure appropriately but had significant bias in others. According to NCQA guidelines, the MCO would receive a reportable result for the measure as a whole, but significantly biased rates within the measure would receive an “NR” result in the Interactive Data Submission System (IDSS), where appropriate.

Upon completion of the audit, HSAG prepared a final audit report for the MCOs that included a completed and signed final audit statement. The reports were forwarded to the Department for review.

For the discussions that follow regarding conclusions drawn from the data for each MCO, full compliance is defined as the lack of any findings that would significantly bias HEDIS reporting by more than 5 percentage points. Additionally, when discussing rates for *Well-Child Visits in the First 15 Months of Life*, assessments are made for *0 Visits* and *6 or More Visits*, as those measures are most indicative of the range of quality of health care. *Frequency of Ongoing Prenatal Care* is also assessed using the two categories of *0–21 Percent of Visits* and *81–100 Percent of Visits*.

To validate the medical record review (MRR) portion of the audit, NCQA policies and procedures require auditors to perform two steps: (1) review the MRR processes employed by the MCO, including staff qualifications, training, data collection instruments/tools, interrater reliability (IRR) testing, and the method used for combining MRR data with administrative data; and (2) abstract and compare the audit team's results to the MCO's abstraction results for a selection of hybrid measures.

HSAG's audit team reviewed the processes in place at each MCO for performance of MRR for all measures reported using the hybrid method. The audit team reviewed data collection tools and training materials to verify that all key HEDIS data elements were captured. Feedback was provided to each MCO's staff if the data collection tools appeared to be missing necessary data elements.

HSAG's audit team also performed a re-abstraction of records selected for MRRs and compared the results to each MCO's findings for the same medical records. This process completed the medical record validation process and provided an assessment of actual reviewer accuracy. HSAG reviewed up to 30 records identified by each MCO as meeting numerator event requirements (determined through MRR) for measures selected for audit and MRR validation. Records were randomly selected from the entire population of MRR numerator positives identified by the MCO, as indicated on the MRR numerator listings submitted to the audit team. If fewer than 30 medical records were found to meet numerator requirements, all records were reviewed. Reported discrepancies only included "critical errors," defined as an abstraction error that affected the final outcome of the numerator event (i.e., changed a positive event to a negative one or vice versa).

For each of the selected measures where the hybrid methodology was used, auditors determined the impact of the findings from the validation process on the MCO's audit designation. The goal of the MRR validation was to determine whether the MCO made abstraction errors that significantly biased its final reported rate. HSAG used the standardized protocol developed by NCQA to validate the integrity of the MRR processes of audited MCOs. The NCQA-endorsed *t*-test was employed to test the difference between the MCO's estimate of the positive rate and the audited estimate of the positive rate. If the test revealed that the difference was greater than 5 percent, the MCO's estimate of the positive rate was rejected and the measure could not be reported using the hybrid methodology.

## Findings

### Family Health Network (FHN)

The Medicaid HEDIS 2011 rates for **FHN** and the National Medicaid 2010 HEDIS 50th percentiles are presented below (Table 6.2). As a visual aid for quick reference, numbers highlighted in yellow indicate the rates that were at or above the 50th percentile.

**Table 6.2—FHN HEDIS 2011 Rates**

HEDIS Measures	FHN	2010 HEDIS 50th Percentiles
<b>Child and Adolescent Care</b>		
<i>Childhood Immunizations—Combo 2</i>	75.7%	76.6%
<i>Childhood Immunizations—Combo 3</i>	70.4%	71.0%
<i>Lead Screening in Children</i>	81.9%	71.6%
<i>Well-Child Visits in the First 15 Months (0 Visits)*</i>	3.5%	1.4%
<i>Well-Child Visits in the First 15 Months (6+ Visits)</i>	53.8%	60.1%
<i>Well-Child Visits (3–6 Years)</i>	67.4%	71.8%
<i>Adolescent Well-Care Visits</i>	43.9%	46.8%
<i>Immunizations for Adolescents (Combined Rate)</i>	40.5%	42.4%
<b>Children’s and Adolescents’ Access to PCPs</b>		
<i>12–24 Months</i>	82.2%	96.8%
<i>25 Months–6 Years</i>	69.9%	89.8%
<i>7–11 Years</i>	51.1%	91.3%
<i>12–19 Years</i>	53.0%	88.9%
<b>Adults’ Access to Preventive/Ambulatory Care</b>		
<i>20–44 Years of Age</i>	64.6%	82.9%
<i>45–64 Years of Age</i>	67.4%	88.1%
<b>Preventive Screening for Women</b>		
<i>Breast Cancer Screening (Combined Rate)</i>	47.7%	52.0%
<i>Cervical Cancer Screening</i>	69.4%	67.8%
<i>Chlamydia Screening (Combined Rate)</i>	66.3%	55.7%
<b>Maternity-Related Measures</b>		
<i>Frequency of Ongoing Prenatal Care (&lt; 21% Visits)*</i>	18.2%	7.0%
<i>Frequency of Ongoing Prenatal Care (81–100% Visits)</i>	42.3%	64.2%
<i>Timeliness of Prenatal Care</i>	62.4%	86.0%
<i>Postpartum Care</i>	40.2%	65.5%

Table 6.2—FHN HEDIS 2011 Rates

HEDIS Measures	FHN	2010 HEDIS 50th Percentiles
<b>Chronic Conditions/Disease Management</b>		
<i>Controlling High Blood Pressure (Combined Rate)</i>	45.6%	57.1%
<i>Diabetes Care (HbA1C Testing)</i>	79.2%	81.1%
<i>Diabetes Care (Good HbA1c Control)</i>	31.7%	46.6%
<i>Diabetes Care (Poor HbA1c Control)*</i>	69.9%	43.2%
<i>Diabetes Care (Eye Exam)</i>	31.7%	54.0%
<i>Diabetes Care (LDL-C Screening)</i>	68.9%	75.4%
<i>Diabetes Care (LDL-C Level &lt; 100 mg/DI)</i>	29.5%	33.6%
<i>Diabetes Care (Nephropathy Monitoring)</i>	84.7%	77.7%
<i>Diabetes Care (BP &lt; 140/90)</i>	54.6%	61.6%
<i>Diabetes Care (BP &lt; 140/80)**</i>	34.4%	NA**
<i>Appropriate Medications for Asthma (Combined Rate)</i>	90.3%	88.6%
<i>Follow-up After Hospitalization for Mental Illness—7 Days</i>	70.9%	43.5%
<i>Follow-up After Hospitalization for Mental Illness—30 Days</i>	80.2%	62.6%
* Lower rates indicate better performance for these measures.		
** This is a new or changed HEDIS measure; therefore, no benchmarks are available.		

FHN had seven measures with rates that exceeded the 2010 HEDIS Medicaid 50th percentiles: one measure in the Child and Adolescent Care category, two in Preventive Screening for Women, and four in the Chronic Conditions/Disease Management category. FHN performed the lowest compared to the 50th percentiles on measures related to maternity care and access to care. Access to care measures rely completely on encounter data, which is challenging in a capitated model of reimbursement.

**Encounter Data Completeness for FHN**

Table 6.3 provides an estimate of the data completeness for FHN’s hybrid performance measures. These measures use administrative encounter data and supplement the results with medical record data. The rates in the table represent the percentage of the final HEDIS rate that was determined solely through the use of administrative encounter data. A rate of 100 percent for the last column indicates that the encounter data were complete for that HEDIS measure. Rates highlighted in green indicate a 90.0 percent or more encounter data completion rate, while rates highlighted in red indicate a 50.0 percent or less encounter data completion rate.



**Table 6.3—FHN Estimated Encounter Data Completeness for Hybrid Measures**

Performance Measures	Final HEDIS 2011 Rate	Percent From Administrative Data
<i>Childhood Immunizations—Combo 2</i>	75.7%	<b>10.4%</b>
<i>Childhood Immunizations—Combo 3</i>	70.4%	<b>10.5%</b>
<i>Lead Screening in Children</i>	81.9%	75.7%
<i>Well-Child Visits in the First 15 Months (6+ Visits)</i>	53.8%	<b>43.3%</b>
<i>Well-Child Visits (3–6 Years)</i>	67.4%	73.3%
<i>Adolescent Well-Care Visits</i>	43.9%	67.4%
<i>Immunizations for Adolescents (Combined Rate)</i>	40.5%	66.9%
<i>Cervical Cancer Screening</i>	69.4%	57.7%
<i>Chlamydia Screening</i>	66.3%	57.6%
<i>Frequency of Ongoing Prenatal Care (81–100%)</i>	42.3%	<b>31.7%</b>
<i>Timeliness of Prenatal Care</i>	62.4%	<b>26.7%</b>
<i>Postpartum Care</i>	40.2%	<b>25.3%</b>
<i>Diabetes Care (HbA1c Testing)</i>	79.2%	<b>10.3%</b>
<i>Diabetes Care (Good HbA1c Control)</i>	31.7%	<b>0.0%</b>
<i>Diabetes Care (Eye Exam)</i>	31.7%	<b>39.7%</b>
<i>Diabetes Care (LDL-C Screening)</i>	68.9%	<b>8.7%</b>
<i>Diabetes Care (LDL-C Level &lt; 100 mg/dl)</i>	29.5%	<b>0.0%</b>
<i>Diabetes Care (Nephropathy Monitoring)</i>	84.7%	<b>37.4%</b>

Overall, the results show that **FHN** does not receive all of its encounter data. Twelve measures had less than a 50.0 percent encounter data completeness rate. Six of the 18 HEDIS measures had more than a 50.0 percent encounter data completeness rate, but none of the measures had a data completion rate at or above 90.0 percent.

**FHN** continues to demonstrate difficulty in obtaining complete encounter data for childhood immunizations and lab-related measures for diabetes care. Encounter data for maternity-related care was also quite low.

### **Compliance Audit Results for FHN**

The HEDIS 2011 compliance audit indicated that **FHN** was in compliance with the *HEDIS 2011 Technical Specifications* (Table 6.4). Membership data supported all necessary HEDIS calculations,

medical data were partially compliant with the audit standards, and measure calculations resulted in rates that were not significantly biased. Furthermore, all selected HEDIS performance measures attained an R designation.

**Table 6.4—FHN 2011 HEDIS Compliance Audit Results**

Main Information Systems			Selected 2010 HEDIS Measures
Membership Data	Medical Data	Measure Calculation	All of the selected HEDIS measures received an R audit designation.
Fully Compliant	Partially Compliant	Fully Compliant	

The rationale for full compliance with membership data, medical data, and measure calculation was based on the findings summarized below for the IS standards. Any deviation from the standards that could bias the final results was identified. Recommendations for improving MCO processes were also identified.

**IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry**

FHN was fully compliant with IS 1.0, medical services data processing. Family Health Network acted upon the findings from the HEDIS 2010 audit and implemented several changes during 2010 to bring its processes back into compliance with the HEDIS standards. In order to bring the code set edits up to date, FHN implemented the McKesson coding software in July 2010. FHN has also implemented a formal process for tracking encounter data submissions from its provider health organizations (PHOs) and creation of an encounter data feedback report. As part of its pay for performance initiatives, FHN incentivized providers monetarily for submitting clean and timely encounter data. It was recommended that FHN should create a mechanism to monitor the volume of encounter data submitted each month by the PHOs. This would allow FHN to address significant changes in the volume of data submitted by each PHO and quickly address concerns with the PHO.

FHN is planning to purchase a new transactional system in 2011. The implementation of this new system will greatly improve the efficiency, accuracy, and completeness of claims and encounter data. As the transition begins, FHN should document the processes for transitioning to the new system and steps taken to ensure a smooth transition and minimal data loss.

**IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry**

FHN was fully compliant with the processing of enrollment data standards. There were no concerns with the eligibility data received and processed. There was an increase of approximately 4,500 members from the previous year and membership continues to grow. FHN received a monthly 834 file from the State that contained enrollment data for the subsequent month. All data were processed through a system called “Grandpa” and loaded into the capitation system where

enrollment files and payments are produced for each PHO. FHN performed a reconciliation between the State's payment file and the eligibility file as payment files were received from the State. Due to the ability for a member to continually change health plans, FHN saw a continual shift in enrollment and continues to deal with the challenges this creates. The ability for a member to change health plans multiple times throughout a calendar year is costly to the health plan and makes continuity of care difficult to monitor. The State should consider a "lock-in" period for Medicaid members that would require a member to remain with a health plan for a designated length of time before changing health plans. This could help to improve performance on HEDIS reporting for all Illinois health plans and the State overall.

**IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry**

FHN was fully compliant with IS 3.0 for practitioner data. There were no concerns with the processing of provider data. For the purpose of the measures under the scope of this audit, FHN was able to identify the rendering provider type and determine if the rendering provider was a primary care physician (PCP). FHN also continued to work to ensure that provider IDs were captured for reporting to the State.

**IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight**

FHN was fully compliant with the IS 4.0 requirements for medical record review processes. Medical record pursuit and data collection was conducted by health plan staff using internally developed data abstraction tools. The tools contained all the necessary edits to ensure consistent data collection practices. The data abstraction tools and corresponding instructions were reviewed and approved by HSAG. Reviewer qualifications, training, and oversight were also appropriate. A convenience sample was not required since there were no changes to the plan's medical record process, and no problems were identified during the 2010 over-read validation.

**Table 6.5—FHN Selected HEDIS 2011 Measures for Medical Record Validation**

Measure	Product Line	Number of Records	T-test	Pass/Fail
Well-Child Visits in the First 15 Months of Life (6+ Visits)	Medicaid	30	-2.351	Pass
Prenatal and Postpartum Care—Postpartum Care	Medicaid	30	NA	Pass

**IS 5.0—Supplemental Data—Capture, Transfer, and Entry**

For HEDIS 2011, FHN did not use any non-standard supplemental data files. In the past, FHN created lists of non-compliant members based on the HEDIS measures and asked the PHOs to submit the missing service data. These data were then entered into a database and used for HEDIS reporting. Since this process was time consuming and did not yield a large return, FHN

decided to discontinue this project and now requests that all PHOs submit any outstanding encounter data electronically for the measurement year. Standard supplemental data sources that **FHN** may consider for future HEDIS reporting periods include Cornerstone and HealthyKids; State registries for immunization; and well-child visit data, if received in a timely fashion.

**IS 6.0—Member Call Center Data—Capture, Transfer, and Entry**

Member call center data were not applicable under the scope of the audit.

**IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity**

**FHN** was fully compliant with IS 7.0 for data integration. There were no concerns with the processes in place for data integration and HEDIS reporting. Appropriate reconciliation and validation steps occurred to ensure data were not duplicated or reported in error. **FHN** retained State copies of all data sets used for data integration to ensure the performance measures can be recalculated if needed. **FHN** produces its own source code for the reported measures, and all source code passed validation and review. Primary source verification was performed on *Postpartum Care, Well-Child Visits in the First 15 Months of Life, and Childhood Immunization Status-Combo 3* measures, with no issues identified. **FHN** had adequate security and back-up procedures in place to ensure that all data were secure and at minimal risk for loss.

**FHN Trended Results**

Table 6.6 provides the results of **FHN**'s trended performance measures. Only HEDIS measures reported for at least the last two years are included in the table. The last column denotes the difference in the rates between the HEDIS 2008 rate, or the baseline rate, and HEDIS 2011 results.

**Table 6.6—FHN Trended HEDIS Results**

HEDIS Measures	HEDIS 2008	HEDIS 2009	HEDIS 2010	HEDIS 2011	Difference From Baseline
<i>Childhood Immunizations—Combo 2</i>	68.9%	72.0%	75.5%	75.7%	6.8%
<i>Childhood Immunizations—Combo 3</i>	53.0%	65.8%	69.7%	70.4%	17.4%
<i>Lead Screening in Children</i>	70.4%	69.5%	82.2%	81.9%	11.5%
<i>Well-Child Visits in the First 15 Months (0 Visits)*</i>	10.0%	7.7%	5.1%	3.5%	-6.5%*
<i>Well-Child Visits in the First 15 Months (6+ Visits)</i>	29.0%	43.5%	48.4%	53.8%	24.8%
<i>Well-Child Visits (3–6 Years)</i>	68.4%	74.8%	79.2%	67.4%	-1.0%
<i>Adolescent Well Care Visits</i>	32.2%	36.9%	45.7%	43.9%	11.7%
<i>Immunizations for Adolescents (Combined Rate)</i>	NA	NA	18.2%	40.5%	22.3%

Table 6.6—FHN Trended HEDIS Results

HEDIS Measures	HEDIS 2008	HEDIS 2009	HEDIS 2010	HEDIS 2011	Difference From Baseline
Children’s Access to PCP (12–24 Months)	77.3%	81.8%	84.1%	82.2%	4.9%
Children’s Access to PCP (25 Months–6 Years)	65.2%	68.9%	70.6%	69.9%	4.7%
Children’s Access to PCP (7–11 Years)	52.4%	49.5%	47.8%	51.1%	-1.3%
Adolescent’s Access to PCP (12–19 Years)	48.4%	49.9%	46.7%	53.0%	4.6%
Adults’ Access (20–44 Years)	56.6%	59.4%	65.4%	64.6%	8.0%
Adults’ Access (45–64 Years)	48.6%	58.8%	69.9%	67.4%	18.8%
Breast Cancer Screening (Combined Rate)	27.8%	33.9%	44.9%	47.7%	19.9%
Cervical Cancer Screening	68.0%	55.4%	63.9%	69.4%	1.4%
Chlamydia Screening in Women (Combined Rate)	47.7%	53.7%	56.4%	66.3%	18.6%
Frequency of Ongoing Prenatal Care (< 21% Visits)*	29.4%	39.3%	16.9%	18.2%	-11.2%*
Frequency of Ongoing Prenatal Care (81–100% Visits)	33.4%	25.6%	26.1%	42.3%	8.9%
Timeliness of Prenatal Care	45.4%	49.4%	49.2%	62.4%	17.0%
Postpartum Care	32.3%	32.9%	39.3%	40.2%	7.9%
Controlling High Blood Pressure (Combined Rate)	45.3%	54.6%	27.0%	45.6%	0.3%
Diabetes Care (HbA1C Testing)	68.5%	66.9%	77.6%	79.2%	10.7%
Diabetes Care (Good HbA1c Control)	12.0%	27.0%	30.9%	31.7%	19.7%
Diabetes Care (Poor HbA1c Control)*	56.5%	65.5%	69.1%	69.9%	13.4%*
Diabetes Care (Eye Exam)	22.8%	24.3%	25.0%	31.7%	8.9%
Diabetes Care (LDL-C Screening)	56.5%	60.8%	69.1%	68.9%	12.4%
Diabetes Care (LDL-C Level < 100 mg/dL)	15.2%	19.6%	27.0%	29.5%	14.3%
Diabetes Care (Nephropathy Monitoring)	57.6%	79.7%	85.5%	84.7%	27.1%
Diabetes Care (BP < 140/90)	51.1%	45.3%	40.8%	54.6%	3.5%
Appropriate Medications for Asthma (Combined Rate)	79.3%	85.0%	93.0%	90.3%	11.0%
Follow-up After Hospitalization for Mental Illness—7 Days	56.4%	64.2%	66.9%	70.9%	14.5%
Follow-up After Hospitalization for Mental Illness—30 Days	67.9%	76.5%	79.8%	80.2%	12.3%

\* Lower rates indicate better performance for these measures.

The results show that 31 of the 33 trended measures improved since HEDIS 2008 (or the baseline rate), and 18 measures improved by more than 10.0 percentage points. *Well-Child Visits in the First 15 Months of Life (6+ Visits)*, *Immunizations for Adolescents (Combined Rate)*, and *Diabetes Care (Nephropathy Monitoring)* each improved by more than 20.0 percentage points.

Rates for two of the 33 measures declined. Of particular concern was the 13.4 percentage point increase for *Diabetes Care (Poor HbA1c Control)*. For this measure, a lower rate indicates better

performance, and the 13.4 percentage point increase represents a continuing trend for this measure. The other measure with a decline was *Children's Access to PCP (7–11 Years)*, which had an insignificant decline of 1.3 percentage points since HEDIS 2008. Nevertheless, the lack of improvement with this rate, along with very low improvement in the other measures related to access, indicate that there may be potential access issues and/or provider network adequacy issues.

**Harmony Health Plan (Harmony)**

The Medicaid HEDIS 2011 rates for **Harmony** and the national Medicaid 2010 HEDIS 50th percentiles are presented in Table 6.7. As a visual aid for quick reference, numbers highlighted in yellow indicate the rates that were at or above the 50th percentile.

**Table 6.7—Harmony HEDIS 2011 Rates**

HEDIS Measures	Harmony	2010 HEDIS 50th Percentiles
<b>Child and Adolescent Care</b>		
<i>Childhood Immunizations—Combo 2</i>	65.9%	76.6%
<i>Childhood Immunizations—Combo 3</i>	61.6%	71.0%
<i>Lead Screening in Children</i>	78.1%	71.6%
<i>Well-Child Visits in the First 15 Months (0 Visits)*</i>	5.4%	1.4%
<i>Well-Child Visits in the First 15 Months (6+ Visits)</i>	51.3%	60.1%
<i>Well-Child Visits (3–6 Years)</i>	71.8%	71.8%
<i>Adolescent Well-Care Visits</i>	38.9%	46.8%
<i>Immunizations for Adolescents (Combined Rate)</i>	29.9%	42.4%
<b>Children’s and Adolescents’ Access to PCPs</b>		
<i>12–24 Months</i>	86.5%	96.8%
<i>25 Months–6 Years</i>	73.3%	89.8%
<i>7–11 Years</i>	70.5%	91.3%
<i>12–19 Years</i>	71.4%	88.9%
<b>Adults’ Access to Preventive/Ambulatory Care</b>		
<i>20–44 Years of Age</i>	69.3%	82.9%
<i>45–64 Years of Age</i>	68.8%	88.1%
<b>Preventive Screening for Women</b>		
<i>Breast Cancer Screening (Combined Rate)</i>	30.7%	52.0%
<i>Cervical Cancer Screening</i>	69.8%	67.8%
<i>Chlamydia Screening (Combined Rate)</i>	50.9%	55.7%
<b>Maternity-Related Measures</b>		
<i>Frequency of Ongoing Prenatal Care (&lt; 21% Visits)*</i>	16.5%	7.0%
<i>Frequency of Ongoing Prenatal Care (81–100% Visits)</i>	39.9%	64.2%
<i>Timeliness of Prenatal Care</i>	64.7%	86.0%
<i>Postpartum Care</i>	48.7%	65.5%

**Table 6.7—Harmony HEDIS 2011 Rates**

HEDIS Measures	Harmony	2010 HEDIS 50th Percentiles
<b>Chronic Conditions/Disease Management</b>		
<i>Controlling High Blood Pressure (Combined Rate)</i>	42.6%	57.1%
<i>Diabetes Care (HbA1C Testing)</i>	69.6%	81.1%
<i>Diabetes Care (Good HbA1c Control)</i>	29.4%	46.6%
<i>Diabetes Care (Poor HbA1c Control)*</i>	65.9%	43.2%
<i>Diabetes Care (Eye Exam)</i>	18.2%	54.0%
<i>Diabetes Care (LDL-C Screening)</i>	63.7%	75.4%
<i>Diabetes Care (LDL-C Level &lt; 100 mg/Dl)</i>	17.5%	33.6%
<i>Diabetes Care (Nephropathy Monitoring)</i>	67.4%	77.7%
<i>Diabetes Care (BP &lt; 140/90)</i>	49.6%	61.6%
<i>Diabetes Care (BP &lt; 140/80)**</i>	31.1%	NA**
<i>Appropriate Medications for Asthma (Combined Rate)</i>	86.0%	88.6%
<i>Follow-up After Hospitalization for Mental Illness—7 Days</i>	42.7%	43.5%
<i>Follow-up After Hospitalization for Mental Illness—30 Days</i>	56.1%	62.6%
* Lower rates indicate better performance for these measures.		
** This is a new or changed HEDIS measure; therefore, no benchmarks are available.		

**Harmony** reported three measures with rates at or above the Medicaid 2010 HEDIS 50th percentiles: *Lead Screening in Children*, *Well-Child Visits (3–6 Years)*, and *Cervical Cancer Screening*. Compared to the 50th percentiles, **Harmony** generally performed the lowest on maternity-related measures, diabetes care measures, and access measures.

**Encounter Data Completeness for Harmony**

Table 6.8 provides an estimate of the data completeness for **Harmony**'s hybrid performance measures. These measures use administrative encounter data and supplement the results with medical record data. The rates in the table represent the percentage of the final HEDIS rate that was determined solely through the use of administrative encounter data. A rate of 100 percent for the last column indicates that the encounter data were complete for that HEDIS measure. Rates highlighted in green indicate a 90.0 percent or more encounter data completion rate, while rates highlighted in red indicate a 50.0 percent or less encounter data completion rate.

**Table 6.8—Harmony Estimated Encounter Data Completeness for Hybrid Measures**

Performance Measures	Final HEDIS 2011 Rate	Percent From Administrative Data
<i>Childhood Immunizations—Combo 2</i>	65.9%	76.0%
<i>Childhood Immunizations—Combo 3</i>	61.6%	74.7%



**Table 6.8—Harmony Estimated Encounter Data Completeness for Hybrid Measures**

Performance Measures	Final HEDIS 2011 Rate	Percent From Administrative Data
Lead Screening in Children	78.1%	28.3%
Well-Child Visits in the First 15 Months (6+ Visits)	51.3%	70.6%
Well-Child Visits (3–6 Years)	71.8%	91.2%
Adolescent Well-Care Visits	38.9%	86.3%
Immunizations for Adolescents (Combined Rate)	29.9%	71.5%
Cervical Cancer Screening	69.8%	91.3%
Frequency of Ongoing Prenatal Care (81–100%)	39.9%	82.9%
Timeliness of Prenatal Care	64.7%	49.6%
Postpartum Care	48.7%	75.0%
Diabetes Care (HbA1c Testing)	69.6%	78.7%
Diabetes Care (Good HbA1c Control)	29.4%	9.1%
Diabetes Care (Eye Exam)	18.2%	45.3%
Diabetes Care (LDL-C Screening)	63.7%	77.5%
Diabetes Care (LDL-C Level < 100 mg/Dl)	17.5%	9.7%
Diabetes Care (Nephropathy Monitoring)	67.4%	63.5%

The rates indicate **Harmony** has reasonably good encounter data completeness. Two measures had more than a 90.0 percent data completion rate, two were above 80.0 percent, seven were above 70.0 percent, and one measure was above 60.0 percent. However, five of the measures had less than 50.0 percent data completion rate.

**Harmony** continues to demonstrate some difficulty in obtaining complete encounter data for lead screening, prenatal care, and some lab-related measures for diabetes care—especially those that require actual lab results. **Harmony** should concentrate efforts toward obtaining complete lab data.

### Compliance Audit Results for Harmony

The HEDIS 2011 compliance audit indicated that **Harmony** was in full compliance with the *HEDIS 2010 Technical Specifications* (Table 6.9). Membership data supported all necessary HEDIS calculations, medical data were fully compliant with the audit standards, and measure calculations resulted in rates that were not significantly biased. Furthermore, all selected HEDIS performance measures attained an R designation.

**Table 6.9—Harmony HEDIS 2011 Compliance Audit Results**

Main Information Systems			Selected 2010 HEDIS Measures
<b>Membership Data</b>	<b>Medical Data</b>	<b>Measure Calculation</b>	All of the selected HEDIS measures received an <i>R</i> audit designation.
Fully Compliant	Fully Compliant	Fully Compliant	

The rationale for full compliance with membership data, medical data, and measure calculation was based on the findings summarized below for the IS standards. Any deviation from the standards that could bias the final results was identified. Recommendations for improving MCO processes were also identified.

**IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry**

**Harmony** was fully compliant with IS 1.0 for medical services data. Edit checks were appropriately employed throughout both the claim system and the encounter system. Industry standard codes (e.g., ICD-9-CM, CPT, DRG, HCPCS) were used, and all characters were captured. **Harmony** used industry standard submission forms and was able to capture all fields relevant to HEDIS reporting. **Harmony** also met all data entry standards, and its processes were timely and accurate. The processes included sufficient edit checks to ensure accurate entry of data in **Harmony**'s transaction files for HEDIS reporting.

In prior years, **Harmony had** several provider groups that were submitting claims via flat files. For HEDIS 2011, this was reduced to only one provider group. **Harmony** expects that no provider groups will be submitting claims in nonstandard formats by next year.

**IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry**

**Harmony** was fully compliant with IS 2.0 for enrollment data. There were no concerns with the processing of the enrollment file received from the State. Monthly files were received and loaded into **Harmony**'s data system. Processing of membership information complied with standards. There were sufficient edits checks in place to ensure that files loaded did not contain errors. Enrollment files were reconciled monthly against the capitation file as an additional validation check to ensure that all eligible members were being captured for service and payment.

**IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry**

**Harmony** was fully compliant with IS 3.0 for practitioner data. **Harmony** used Visual CACTUS for part of the 2010 measurement year and Encompass for the remainder of the year for managing its provider data. Visual CACTUS was in the process of being phased out of the credentialing process. The auditors observed that no new credentialing information was being entered into Visual CACTUS. All credentialing was being done by an NCQA Certified Credentials Verification

Organization (CVO), Medversant. **Harmony** conducted a 100 percent over-read of all provider documents within Medversant. **Harmony** used Paradigm software to produce its provider directory, and the system was reconciled against the Encompass system to ensure data completeness. Specialties and subspecialties were accounted for in both systems. The specialty mapping has been reviewed, and there were no significant changes to any specialty that relates to the measures under the scope of the audit. **Harmony** ensured that there were sufficient provider identifiers in place to appropriately monitor and count providers. All provider mappings were sent to Medversant and McKesson for use in the administrative and hybrid measures.

**IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight**

**Harmony** was fully compliant with IS 4.0 for the medical record review process. **Harmony** used the CRMS NCQA certified software. Medical record pursuit and data collection was conducted by a medical record vendor. The tool and corresponding instructions were reviewed by HSAG. **Harmony** validated all potential exclusions that were identified by the vendor’s review staff. Reviewer qualifications, training, IRR process, and vendor oversight were appropriate. A convenience sample was not required since there were no changes to the **Harmony's** medical record process, and no problems were identified during the HEDIS 2010 over-read validation.

**Table 6.10—Harmony Selected HEDIS 2011 Measures for Medical Record Validation**

HEDIS Measure	Product Line	Number of Records	T-test	Pass/Fail
Well-Child Visits in the First 15 Months of Life (6+ Visits)	Medicaid	30	-14.57	Pass
Childhood Immunization Status—Combo 3	Medicaid	30	NA	Pass

**IS 5.0—Supplemental Data—Capture, Transfer, and Entry**

**Harmony** was fully compliant with IS 5.0 for supplemental data. **Harmony** used several nonstandard supplemental data sources for reporting its Medicaid measures. These nonstandard data sources included the Cornerstone and **Harmony** Kids immunization registries which were received monthly. No issues were identified during the measurement year. During the load process to the data warehouse, edit checks ensured that members in the registry were actual members of the health plan. The edit checks also determined if standard codes were being submitted.

**IS 6.0—Member Call Center Data—Capture, Transfer, and Entry**

Member call center data were not applicable to the scope of the audit.

**IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity**

**Harmony** was fully compliant with IS 7.0 for data integration. **Harmony** consolidated data from several different data sources and systems. **Harmony** maintained sufficient processes to integrate these data sources for HEDIS reporting. In addition, **Harmony** used CRMS, an NCQA certified software provided through McKesson, to report its HEDIS measures. There was sufficient documentation ensuring that appropriate fields were mapped. Initial rates were available from McKesson and reviewed on-site. The rates appeared to be congruent with the previous year's data. The audit team conducted primary source verification on several members from each measure to ensure that the software was working and to determine if the source records matched the target records. All primary source verification was found to be compliant.

**Harmony Trended Results**

Table 6.11 provides the results of **Harmony's** trended performance measures. Only HEDIS measures reported for at least the last two years are included. The last column denotes the difference in the rates between the HEDIS 2008 rate, or the baseline rate, and HEDIS 2011 results.

**Table 6.11—Harmony Trended HEDIS Results**

HEDIS Measures	HEDIS 2008	HEDIS 2009	HEDIS 2010	HEDIS 2011	Difference From Baseline
<i>Childhood Immunizations—Combo 2</i>	53.8%	62.5%	67.4%	65.9%	12.1%
<i>Childhood Immunizations—Combo 3</i>	42.8%	51.6%	60.6%	61.6%	18.8%
<i>Lead Screening in Children</i>	65.9%	69.8%	74.7%	78.1%	12.2%
<i>Well-Child Visits in the First 15 Months (0 Visits)*</i>	9.2%	4.6%	4.1%	5.4%	-3.8%*
<i>Well-Child Visits in the First 15 Months (6+ Visits)</i>	21.7%	40.4%	45.7%	51.3%	29.6%
<i>Well-Child Visits (3–6 Years)</i>	57.4%	65.9%	69.8%	71.8%	14.4%
<i>Adolescent Well Care Visits</i>	37.7%	37.7%	37.2%	38.9%	1.2%
<i>Immunizations for Adolescents (Combined Rate)</i>	NA	NA	23.4%	29.9%	6.5%
<i>Children's Access to PCP (12–24 Months)</i>	82.5%	83.3%	82.2%	86.5%	4.0%
<i>Children's Access to PCP (25 Months–6 Years)</i>	65.7%	70.1%	73.1%	73.3%	7.6%
<i>Children's Access to PCP (7–11 Years)</i>	60.7%	61.6%	69.3%	70.5%	9.8%
<i>Adolescent's Access to PCP (12–19 Years)</i>	58.7%	60.8%	68.6%	71.4%	12.7%
<i>Adults' Access (20–44 Years)</i>	57.5%	66.3%	67.3%	69.3%	11.8%
<i>Adults' Access (45–64 Years)</i>	54.6%	63.3%	67.6%	68.8%	14.2%
<i>Breast Cancer Screening (Combined Rate)</i>	35.5%	32.5%	31.5%	30.7%	-4.8%
<i>Cervical Cancer Screening</i>	59.1%	62.0%	69.3%	69.8%	10.7%

**Table 6.11—Harmony Trended HEDIS Results**

HEDIS Measures	HEDIS 2008	HEDIS 2009	HEDIS 2010	HEDIS 2011	Difference From Baseline
<i>Chlamydia Screening in Women (Combined Rate)</i>	49.3%	48.8%	49.9%	50.9%	1.6%
<i>Frequency of Ongoing Prenatal Care (&lt; 21% Visits)*</i>	21.9%	27.0%	17.8%	16.5%	-5.4%*
<i>Frequency of Ongoing Prenatal Care (81–100% Visits)</i>	31.4%	33.6%	39.4%	39.9%	8.5%
<i>Timeliness of Prenatal Care</i>	56.4%	56.4%	65.2%	64.7%	8.3%
<i>Postpartum Care</i>	35.0%	40.1%	49.6%	48.7%	13.7%
<i>Controlling High Blood Pressure (Combined Rate)</i>	34.3%	39.7%	43.3%	42.6%	8.3%
<i>Diabetes Care (HbA1C Testing)</i>	57.7%	68.1%	67.0%	69.6%	11.9%
<i>Diabetes Care (Good HbA1c Control)</i>	15.6%	24.6%	28.8%	29.4%	13.8%
<i>Diabetes Care (Poor HbA1c Control)*</i>	72.7%	67.3%	64.2%	65.9%	-6.8%*
<i>Diabetes Care (Eye Exam)</i>	9.0%	13.3%	15.0%	18.2%	9.2%
<i>Diabetes Care (LDL-C Screening)</i>	52.3%	58.0%	58.2%	63.7%	11.4%
<i>Diabetes Care (LDL-C Level &lt; 100 mg/dL)</i>	12.4%	17.7%	18.6%	17.5%	5.1%
<i>Diabetes Care (Nephropathy Monitoring)</i>	59.9%	69.9%	68.4%	67.4%	7.5%
<i>Diabetes Care (BP &lt; 140/90)</i>	45.0%	54.0%	51.3%	49.6%	4.6%
<i>Appropriate Medications for Asthma (Combined Rate)</i>	84.1%	86.6%	86.5%	86.0%	1.9%
<i>Follow-up After Hospitalization for Mental Illness—7 Days</i>	20.0%	43.2%	49.2%	42.7%	22.7%
<i>Follow-up After Hospitalization for Mental Illness—30 Days</i>	32.3%	55.6%	58.7%	56.1%	23.8%
* Lower rates indicate better performance for these measures.					

The results show that 32 of the 33 trended measures improved since HEDIS 2008, or the baseline rate; and 15 measures improved by more than 10.0 percentage points. Three measures improved by more than 20.0 percentage points: *Well-Child Visits in the First 15 Months of Life (6+ Visits)* and *Follow-up After Hospitalization for Mental Illness (7-Days and 30-Days)*.

Only the rate for the *Breast Cancer Screening (Combined Rate)* measure declined. The HEDIS 2011 rate represented a 4.8 percentage point decrease since compared to HEDIS 2008.

**Meridian Health Plan (Meridian)**

Due to **Meridian**'s low population size, **Meridian** did not have more than 30 eligible members for many of the reported HEDIS measures for HEDIS 2011, and trending rates across years was not possible. In accordance with NCQA requirements, the rates for these measures are not applicable (NA). Since the enrollment for **Meridian** was expected to still be low, the audited measures required for **Meridian** were changed to the following measures:

- ◆ *Children's and Adolescents' Access to Primary Care Practitioners (PCPs)*
- ◆ *Adults' Access to Preventive/ Ambulatory Care*
- ◆ *Prenatal and Postpartum Care*

**Meridian** also reported on other HEDIS measures that were not validated during the audit, although the processes for collecting and calculating each measure were validated. The rates for these HEDIS measures are included in this report and consist of the following performance measures:

- ◆ *Well-Child Visits (3–6 Years)*
- ◆ *Adolescent Well Care Visits*
- ◆ *Cervical Cancer Screening*
- ◆ *Chlamydia Screening in Women*
- ◆ *Frequency of Ongoing Prenatal Care (0–21 Percent of Visits and 81–100 Percent of Visits)*

In addition, **Meridian** reported all measures using the administrative method. Therefore, an encounter data completeness (between medical record data versus administrative data) was not applicable and was not provided in this report.

**Compliance Audit Results for Meridian**

**Table 6.12—Meridian HEDIS 2011 Compliance Audit Results**

Main Information Systems			Selected 2010 HEDIS Measures
Membership Data	Medical Data	Measure Calculation	All of the selected HEDIS measures received an R audit designation.
Fully Compliant	Fully Compliant	Fully Compliant	

The HEDIS 2011 compliance audit indicated that **Meridian** was in full compliance with the *HEDIS 2010 Technical Specifications* (Table 6.12). Membership data supported all necessary HEDIS calculations, medical data were fully compliant with the audit standards, and measure calculations

resulted in rates that were not significantly biased. Furthermore, all selected HEDIS performance measures attained an R designation.

The rationale for full compliance with membership data, medical data, and measure calculation was based on the findings summarized below for the IS standards. Any deviation from the standards that could bias the final results was identified. Recommendations for improving MCO processes were also identified.

### **IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry**

**Meridian** was compliant with I.S. Standard 1.0 for medical services data. The audit team did not identify any issues with **Meridian**'s claims processing system. As in the previous HEDIS year, **Meridian** used scanning for paper claims that are submitted directly to the plan. A process called vertexing allowed **Meridian** to pend claims for manual inspection, ensuring certain fields are validated prior to adjudication. Additionally, claims were audited by an internal claims inspector daily, and reports were produced specific to Illinois Medicaid; no issues were identified.

### **IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry**

**Meridian** was compliant with I.S. Standard 2.0 for enrollment data. **Meridian** has sufficient processes in place to ensure that enrollment data are complete and accurate. The State submits a file weekly that shows any recent updates, changes, and additions. **Meridian** reconciles any discrepancies with the State both weekly and monthly. **Meridian** also checks for duplicate members weekly and monthly. A review of the duplicated process on-site showed sufficient evidence that **Meridian** does not maintain multiple identification numbers for the same member. No issues were identified with **Meridian**'s enrollment data.

### **IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry**

**Meridian** was compliant with I.S. Standard 3.0 for practitioner data. **Meridian** is able to distinguish between provider types and specialties required for HEDIS reporting. All providers are paid on a fee-for-service basis, so data completion does not appear to be an issue; and **Meridian** reported all measures administratively. There were no issues identified with the provider data.

### **IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight**

**Meridian** reported all the measures under the scope of the audit via the administrative methodology; therefore, no medical record review was required.

### IS 5.0—Supplemental Data—Capture, Transfer, and Entry

**Meridian** was compliant with I.S. Standard 5.0 for supplemental data. **Meridian** used supplemental data for several measures: *Timeliness of Prenatal Care*, *Postpartum Care*, and *Childhood Immunization Status*. The supplemental data collected for *Timeliness of Prenatal Care* and *Postpartum Care* were limited to lab data results; therefore, very little supplemental data contributed to the final rate. Since the CIS measure was not under the scope of the audit for **Meridian** this year, the audit team did not perform primary source verification for that measure.

### IS 6.0—Member Call Center Data—Capture, Transfer, and Entry

Member call center data were not applicable to the scope of this audit.

### IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

**Meridian** was compliant with I.S. Standard 7.0 for data integration. The audit team conducted primary source verification of all measures under the scope of the audit and found no issues. **Meridian** has sufficient processes in place to ensure that data were accurate, could be reproduced, and were securely stored. The source code was approved, and primary source validation did not identify any issues. All rates were produced via the administrative only process (i.e., no medical record data were used), and **Meridian** was able to report all measures.



**Meridian Health Plan**

The Medicaid HEDIS 2011 rates for **Meridian** and the national Medicaid 2010 HEDIS 50th percentiles are presented in Table 6.13. As a visual aid for quick reference, numbers highlighted in yellow indicate the rates that were at or above the 50th percentile.

**Table 6.13—Meridian HEDIS 2011 Rates**

HEDIS Measures	Meridian		2010 HEDIS 50th Percentiles
	N	Rate	
<b>Children’s and Adolescents’ Access to PCPs</b>			
<i>Well-Child Visits (3–6 Years)</i>	80	85.0%	71.8%
<i>Adolescent Well-Care Visits</i>	62	71.0%	46.8%
<i>12–24 Months</i>	78	100.0%	96.8%
<i>25 Months–6 Years</i>	101	92.1%	89.8%
<i>7–11 Years</i>	6	NA	91.3%
<i>12–19 Years</i>	15	NA	88.9%
<b>Adults’ Access to Preventive/Ambulatory Care</b>			
<i>20–44 Years of Age</i>	148	90.5%	82.9%
<i>45–64 Years of Age</i>	20	NA	88.1%
<b>Preventive Screening for Women</b>			
<i>Cervical Cancer Screening</i>	99	87.5%	67.8%
<i>Chlamydia Screening in Women (Combined Rate)</i>	33	60.6%	55.7%
<b>Maternity-Related Measures</b>			
<i>Frequency of Ongoing Prenatal Care (&lt; 21% Visits)*</i>	55	1.8%	7.0%
<i>Frequency of Ongoing Prenatal Care (81–100% Visits)</i>	55	96.4%	64.2%
<i>Timeliness of Prenatal Care</i>	55	98.2%	86.0%
<i>Postpartum Care</i>	55	85.5%	65.5%

All of **Meridian’s** reported rates were above the 50th percentiles. Three rates had fewer than 30 eligible cases in the denominator; therefore, in accordance with NCQA requirements, the rates for these measures were reported as not applicable (NA).

## Plan Comparisons

This section of the report compares the performance measure results for **FHN**, **Harmony**, and **Meridian** based on the HEDIS 2011 measures listed in Table 6.14. The measures have been classified into related categories for discussion purposes.

**Table 6.14—Classification of HEDIS 2011 Measures**

Category	HEDIS 2011 Measure
Child and Adolescent Care	<i>Childhood Immunization Status (Combinations 2 and 3)</i>
	<i>Lead Screening in Children</i>
	<i>Well-Child Visits in the First 15 Months of Life (0 Visits and 6+ Visits)</i>
	<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>
	<i>Adolescent Well-Care Visits</i>
	<i>Immunizations for Adolescents (Combined Rate)</i>
Access to Care	<i>Children’s and Adolescents’ Access to Primary Care Practitioners</i>
	<i>Adults’ Access to Preventive/Ambulatory Care</i>
Maternity-Related Care	<i>Frequency of Ongoing Prenatal Care (0–21 Percent of Visits and 81–100 Percent of Visits)</i>
	<i>Timeliness of Prenatal Care</i>
	<i>Postpartum Care</i>
Preventive Screening for Women	<i>Breast Cancer Screening</i>
	<i>Cervical Cancer Screening</i>
	<i>Chlamydia Screening in Women (Combined Rate)</i>
Chronic Conditions/Disease Management	<i>Controlling High Blood Pressure (Combined Rate)</i>
	<i>Comprehensive Diabetes Care</i>
	<i>Use of Appropriate Medications for People With Asthma (Combined Rate)</i>
	<i>Follow-up After Hospitalization for Mental Illness (7-Days and 30-Days)</i>

Due to **Meridian**’s low population size, **Meridian** only reported the following measures: *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, *Adolescent Well-Care Visits*, *Children’s and Adolescents’ Access to Primary Care Practitioners*, *Adults’ Access to Preventive/Ambulatory Care*, *Cervical Cancer Screening*, *Chlamydia Screening in Women (Combined Rate)*, *Frequency of Ongoing Prenatal Care (0–21 Percent of Visits and 81–100 Percent of Visits)*, *Timeliness of Prenatal Care*, and *Postpartum Care*.

For most measures, comparisons to **FHN** and **Harmony** were not applicable. **Meridian** was, however, included in the graphs for the reported measures; but comparisons should be used cautiously due to the small denominators for **Meridian**.

### Child and Adolescent Care

This section addresses HEDIS measures regarding care for children and adolescents. The HEDIS measures were: Childhood Immunization Status; Lead Screening in Children; Well-Child Visits in the First 15 Months of Life; Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life; Adolescent Well-Care Visits; and Immunizations for Adolescents.

#### Childhood Immunization Status

Figure 6.1 displays comparative rates for *Childhood Immunizations—Combination 2* (i.e., diphtheria, tetanus toxoids, and acellular pertussis/diphtheria-tetanus toxoid [DTaP/DT]; inactivated poliovirus vaccine [IPV]; measles-mumps-rubella [MMR]; Haemophilus influenzae type b [HIB]; hepatitis B [Hep B]; and varicella-zoster virus [VZV]) for the past four years.

Overall, **FHN** has improved from 6.8 percentage points from HEDIS 2008 to HEDIS 2011, and **FHN**'s rate was 0.9 percentage points below the National Medicaid HEDIS 2010 50th percentile of 76.6 percent. **Harmony**'s rate increased 12.1 percentage points from HEDIS 2008 to HEDIS 2011. Although the rate for **Harmony** has shown more improvement over time, the rate has been lower than **FHN**'s rate each year and is more than 10 percentage points below the 50th percentile.

**Figure 6.1—Comparison of HFS MCO Performance for Childhood Immunizations—Combination 2**

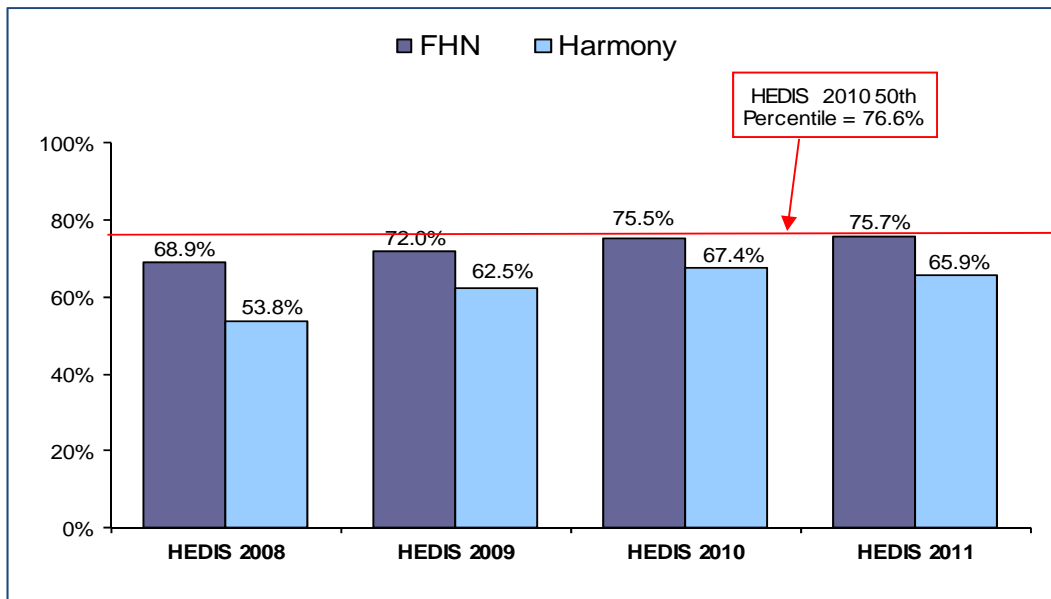
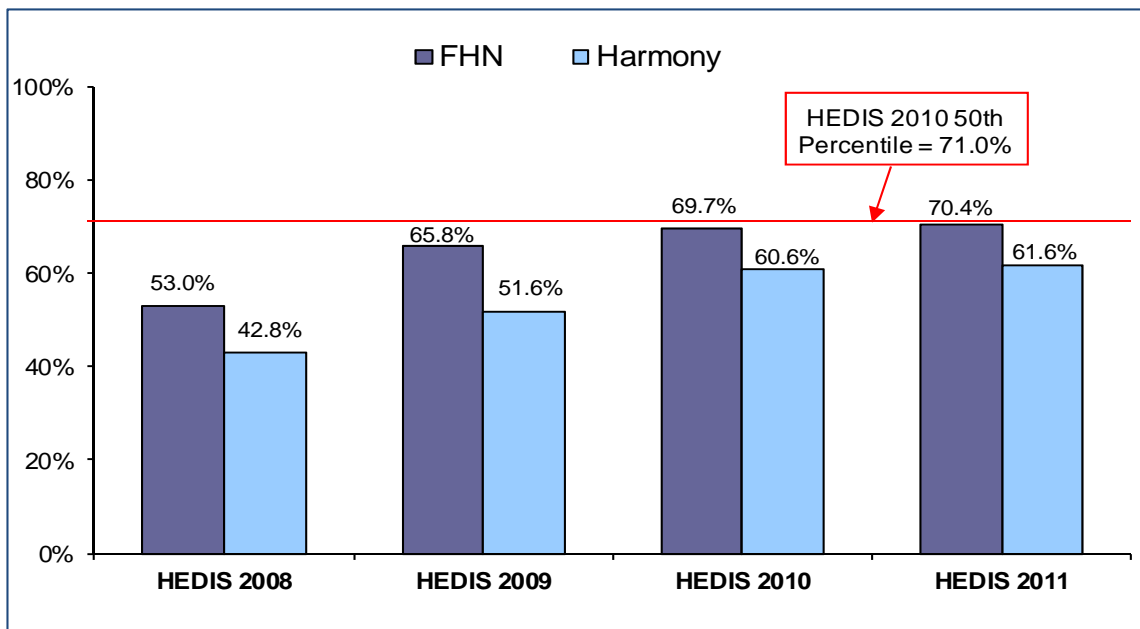


Figure 6.2 displays comparative rates for *Childhood Immunizations—Combination 3* (i.e., DTaP/DT, IPV, MMR, Hib, Hep B, VZV, and pneumococcal conjugate vaccine [PCV]).

FHN's rate of 70.4 percent for HEDIS 2011 was 0.6 percentage points below the National Medicaid HEDIS 2010 50th percentile of 71.0 percent, an improvement of 17.4 percentage points since HEDIS 2008. The rate for **Harmony** demonstrated similar improvement, increasing from 42.8 percent to 61.6 percent, an 18.8 percentage point improvement since HEDIS 2008.

**Figure 6.2—Comparison of HFS MCO Performance for *Childhood Immunizations—Combination 3***

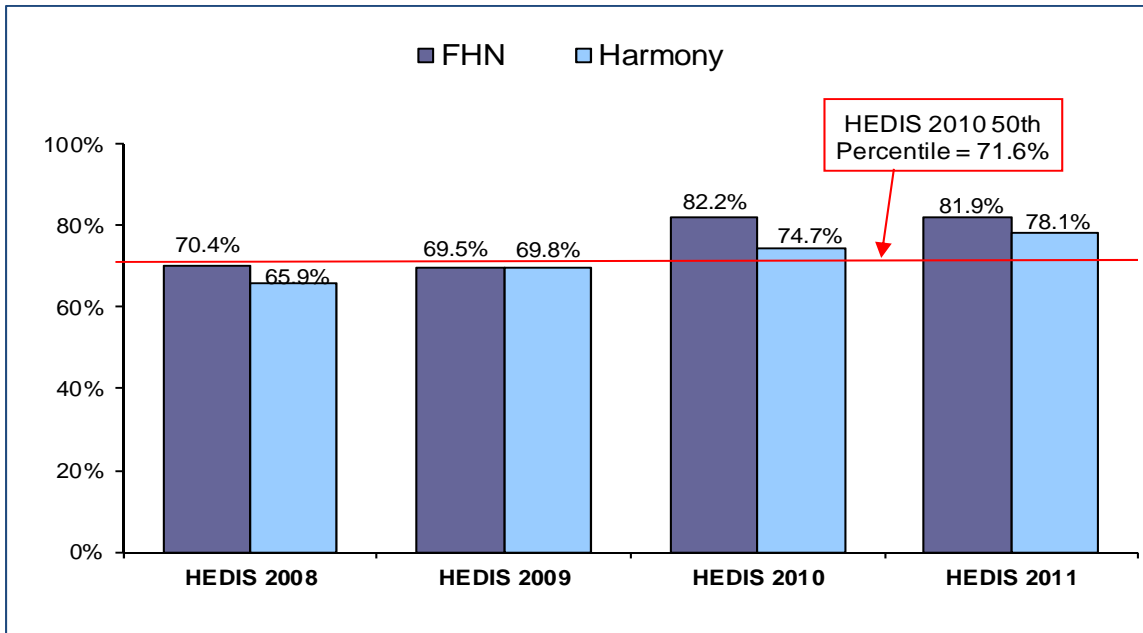


### Lead Screening in Children

Figure 6.3 presents the comparative performance of the MCOs for *Lead Screening in Children*. This became a new HEDIS measure in 2008.

Both MCOs have continued to demonstrate good results for this measure. The rates for both MCOs exceeded the National Medicaid HEDIS 2010 50th percentile of 71.6 percent. This is the second year in a row that both MCOs exceeded the 50th percentile. Overall, **FHN** has improved 11.5 percentage points since HEDIS 2008, while **Harmony** has improved by 12.2 percentage points.

**Figure 6.3—Comparison of HFS MCO Performance for Lead Screening in Children**

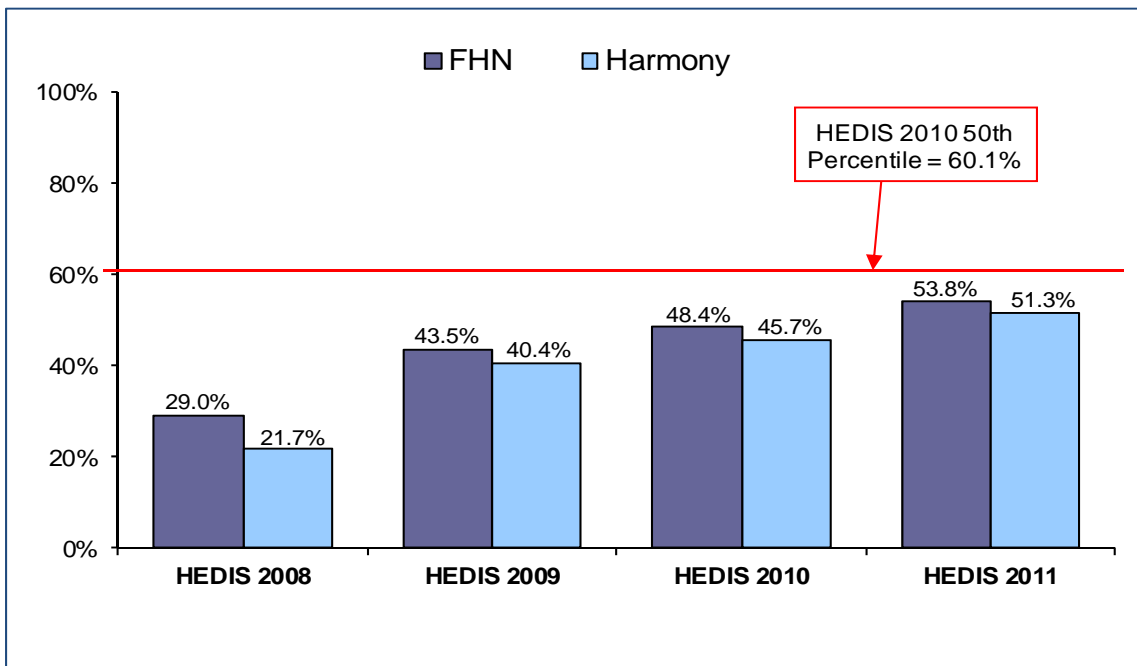


### Well-Child Visits in the First 15 Months of Life

Figure 6.4 presents the comparative performance of the MCOs for *Well-Child Visits in the First 15 Months of Life—Six or More Visits*. Neither MCO achieved a rate above the national HEDIS 2009 Medicaid 50th percentile of 60.6 percent.

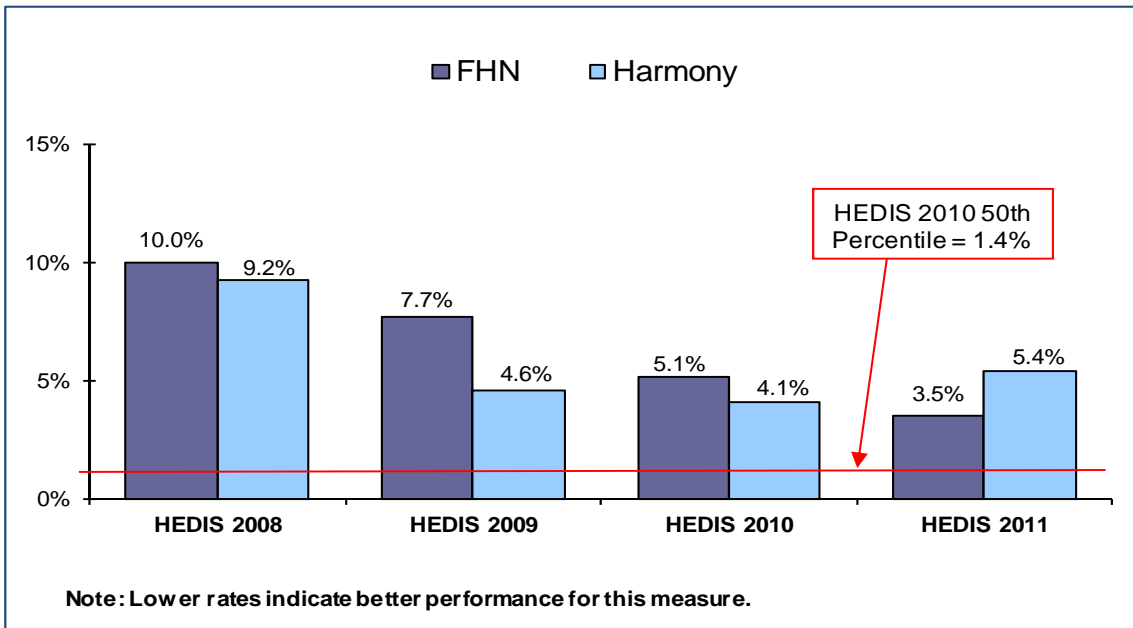
Since HEDIS 2008, **FHN**'s rate has improved by 24.8 percentage points, while **Harmony**'s rate has improved by 29.6 percentage points. Despite the improvements, the rates for both MCOs are well below the National Medicaid HEDIS 2010 50th percentile of 60.1 percent.

**Figure 6.4—Comparison of HFS MCO Performance for Well-Child Visits During the First 15 Months of Life—Six or More Visits**



For the *Zero Visits* numerator, lower rates indicate better performance. **FHN** has continued to improve on this measure each year. Overall, **FHN** has improved by 6.5 percentage points since HEDIS 2008. **Harmony**'s rate for this year was slightly higher than last year, but the overall trend has improved, going from 9.2 percent in 2008 to 5.4 percent in 2011. These results indicate that approximately 95.0 percent of the eligible children receive at least one well-child visit in their first 15 months of life.

**Figure 6.5—Comparison of HFS MCO Performance for Well-Child Visits During the First 15 Months of Life—Zero Visits**



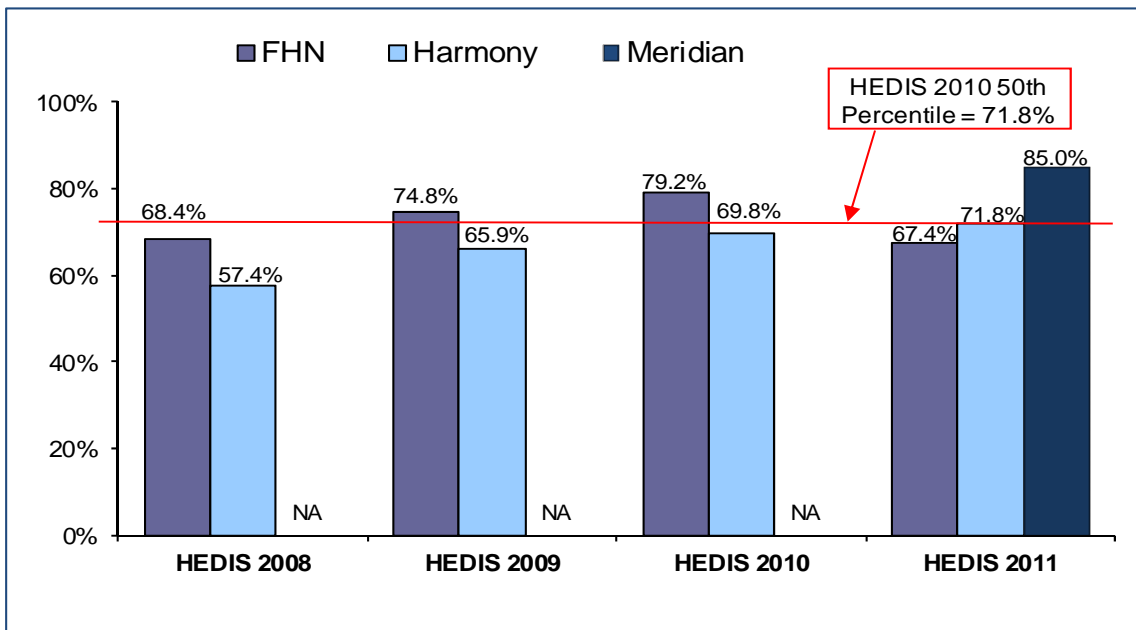
### Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life

Figure 6.6 presents the comparative rates for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life*. This was the first year for reporting an actual rate for **Meridian**. However, **Meridian**'s rate of 85.0 percent was based on just 80 eligible cases; therefore, caution should be used when comparing **Meridian** to the other two health plans.

Since HEDIS 2008, the rate for **FHN** has declined from 68.4 percent to 67.4 percent, or a loss of one percentage point over the four-year period. By contrast, the rate for **Harmony** improved by 14.4 percentage points, increasing from 57.4 percent to 71.8 percent for HEDIS 2011.

**Harmony**'s rate for this year matched the National Medicaid HEDIS 2010 50th percentile of 71.8 percent.

**Figure 6.6—Comparison of HFS MCO Performance for Well-Child Visits During the Third, Fourth, Fifth, and Sixth Year of Life**



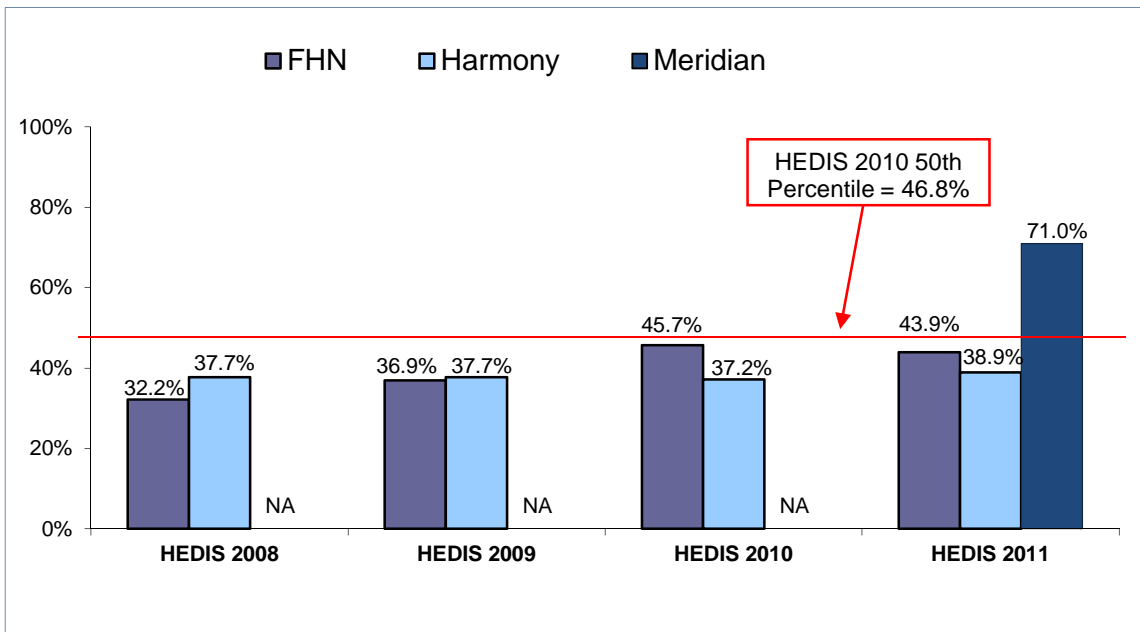


### Adolescent Well-Care Visits

Figure 6.7 presents the comparative rates for *Adolescent Well-Care Visits*. This was the first year for reporting an actual rate for **Meridian**. However, **Meridian**'s rate of 71.0 percent was based on just 62 eligible cases; therefore, caution should be used when comparing **Meridian** to the other two health plans.

Although **FHN**'s rate for this year declined compared to last year, the overall trend has shown an improvement of 11.7 percentage points between HEDIS 2008 and HEDIS 2011. **Harmony**'s rate has shown a minimal improvement of 1.2 percentage points, going from 37.7 percent for HEDIS 2008 to 38.9 percent for HEDIS 2011. Neither of the MCOs exceeded the National Medicaid HEDIS 2010 50th percentile of 46.8 percent for HEDIS 2011.

**Figure 6.7—Comparison of HFS MCO Performance for Adolescent Well-Care Visits**



### Access to Care

This section addresses HEDIS measures regarding access to care. The HEDIS measures were: *Children’s and Adolescents’ Access to Primary Care Practitioners (PCPs)*, and *Adults’ Access to Preventive/Ambulatory Care (20–44 Years of Age and 45–64 Years of Age)*.

#### Children’s and Adolescents’ Access to PCPs

Figure 6.8 presents the comparative rates for *Children’s and Adolescents’ Access to Primary Care Practitioners (12–24 Months)*. **FHN** and **Harmony** first reported this measure beginning with HEDIS 2008. This was the first year for reporting an actual rate for **Meridian**. However, **Meridian’s** rate of 100.0 percent was based on just 78 eligible cases; therefore, caution should be used when comparing **Meridian** to the other two health plans.

Overall, the rate for **FHN** has improved by 4.9 percentage points. Similarly, the rate for **Harmony** has improved by 4.0 percentage points. The rates for both MCOs remained well below the National Medicaid HEDIS 2010 50th percentile of 96.8 percent.

**Figure 6.8—Comparison of HFS MCO Performance for Children’s and Adolescents’ Access to PCPs (12–24 Months)**

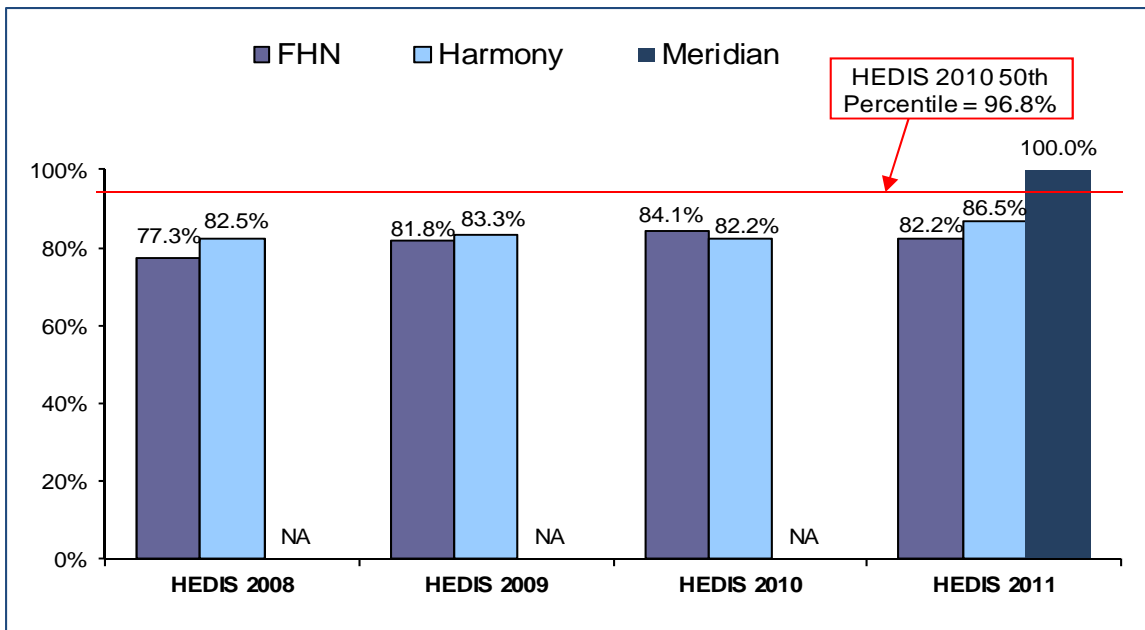


Figure 6.9 presents the comparative rates for *Children’s and Adolescents’ Access to Primary Care Practitioners (25 Months–6 Years)*. **FHN** and **Harmony** first reported this measure beginning with HEDIS 2008. This was the first year for reporting an actual rate for **Meridian**. However, **Meridian’s** rate of 92.1 percent was based on 101 eligible cases; therefore, caution should be used when comparing **Meridian** to the other two health plans.

Overall, the rate for **FHN** has improved by 4.7 percentage points, while the rate for **Harmony** has improved 7.6 percentage points since HEDIS 2008. The rates for both MCOs remained well below the National Medicaid HEDIS 2010 50th percentile of 89.8 percent.

**Figure 6.9—Comparison of HFS MCO Performance for Children’s and Adolescents’ Access to PCPs (25 Months–6 Years)**

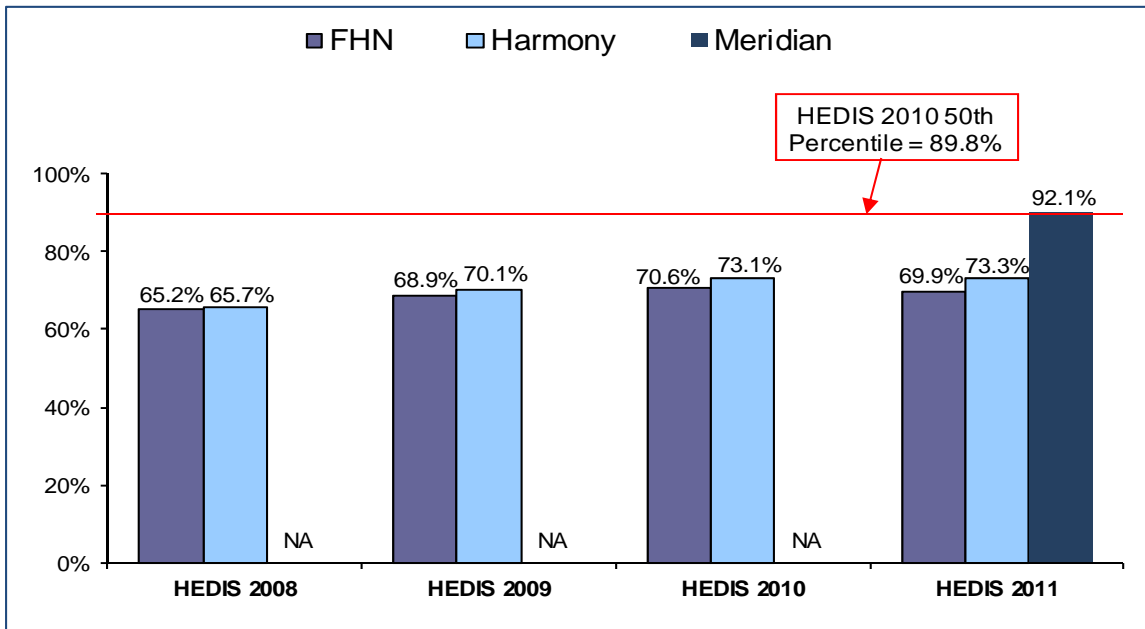


Figure 6.10 presents the comparative rates for *Children’s and Adolescents’ Access to Primary Care Practitioners (7–11 Years)*. The MCOs first reported this measure for HEDIS 2008. **Meridian** had less than 30 eligible cases for this measure; and in accordance with NCQA requirements, the rate was reported as NA and is not shown in the figure below.

The rate for **FHN** has declined 1.3 percentage points for this measure compared to the rate reported for HEDIS 2008, and **FHN** was 40.2 percentage points below the National Medicaid HEDIS 2010 50th percentile of 91.3 percent. By contrast, the rate for **Harmony** improved 9.8 percentage points above the baseline rate of 60.7 percent and has consistently outperformed **FHN**.

**Figure 6.10—Comparison of HFS MCO Performance for Children’s and Adolescents’ Access to PCPs (7–11 Years)**

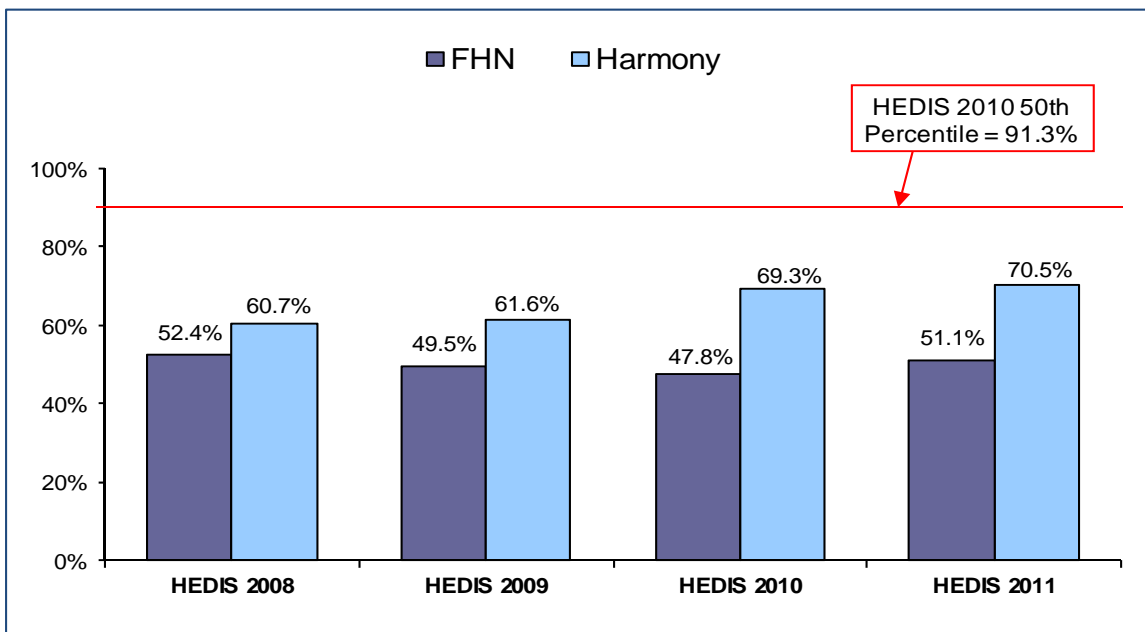
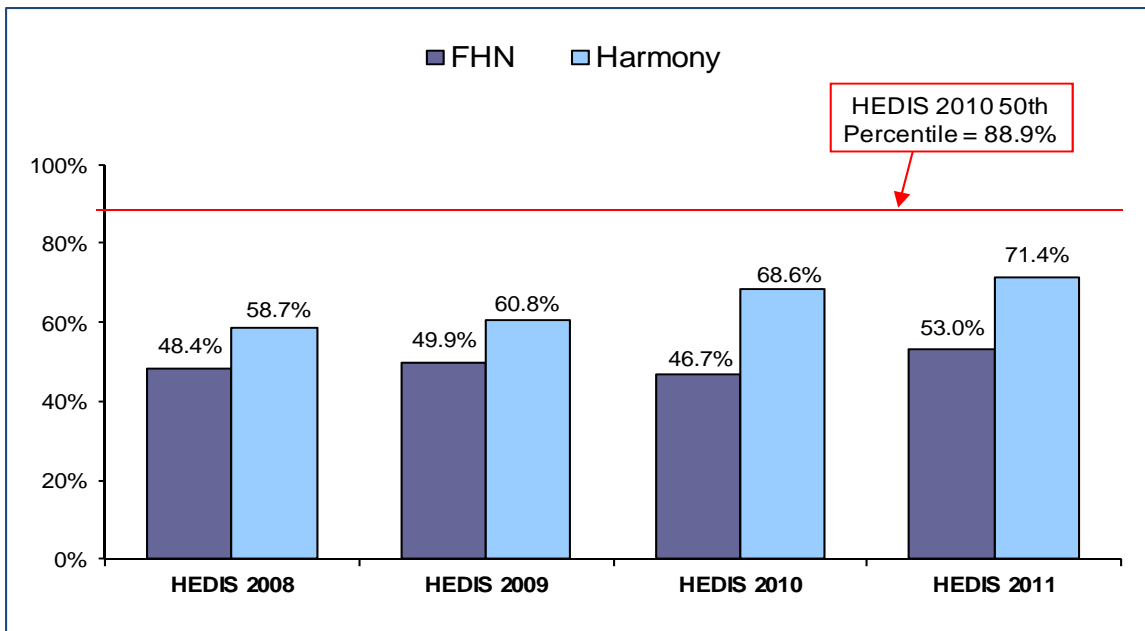


Figure 6.11 presents the comparative rates for *Children’s and Adolescents’ Access to PCPs (12–19 Years)*. The MCOs first reported this measure for HEDIS 2008. **Meridian** had less than 30 eligible cases for this measure; and in accordance with NCQA requirements, the rate was reported as NA and is not shown in the figure below.

**FHN**’s rate improved from 48.4 percent for HEDIS 2008 to 53.0 percent for HEDIS 2011. The rate for **Harmony** showed a consistent upward trend, going from 58.7 percent for HEDIS 2008 to 71.4 percent for HEDIS 2011, or a gain of 12.7 percentage points. In addition, **Harmony** has consistently outperformed **FHN** each year. However, the rates for both MCOs remained well below the National Medicaid HEDIS 2010 50th percentile of 88.9 percent.

**Figure 6.11—Comparison of HFS MCO Performance for Children’s and Adolescents’ Access to PCPs (12–19 Years)**



**Adults’ Access to Preventive/Ambulatory Care**

Figure 6.12 presents the comparative rates for *Adults’ Access to Preventive/Ambulatory Care (Ages 20–44)*. This was the first year for reporting an actual rate for **Meridian**. However, **Meridian’s** rate of 90.5 percent was based on 148 eligible cases; therefore, caution should be used when comparing **Meridian** to the other two health plans.

Overall, the rate for **FHN** has improved 8.0 percentage points from the rate of 56.6 percent reported for HEDIS 2008. **Harmony’s** rate has improved by 11.8 percentage points. **Harmony** has consistently outperformed **FHN** each year. The rates for both MCOs, however, were well below the National Medicaid HEDIS 2010 50th percentile of 82.9 percent.

**Figure 6.12—Comparison of HFS MCO Performance for Adults’ Access to Preventive/Ambulatory Care (Ages 20–44)**

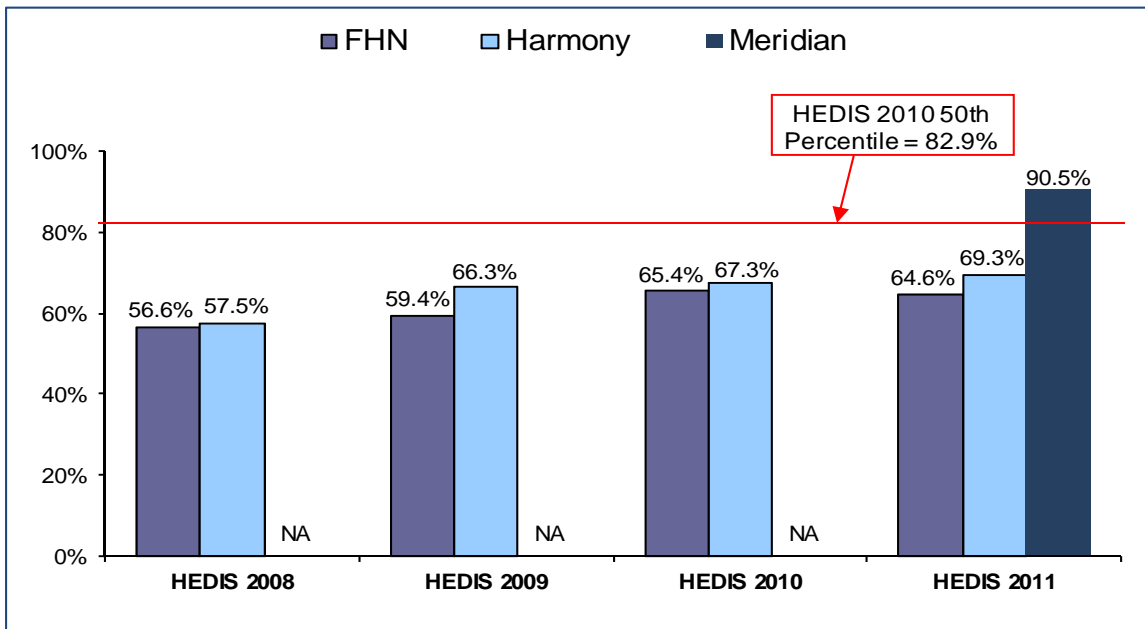
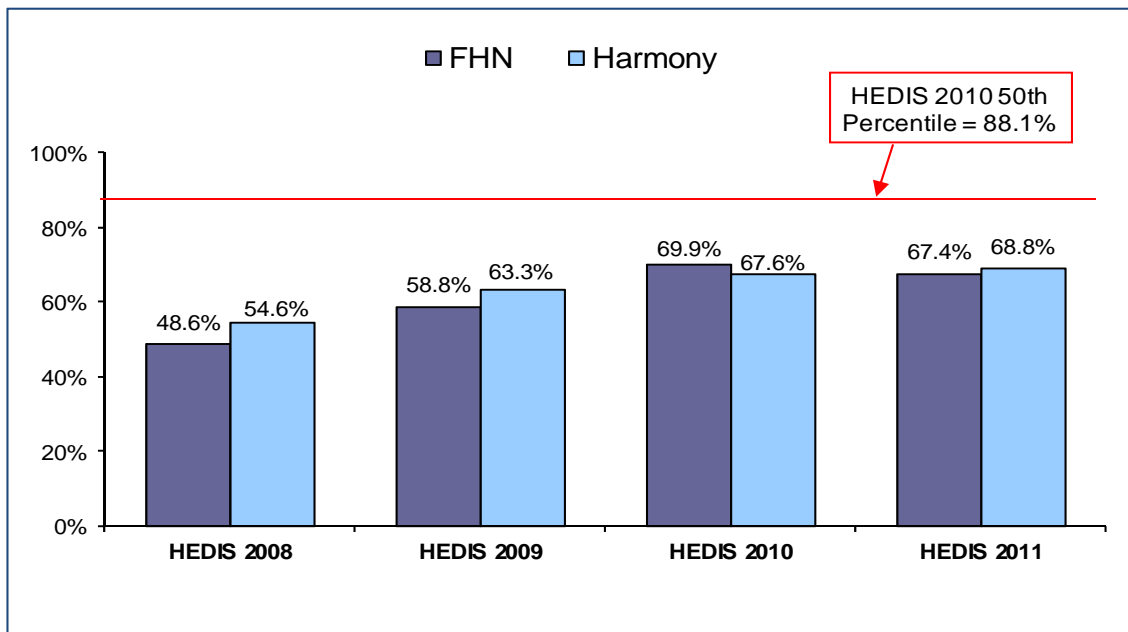


Figure 6.13 presents the comparative rates for *Adults' Access to Preventive/Ambulatory Care (Ages 45–64)*. **Meridian** had less than 30 eligible cases for this measure; and in accordance with NCQA, the rate was reported as NA and is not shown in the figure below.

Although the rate for **FHN** had a slight decrease from last year, the trend since HEDIS 2008 has shown improvement, with an overall increase of 18.8 percentage points. The rate for **Harmony** improved 14.2 percentage points and was 1.4 percentage points above **FHN**'s rate. Both rates remain below the National Medicaid 50th percentile of 88.1 percent.

**Figure 6.13—Comparison of HFS MCO Performance for Adults' Access to Preventive/Ambulatory Care (Ages 45–64)**



The rates for measures related to access continued to improve, but they still remain low and below the national 50th percentiles. This indicates that both **FHN** and **Harmony** need to improve access to care. This finding was mentioned in last year's annual report, and the recommendation remains the same: both **FHN** and **Harmony** should examine their network provider coverage along with potential access-to-care barriers and evaluate internal policies regarding member and provider education. Encounter data submission is another potential barrier that should be addressed.

### Preventive Screenings for Women

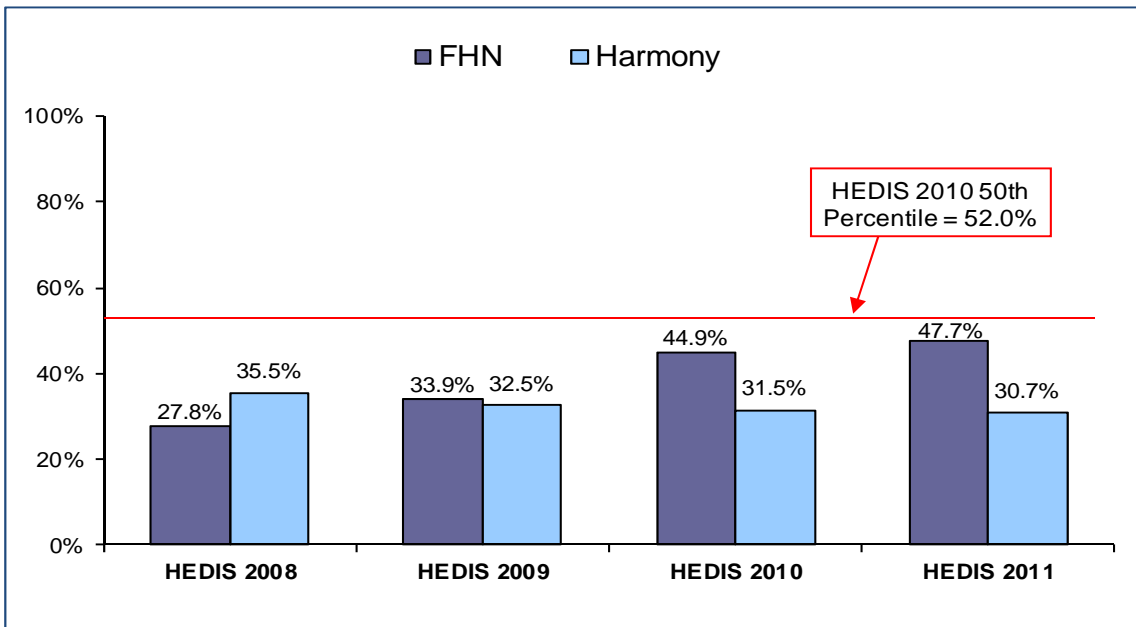
This section addresses HEDIS measures regarding preventive screenings for women. The HEDIS measures were *Breast Cancer Screening*, *Cervical Cancer Screening*, and *Chlamydia Screening in Women*.

### Breast Cancer Screening

Figure 6.14 compares the *Breast Cancer Screening* rates for women enrolled in **FHN** or **Harmony**.

The rate for **FHN** improved 19.9 percentage points since HEDIS 2008 and has continued to improve each year. For HEDIS 2008, **FHN**'s rate was lower than **Harmony**'s rate, but **FHN** surpassed **Harmony** in 2009 and has continued to demonstrate good improvement each year. By contrast, the rate for **Harmony** has continued to decrease each year, with an overall decline of 4.8 percentage points since HEDIS 2008.

**Figure 6.14—Comparison of HFS MCO Performance for Breast Cancer Screening (Combined Rate)**



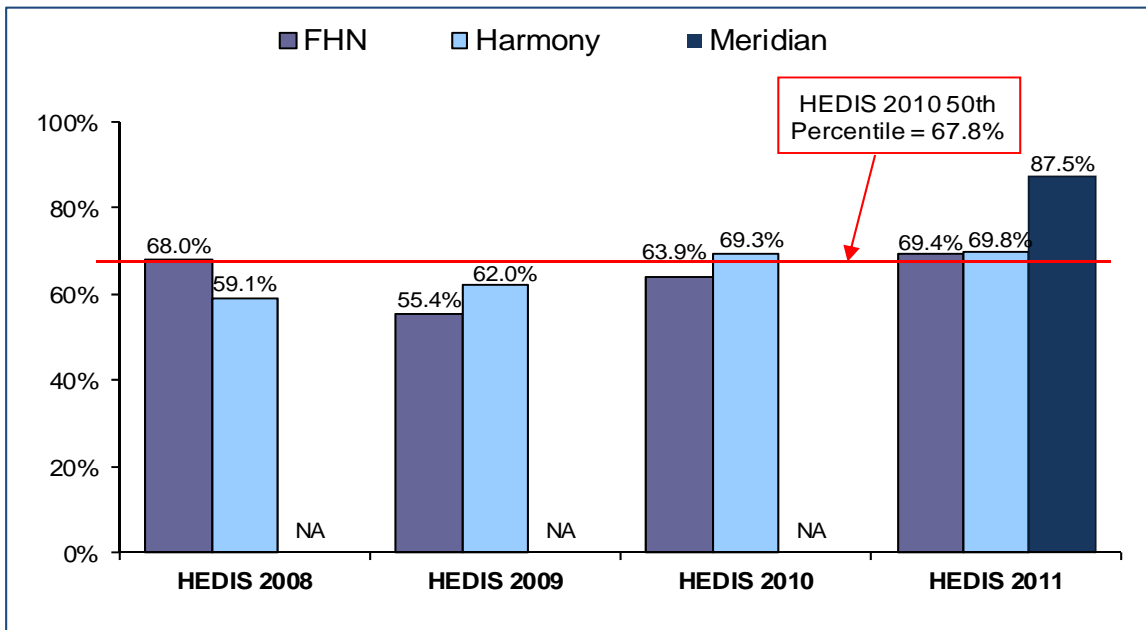


### Cervical Cancer Screening

The rates for *Cervical Cancer Screening* are displayed in Figure 6.15. This was the first year for reporting an actual rate for **Meridian**. However, **Meridian**'s rate of 87.5 percent was based on 99 eligible cases; therefore, caution should be used when comparing **Meridian** to the other two health plans.

The rate for **FHN** has only improved by 1.4 percentage points since HEDIS 2008, but the reported rate of 69.4 percent was above the National HEDIS 2010 Medicaid 50th percentile of 67.8 percent. The rate for **Harmony** improved 10.7 percentage points since HEDIS 2008 and also exceeded the National HEDIS Medicaid 50th percentile.

**Figure 6.15—Comparison of HFS MCO Performance for Cervical Cancer Screening**

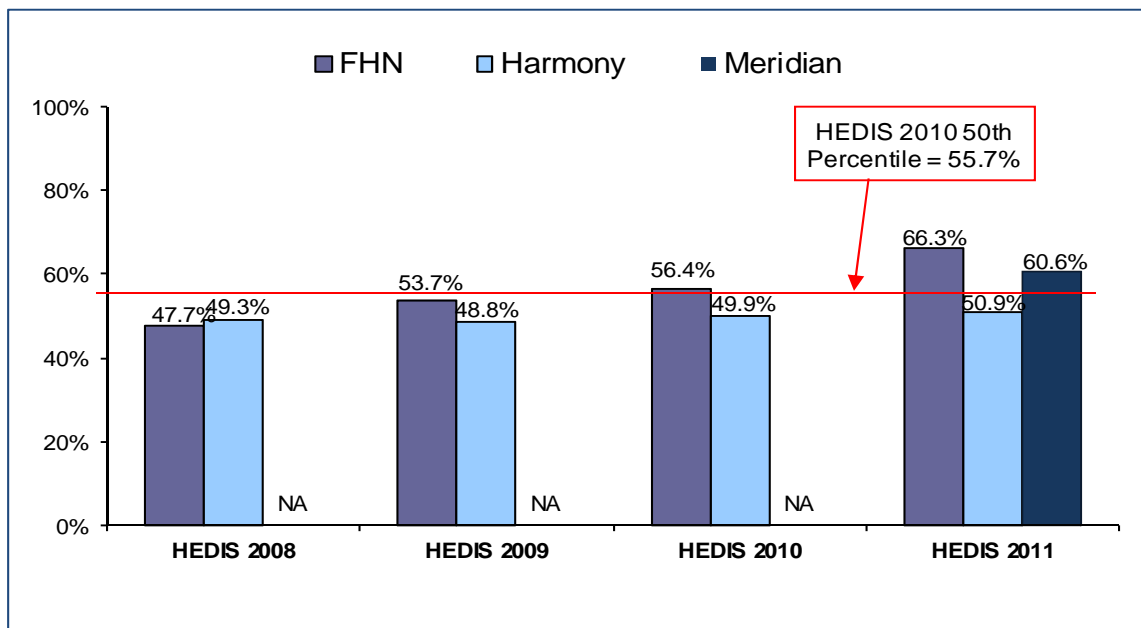


### Chlamydia Screening in Women

Figure 6.16 presents the comparative rates for *Chlamydia Screening in Women*. This was the first year for reporting an actual rate for **Meridian**. However, **Meridian**'s rate of 60.6 percent was based on 33 eligible cases; therefore, caution should be used when comparing **Meridian** to the other two health plans.

**FHN**'s rate of 66.3 percent exceeded the National Medicaid 50th percentile of 55.7 percent and demonstrated an improvement of 18.6 percentage points from HEDIS 2008. **Harmony**'s rate has remained fairly constant each year; the rate has improved just 1.6 percentage points since HEDIS 2008 and remains below the 50th percentile.

**Figure 6.16—Comparison of HFS MCO Performance for *Chlamydia Screening in Women (Combined Rate)***



**Maternity-Related Care**

This section addresses HEDIS measures related to maternity care. The HEDIS measures were *Frequency of Ongoing Prenatal Care*, *Timeliness of Prenatal Care*, and *Postpartum Care*.

**Frequency of Ongoing Prenatal Care**

Figure 6.17 presents the comparative rates for *Frequency of Ongoing Prenatal Care (0–21 Percent of Visits)*. Lower rates are better for this measure since this measure evaluates the percentage of women who received 0–21 percent of their total recommended prenatal care visits. This was the first year for reporting an actual rate for **Meridian**. However, **Meridian**'s rate of 1.8 percent was based on 55 eligible cases; therefore, caution should be used when comparing **Meridian** to the other two health plans.

Both MCOs have demonstrated improvement with this measure since HEDIS 2008, but they still reported rates above the National Medicaid HEDIS 2010 50th percentile of 7.0 percent. **FHN** improved by 11.2 percentage points since HEDIS 2008 but had a slight increase of 1.3 percentage points over last year. **Harmony**'s rate has improved by 5.4 percentage points since HEDIS 2008 and continued the downward trend with a slight, 1.3 percentage point improvement over last year. These trended improvements may be related to the current performance improvement project (PIP) that the MCOs have been conducting.

**Figure 6.17—Comparison of HFS MCO Performance for Frequency of Ongoing Prenatal Care (0–21 Percent of Visits)**

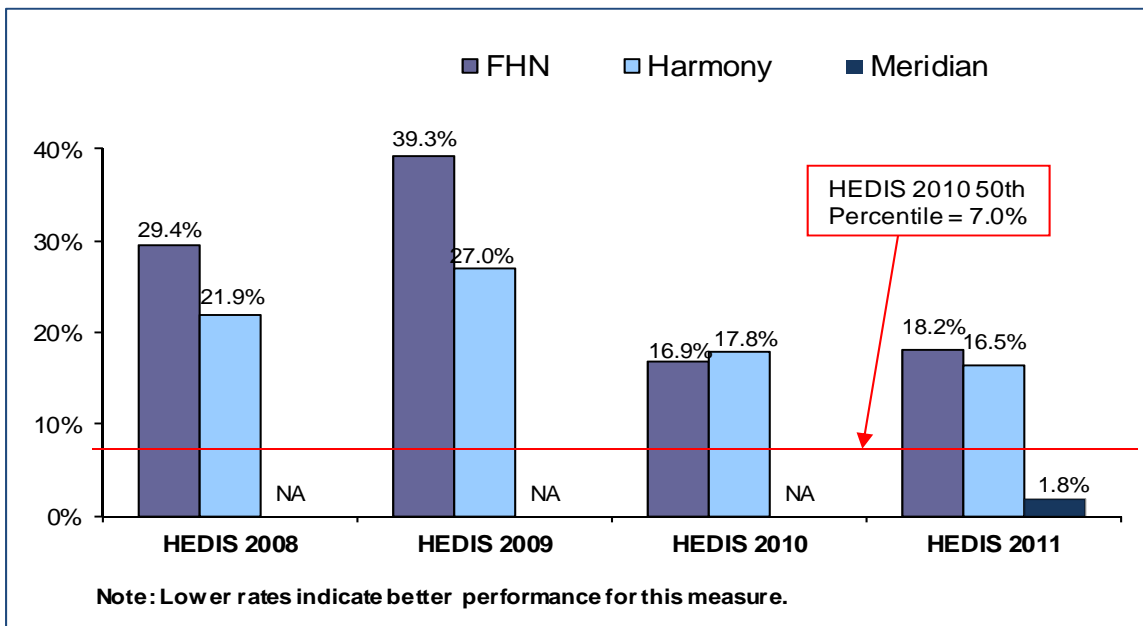
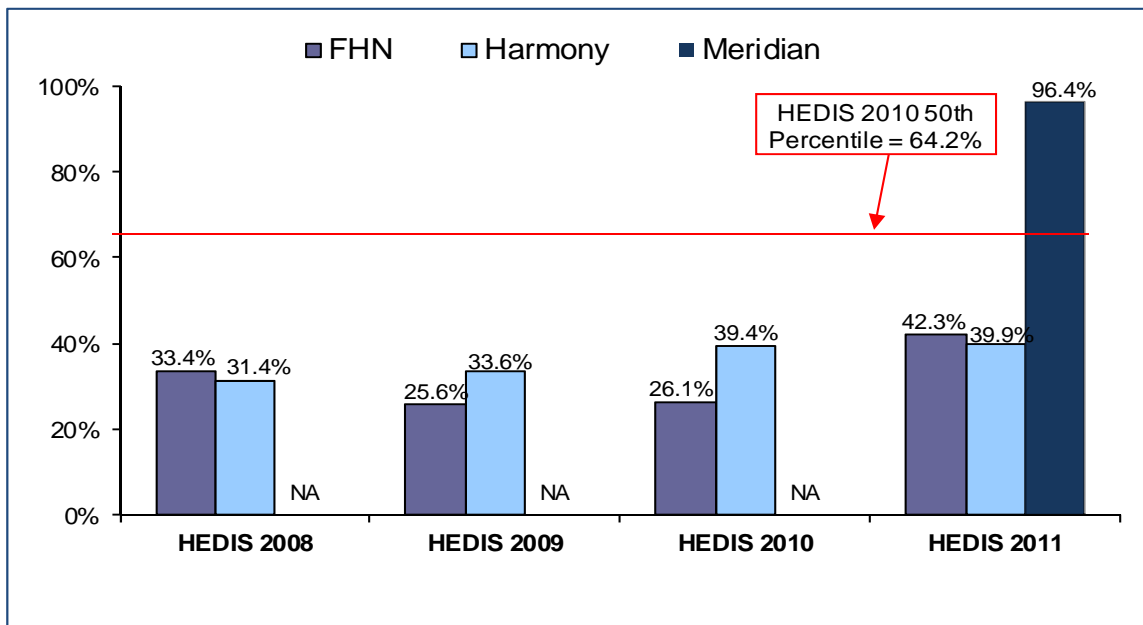


Figure 6.18 presents the comparative rates for *Frequency of Ongoing Prenatal Care (81–100 Percent of Visits)*. In contrast to the previous measure (0–21 percent of visits), higher rates are better for this measure. This was the first year for reporting an actual rate for **Meridian**. However, **Meridian**'s rate of 96.4 percent was based on 55 eligible cases; therefore, caution should be used when comparing **Meridian** to the other two health plans.

The HEDIS rates for **FHN** have fluctuated, with the rates for HEDIS 2009 and HEDIS 2010 lower than the rate reported for HEDIS 2008. However, **FHN**'s rate for HEDIS 2011 improved 8.9 percentage points from HEDIS 2008 and showed a very good improvement of 16.2 percentage points over last year. By contrast, **Harmony**'s rate has shown steady improvement each year and was 8.5 percentage points higher than HEDIS 2008. The rates for both MCOs were still well below the National Medicaid HEDIS 2010 50th percentile of 64.2 percent.

**Figure 6.18—Comparison of HFS MCO Performance for Frequency of Ongoing Prenatal Care (81–100 Percent of Visits)**



The measures related to access to care in this report tend to have low rates and still indicate potential issues with access. In prior years, there were several potential issues identified as probable causes for the poor rates for these measures: the encounter data may be incomplete, the MCO may have had difficulty identifying pregnant members, there may be a network adequacy issue, there may be issues with member compliance, or any combination of these factors. The MCOs should, at a minimum, conduct a root-cause analysis to determine the reason for low compliance and develop interventions to improve the rates for measures related to access to care.

### Timeliness of Prenatal Care

Figure 6.19 presents the comparative performance of the HFS MCOs for *Timeliness of Prenatal Care*. This was the first year for reporting an actual rate for **Meridian**. However, **Meridian**'s rate of 98.2 percent was based on just 55 eligible cases; therefore, caution should be used when comparing **Meridian** to the other two health plans.

For the first three years, the general trend for **FHN** had been relatively flat, indicating no real improvement. However, **FHN**'s rate improved 13.2 percentage points over last year and has improved 17.0 percentage points since HEDIS 2008.

**Harmony**'s rate has improved by 8.3 percentage points since HEDIS 2008 and had a slight decrease from last year. Nevertheless, **Harmony**'s rate has been consistently higher than **FHN**'s rate each year. Both **FHN** and **Harmony** were well below the National HEDIS 2010 Medicaid 50th percentile of 86.0 percent.

**Figure 6.19—Comparison of HFS MCO Performance for *Timeliness of Prenatal Care***

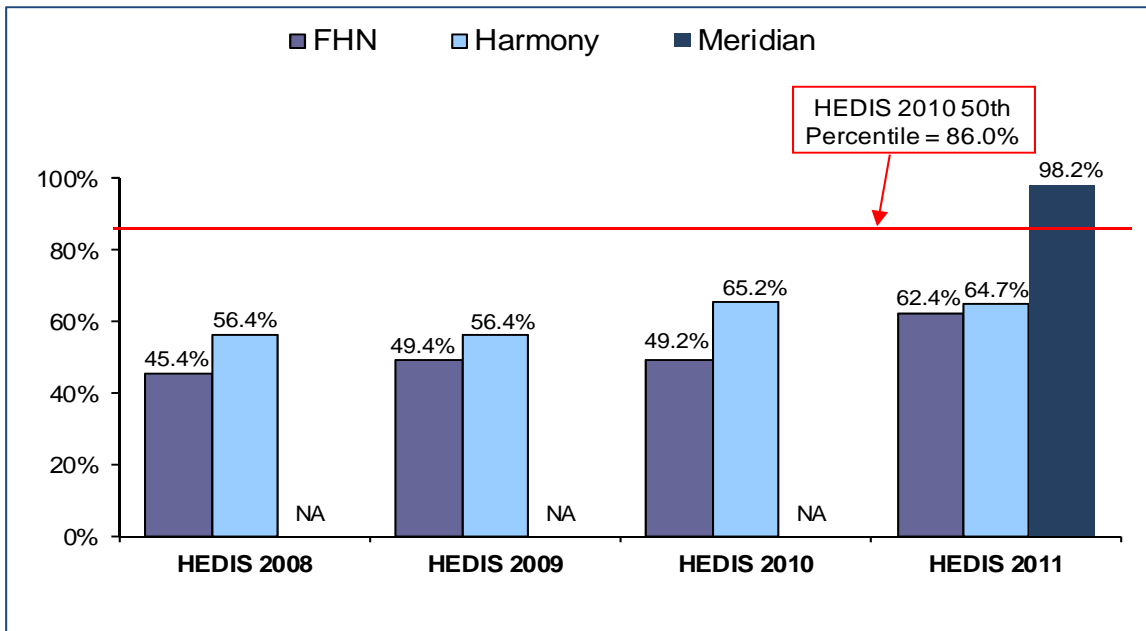
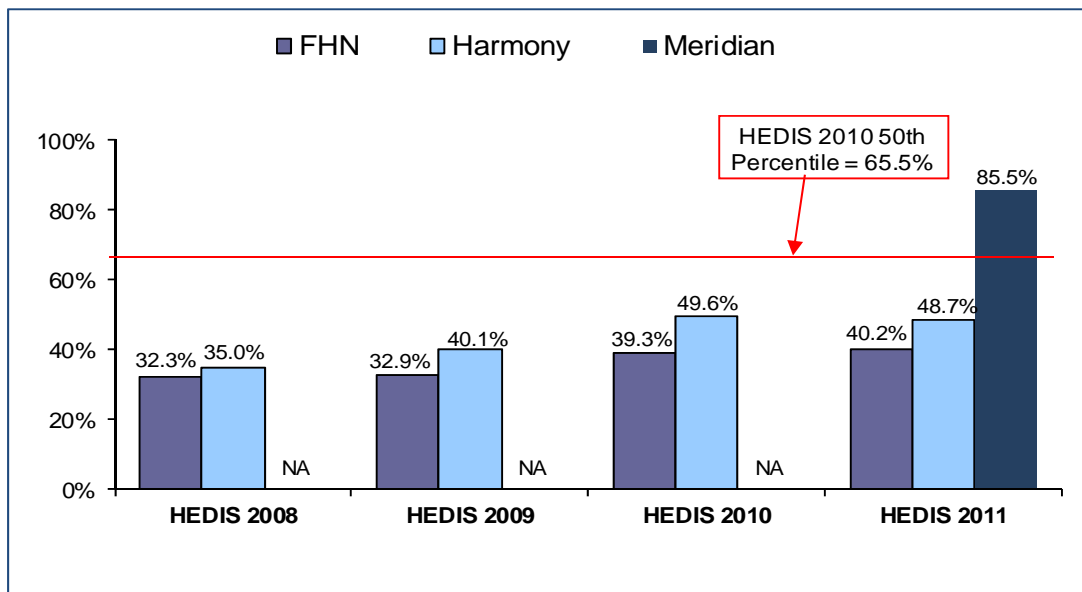


Figure 6.20 presents the comparative performance of the HFS MCOs for the *Postpartum Care* measure. This was the first year for reporting an actual rate for **Meridian**. However, **Meridian**'s rate of 98.2 percent was based on just 55 eligible cases; therefore, caution should be used when comparing **Meridian** to the other two health plans.

**FHN**'s rate increased by 7.9 percentage points since HEDIS 2008, but it only increased by 0.9 percentage points over last year. **Harmony**'s rate increased by 13.7 percentage points since HEDIS 2008 but declined 0.9 percentage points compared to last year. However, **Harmony** has consistently outperformed **FHN** each year. Both **FHN** and **Harmony** were well below the National HEDIS 2010 Medicaid 50th percentile of 65.5 percent.

**Figure 6.20—Comparison of HFS MCO Performance for *Postpartum Care***



As discussed in prior technical reports, both **FHN** and **Harmony** continue to report rates well below the 10th percentile for these maternity-related measures. In response to these low rates, the State and the MCOs began a collaborative perinatal depression screening PIP in 2006–2007. All of these maternity-related measures were included as part of the PIP, as well as several non-HEDIS measures addressing depression and follow-up (for positive depression screening) for these women.

The interventions **FHN** and **Harmony** have implemented were expected to result in higher rates for these HEDIS measures. For most of these measures, the rates improved. **FHN** improved on every measure except *Frequency of Ongoing Prenatal Care (0–21 Percent of Visits)*. However, **Harmony** had only limited success, improving less than 1.5 percentage points for *Frequency of Ongoing Prenatal Care (0–21 Percent of Visits and 81–100 Percent of Visits)*.

### Chronic Conditions/Disease Management

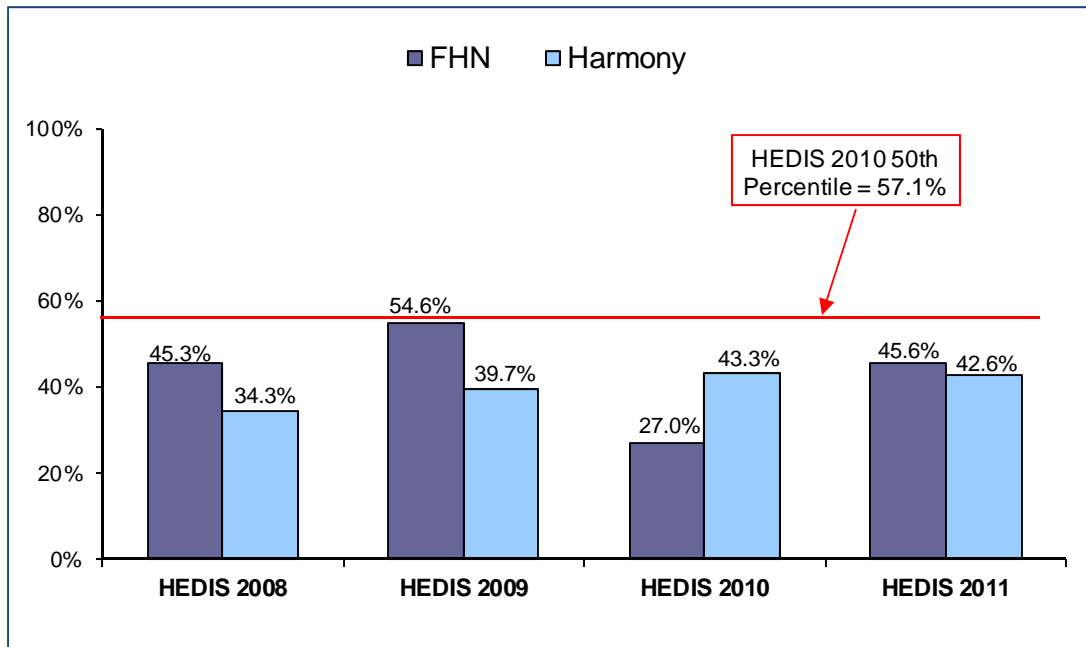
This section addresses HEDIS measures regarding chronic conditions/disease management. The HEDIS measures were *Controlling High Blood Pressure*, *Comprehensive Diabetes Care*, *Use of Appropriate Medications for People With Asthma*, and *Follow-up After Hospitalization for Mental Illness*.

#### Controlling High Blood Pressure

Figure 6.21 presents the comparative rates for *Controlling High Blood Pressure*.

Overall, **FHN**'s rate has increased just 0.3 percentage points since HEDIS 2008. However, this measure has been very unpredictable for **FHN**, with rates drastically increasing and decreasing over the years. By contrast, **Harmony**'s rate has trended upward and was 8.3 percentage points higher for HEDIS 2011 than the rate reported for HEDIS 2008. Neither of the MCOs exceeded the National Medicaid HEDIS 2010 50th percentile of 57.1 percent.

**Figure 6.21—Comparison of HFS MCO Performance for Controlling High Blood Pressure (Combined Rate)**



### Comprehensive Diabetes Care

Figure 6.22 through Figure 6.29 show comparisons for the *Comprehensive Diabetes Care* performance measures: *HbA1c Testing*, *Good HbA1c Control*, *Poor HbA1c Control*, *Eye Exam*, *LDL-C Screening*, *LDL-C Level < 100 mg/dL*, *Nephropathy Monitoring*, *Blood Pressure < 140/90*, and *Blood Pressure < 140/80*.

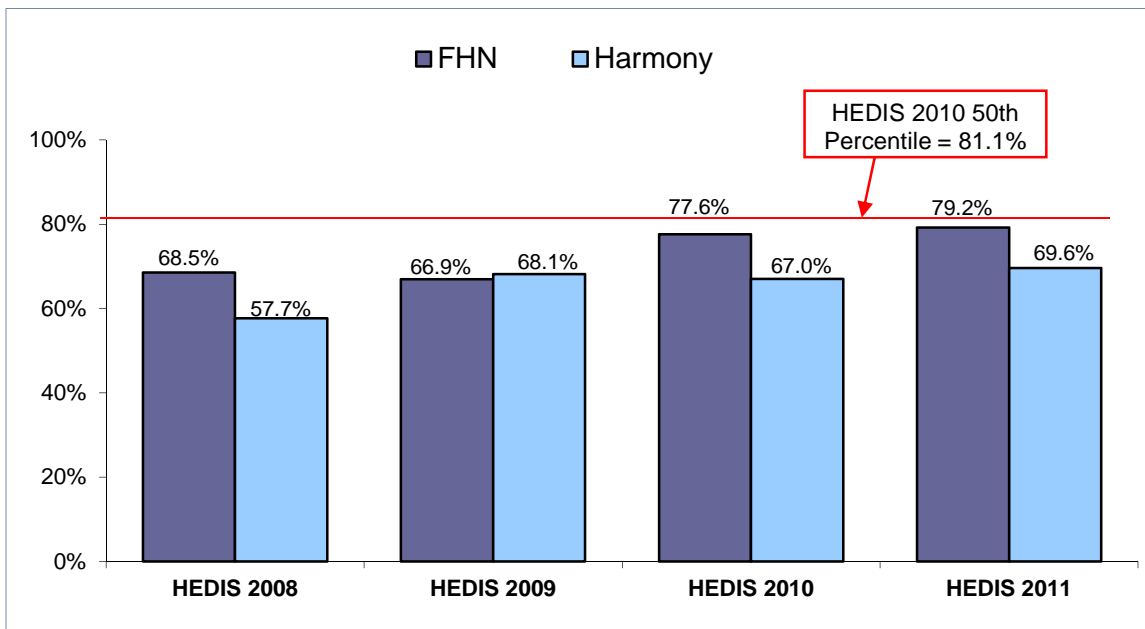
#### Diabetes Care—HbA1c Testing

Figure 6.22 presents the comparative rates for *Diabetes Care—HbA1c Testing*.

Neither MCO had a rate above the National Medicaid HEDIS 2010 50th percentile of 81.1 percent. Overall, **FHN**'s rates have consistently improved, gaining 10.7 percentage points since HEDIS 2008. The HEDIS 2011 rate for **FHN** was 1.9 percentage points lower than the 50th percentile.

**Harmony**'s rate has also shown steady improvement and was 11.9 percentage points higher than the rate reported for HEDIS 2008. However, **Harmony**'s rate remains well below **FHN**'s rate and has remained fairly constant over the past three years.

**Figure 6.22—Comparison of HFS MCO Performance for Diabetes Care—HbA1c Testing**



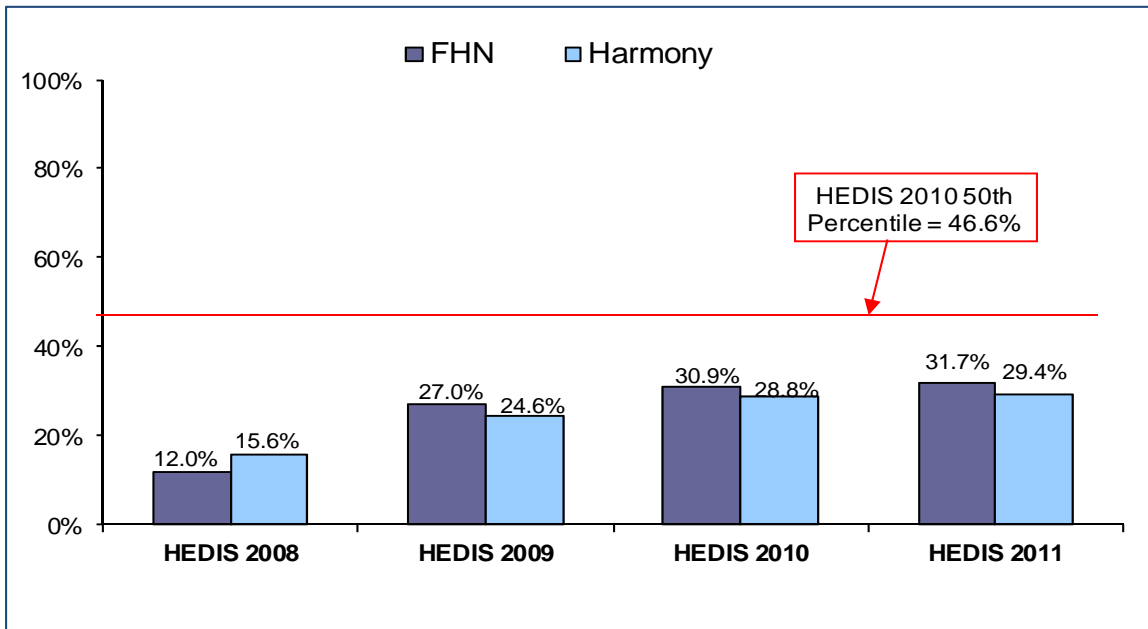


**Diabetes Care—Good HbA1c Control**

Figure 6.23 presents the comparative rates for *Diabetes Care—Good HbA1c Control*.

The rate for **FHN** has improved by 19.7 percentage points since HEDIS 2008 but only had a small, 0.8 percentage point increase over last year. Similarly to **FHN**, **Harmony**'s rate improved 13.8 percentage points since HEDIS 2008 but only 0.6 percentage points over last year. Although both rates continued to improve, the rates were well below the National Medicaid HEDIS 2010 50th percentile of 46.6 percent.

**Figure 6.23—Comparison of HFS MCO Performance for *Diabetes Care—Good HbA1c Control***

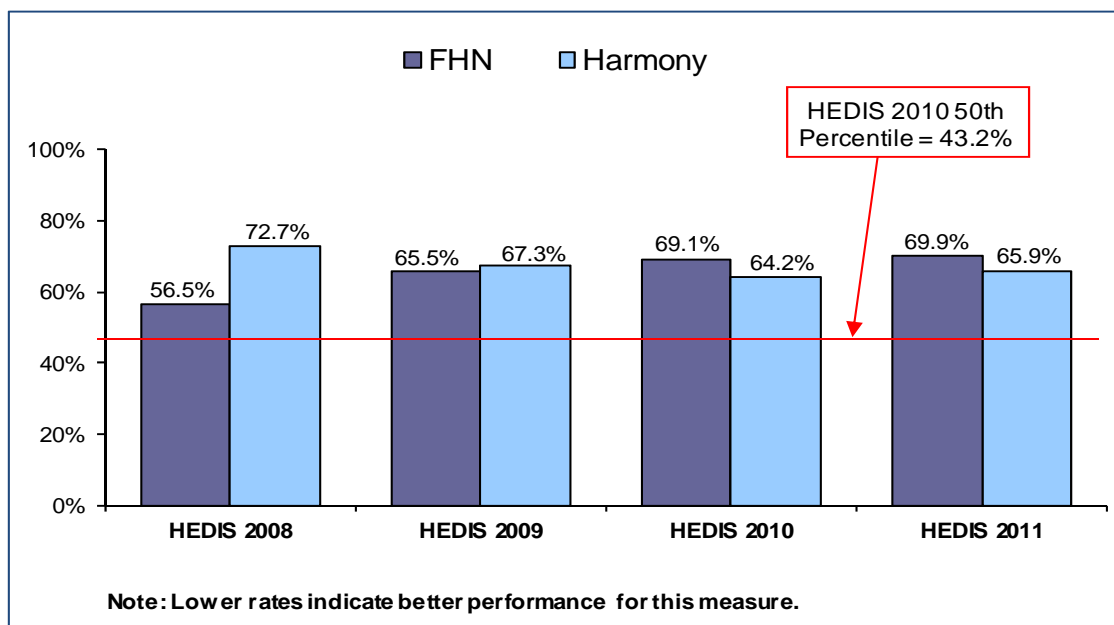


**Diabetes Care—Poor HbA1c Control**

Figure 6.24 presents the comparative rates for *Diabetes Care—Poor HbA1c Control*. Lower rates are better for this measure since this measure evaluates the percentage of members who were in poor control of their diabetes.

Overall, the performance for **FHN** has declined for this measure as indicated by an increase of 13.4 percentage points since HEDIS 2008. **Harmony** has made some improvement with this measure, decreasing its rate by 6.8 percentage points since HEDIS 2008. Neither MCO reported rates below the National Medicaid HEDIS 2010 50th percentile of 43.2 percent.

**Figure 6.24—Comparison of HFS MCO Performance for Diabetes Care—Poor HbA1c Control**

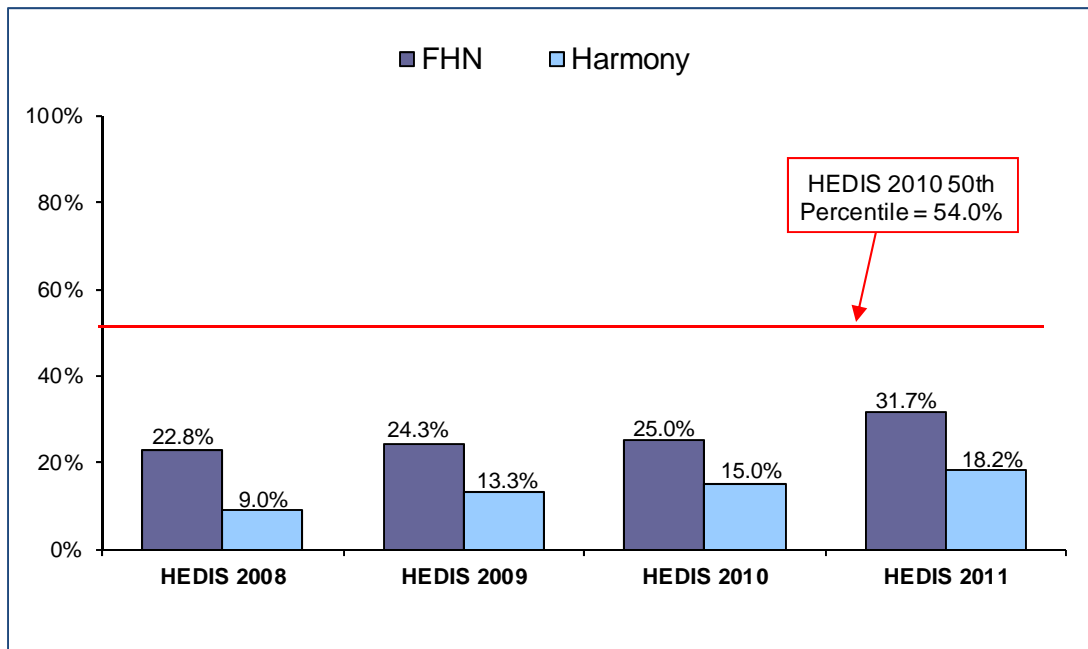


**Diabetes Care—Eye Exam**

Figure 6.25 presents the comparative rates for *Diabetes Care—Eye Exam*.

Overall, **FHN**'s rate has improved 8.9 percentage points from HEDIS 2008, while the rate for **Harmony** has improved by 9.2 percentage points. Despite this improvement over the last few years, the rates remain well below the National Medicaid HEDIS 2010 50th percentile of 54.0 percent.

**Figure 6.25—Comparison of HFS MCO Performance for *Diabetes Care—Eye Exam***



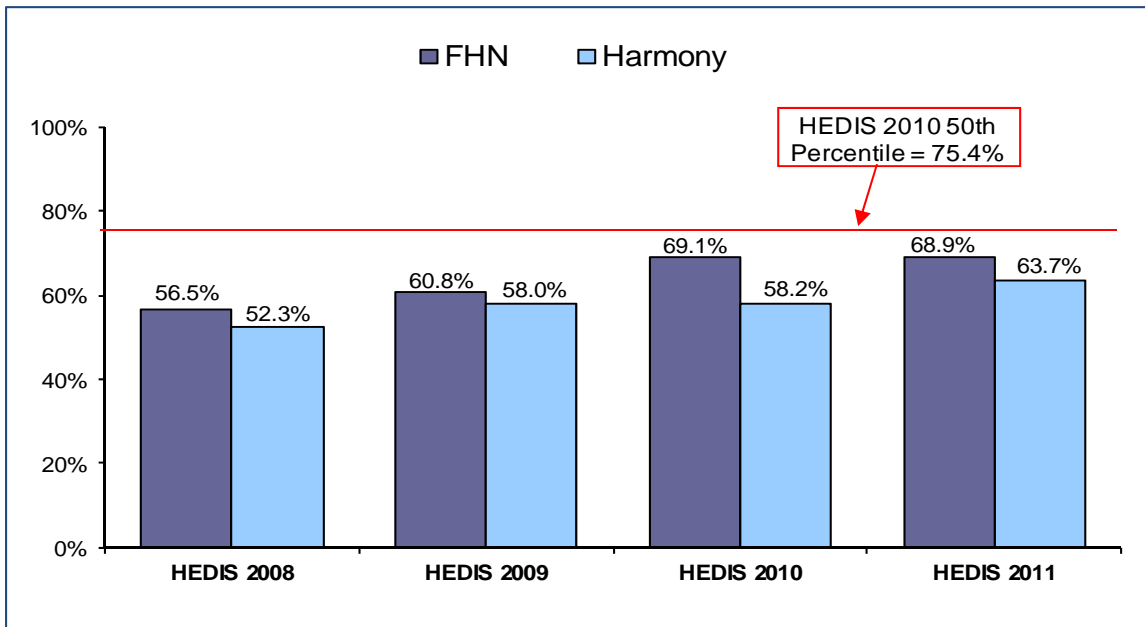
As mentioned in the annual report last year, both MCOs continue to struggle to improve on this measure. Both **FHN** and **Harmony** need to conduct an analysis to determine the reason the rate continues to be so low for this measure. The MCOs and the State should also consider conducting a PIP around this measure. One barrier to consider is that Illinois law allows eye examinations for retinopathy to be performed by an optometrist. Optometry services are carved out of the MCO agreement as a covered service; therefore, the MCOs do not receive the encounter data.

**Diabetes Care –LDL-C Screening**

Figure 6.26 presents the comparative rates for *Diabetes Care—LDL-C Screening*.

Although **FHN**'s HEDIS 2011 rate declined from last year, the overall trend has shown improvement and the rate has increased by 12.4 percentage points since HEDIS 2008. **Harmony** has also demonstrated improvement, with an 11.4 percentage point increase since HEDIS 2008. Both of the rates for the MCOs remained below the National Medicaid HEDIS 2010 50th percentile of 75.4 percent.

**Figure 6.26—Comparison of HFS MCO Performance for Diabetes Care—LDL-C Screening**

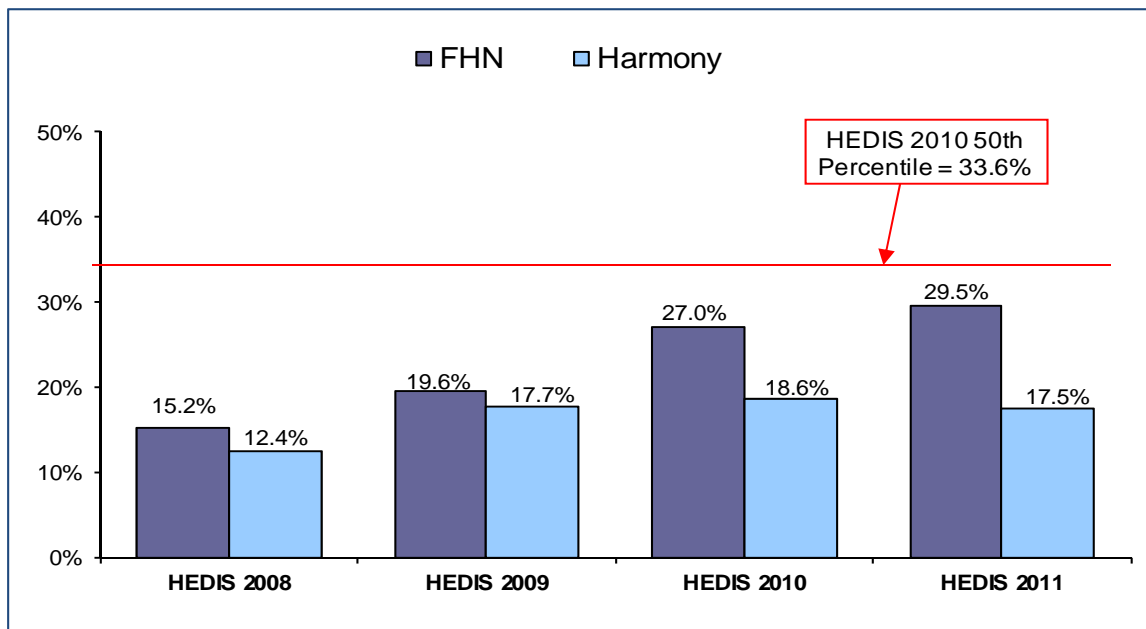


**Diabetes Care—LDL-C Level < 100mg/DL**

Figure 6.27 presents the comparative rates for *Diabetes Care—LDL-C Level < 100mg/DL*.

FHN’s rates have continued to improve each year. Overall, the rate for FHN has improved 14.3 percentage points since HEDIS 2008. Harmony’s rate improved by just 5.1 percentage points since HEDIS 2008, but the MCO has remained virtually constant for the past three years. Both MCOs had rates below the National Medicaid HEDIS 2010 50th percentile of 33.6 percent. The low rates for this measure may be due to lack of encounter data from the contracted laboratories.

**Figure 6.27—Comparison of HFS MCO Performance for *Diabetes Care—LDL-C Level < 100mg/DL***



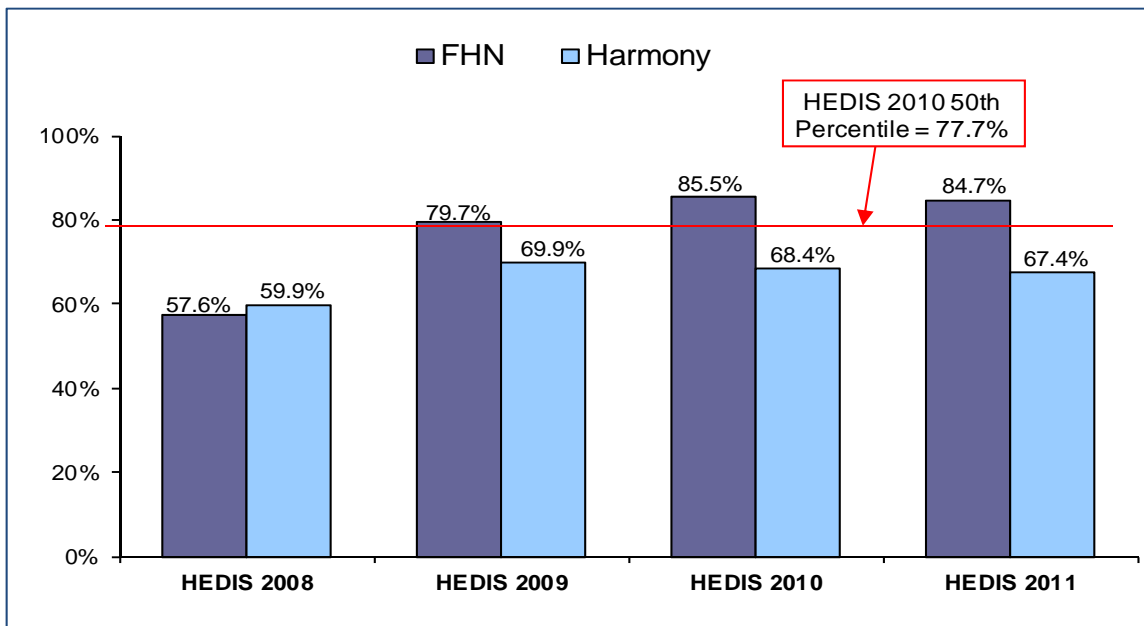
**Diabetes Care—Nephropathy Monitoring**

Figure 6.28 presents the comparative rates for *Diabetes Care—Nephropathy Monitoring*.

FHN’s rate declined from last year, but the rate has improved 27.1 percentage points since HEDIS 2008. This was the third year in a row that the reported rate for FHN exceeded the National Medicaid HEDIS 2010 50<sup>th</sup> percentile, and in fact, this rate was also above the 75<sup>th</sup> percentile.

The rate for Harmony declined by 1.0 percentage point from last year. While the rate has improved by 7.5 percentage points since HEDIS 2008, the rate has had a slight decline each year since HEDIS 2009.

**Figure 6.28—Comparison of HFS MCO Performance for Diabetes Care—Nephropathy Monitoring**



**Diabetes Care—Blood Pressure < 140/90**

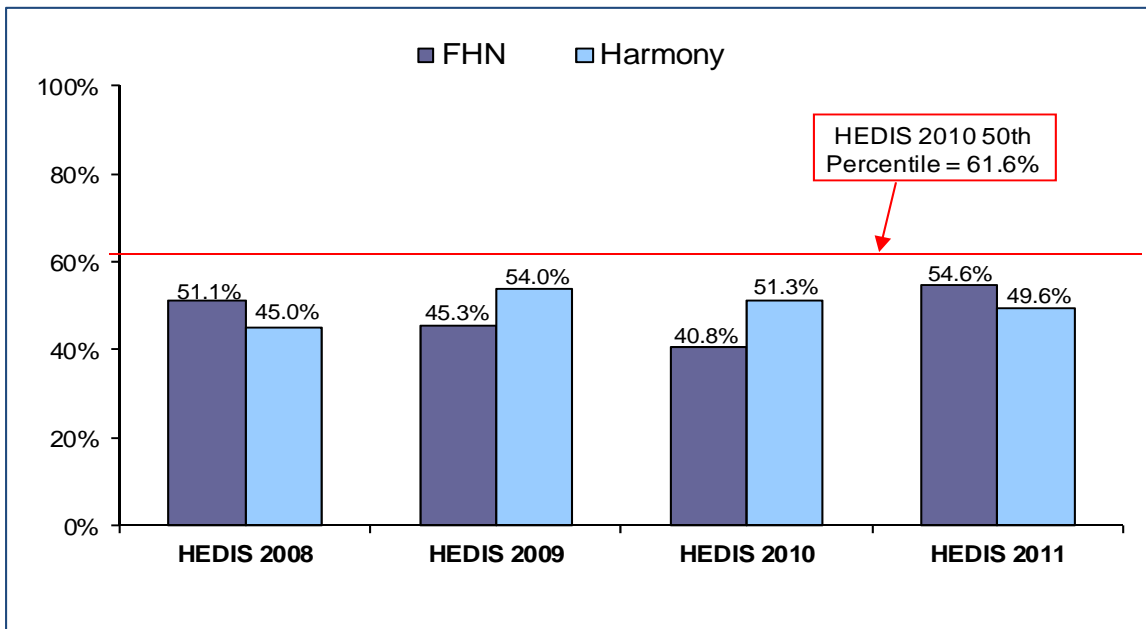
Figure 6.29 presents the comparative rates for *Diabetes Care—Blood Pressure (< 140/90)*.

**FHN**'s rate for this measure has increased 3.5 percentage points since HEDIS 2008. The general trend for this measure had been downward, but the reported rate for this year was 13.8 percentage points higher than last year.

**Harmony**'s rate improved for HEDIS 2009 but has shown a slight but steady decline for the past two years. Overall, **Harmony**'s rate for HEDIS 2011 was 4.6 percentage points higher than the rate reported for HEDIS 2008.

Both rates reported by the MCOs were below the National Medicaid 2010 50th percentile of 61.6 percent.

**Figure 6.29—Comparison of HFS MCO Performance for Diabetes Care—Blood Pressure < 140/90**

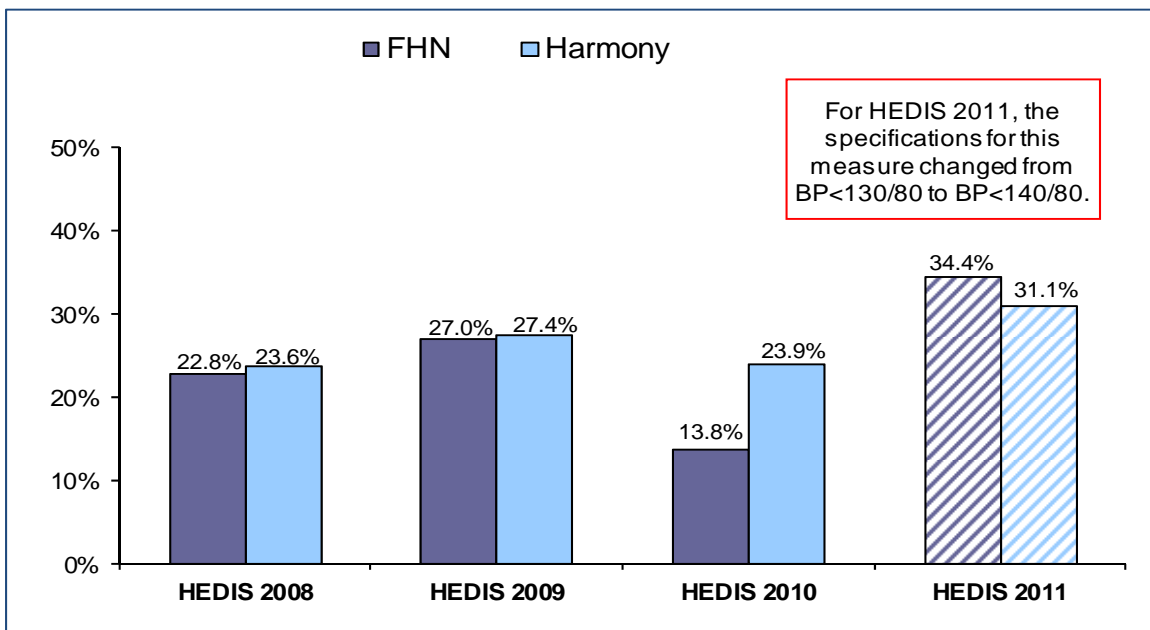


**Diabetes Care—Blood Pressure < 140/80**

Figure 6.30 presents the comparative rates for *Diabetes Care—Blood Pressure < 140/80*. Formerly, this measure was reported for blood pressure < 130/80. Therefore, although displayed on the graph, comparisons to prior years should be viewed with caution. Direct comparisons between years and with percentiles are not appropriate.

Due to the changes in the measure specifications, rates were expected to have significant increases. This, in fact, appeared to be the case as the rate for **FHN** was 20.6 percentage points higher than last year. The rate for **Harmony**, which had a slight decrease between HEDIS 2009 and HEDIS 2010, increased by 7.2 percentage points over last year.

**Figure 6.30—Comparison of HFS MCO Performance for *Diabetes Care—Blood Pressure < 140/80***



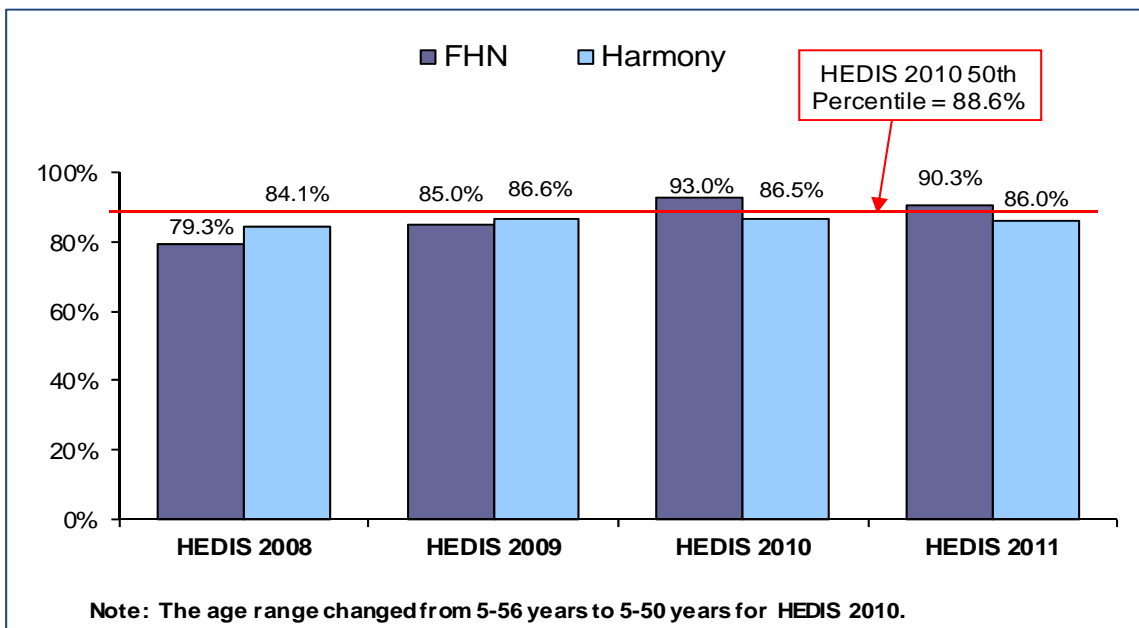


### Use of Appropriate Medications for People With Asthma

Figure 6.31 presents the comparative performance of **FHN** and **Harmony** for *Use of Appropriate Medications for People With Asthma (Combined)*. For HEDIS 2010, the HEDIS technical specifications were modified for the age range; the age range was changed from 5–56 years of age to 5–50 years of age. The change did not have much impact on the rates for this measure; therefore, this measure was still trended.

The rate for **FHN** has improved by 11.0 percentage points since HEDIS 2008, and it exceeded the National Medicaid 50th percentile of 88.6 percent. The rate for **Harmony** had a slight decrease for the second year in a row and remains below the 50th percentile.

**Figure 6.31—Comparison of HFS MCO Performance for Use of Appropriate Medications for People With Asthma (Combined)**



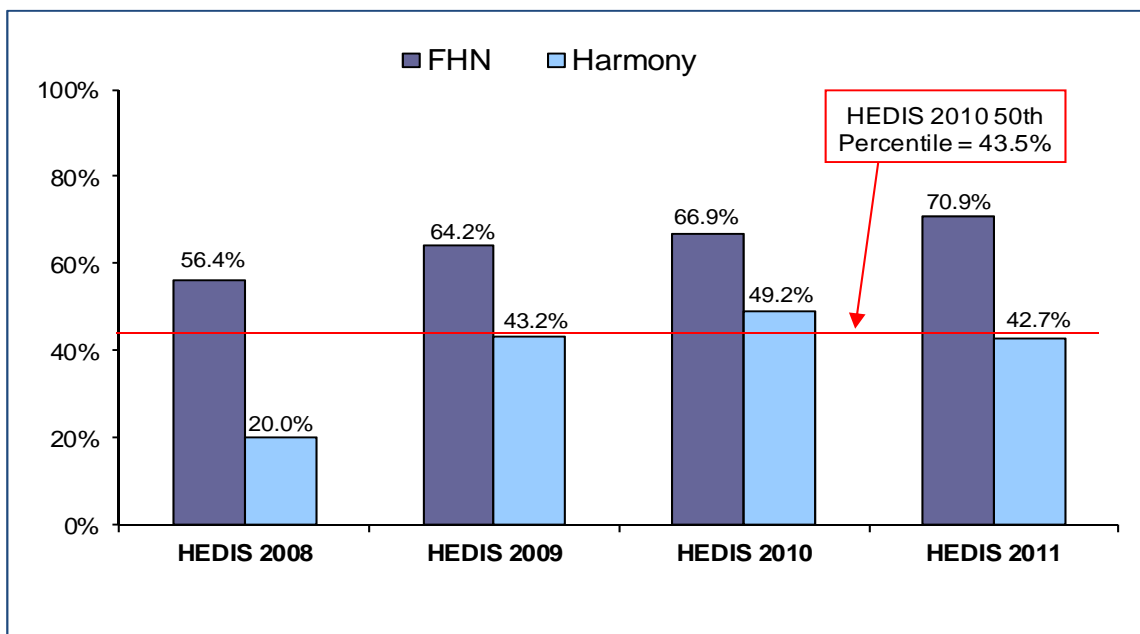
### Follow-up After Hospitalization for Mental Illness—7 Days

Figure 6.32 and Figure 6.33 below present the comparative rates for Follow-up After Hospitalization for Mental Illness (7 Days and 30 Days).

**FHN**'s rate of 70.9 percent was well above the National Medicaid HEDIS 2010 50th percentile of 43.5 percent for the fourth straight year and was actually higher than the 90th percentile of 64.3 percent (not shown in the figure). The rate for **FHN** has improved by 14.5 percentage points since HEDIS 2008.

**Harmony**'s rate declined from 49.2 percent last year to 42.7 percent for HEDIS 2011. This 6.5 percentage point decline moved **Harmony**'s rate below the National Medicaid HEDIS 2010 50th percentile.

**Figure 6.32—Comparison of HFS MCO Performance for Follow-up After Hospitalization for Mental Illness (7 Days)**

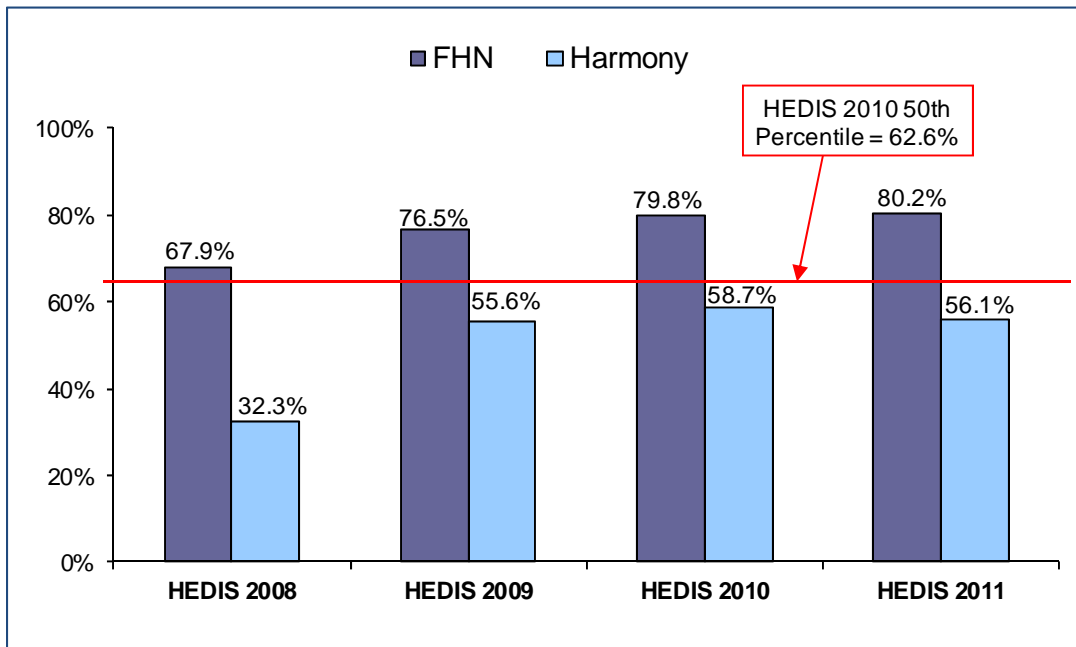


### Follow-up After Hospitalization for Mental Illness—30 Days

For 30-day follow-up, **FHN**'s rate improved from 12.3 percentage points since HEDIS 2008 and was well above the National Medicaid HEDIS 2010 50th percentile of 62.6 percent. This was the fourth straight year that **FHN** exceeded the 50th percentile.

**Harmony**'s rate has improved by 23.8 percentage points since HEDIS 2008. However, the last three years have been fairly constant, with little to no real improvement. The rate for this year declined 2.6 percentage points from last year. **Harmony**'s rate has not exceeded the 50th percentile in any of the past four years.

**Figure 6.33—Comparison of HFS MCO Performance for Follow-up After Hospitalization for Mental Illness (30 Days)**



**Encounter Data Completeness**

Table 6.15 provides an estimate of the data completeness for the hybrid performance measures. These measures use administrative encounter data and supplement the results with medical record data. The rates in the table represent the percentage of the final HEDIS rate that was determined solely through the use of administrative encounter data. A rate of 100 percent for the last two columns indicates that the encounter data were complete for that HEDIS measure. The higher rate of encounter data completeness between **FHN** and **Harmony** is highlighted in green.

**Table 6.15—Estimated Encounter Data Completeness for Hybrid Measures**

Performance Measures	Final HEDIS Rate		Percent Encounter Data	
	FHN	Harmony	FHN	Harmony
<i>Childhood Immunizations—Combo 2</i>	75.7%	65.9%	10.4%	76.0%
<i>Childhood Immunizations—Combo 3</i>	70.4%	61.6%	10.5%	74.7%
<i>Lead Screening in Children</i>	81.9%	78.1%	75.7%	28.3%
<i>Well-Child Visits in the First 15 Months (6+ Visits)</i>	53.8%	51.3%	43.3%	70.6%
<i>Well-Child Visits (3–6 Years)</i>	67.4%	71.8%	73.3%	91.2%
<i>Adolescent Well-Care Visits</i>	43.9%	38.9%	67.4%	86.3%
<i>Immunizations for Adolescents (Combined Rate)</i>	40.5%	29.9%	66.9%	71.5%
<i>Cervical Cancer Screening</i>	69.4%	69.8%	57.7%	91.3%
<i>Chlamydia Screening (Combined Rate)</i>	66.3%	NA	57.6%	NA
<i>Frequency of Ongoing Prenatal Care (81–100%)</i>	42.3%	39.9%	31.7%	82.9%
<i>Timeliness of Prenatal Care</i>	62.4%	64.7%	26.7%	49.6%
<i>Postpartum Care</i>	40.2%	48.7%	25.3%	75.0%
<i>Diabetes Care (HbA1c Testing)</i>	79.2%	69.6%	10.3%	78.7%
<i>Diabetes Care (Good HbA1c Control)</i>	31.7%	29.4%	0.0%	9.1%
<i>Diabetes Care (Eye Exam)</i>	31.7%	18.2%	39.7%	45.3%
<i>Diabetes Care (LDL-C Screening)</i>	68.9%	63.7%	8.7%	77.5%
<i>Diabetes Care (LDL-C Level &lt; 100 mg/Dl)</i>	29.5%	17.5%	0.0%	9.7%
<i>Diabetes Care (Nephropathy Monitoring)</i>	84.7%	67.4%	37.4%	63.5%

Although **FHN's** encounter data completeness was over 75.0 percent for *Lead Screening in Children*, none of the encounter data were more than 90.0 percent complete; and 14 measures had encounter data completeness rates of less than 60.0 percent. These results indicate that **FHN** continues to have difficulty obtaining complete encounter data. This concern was mentioned in the prior EQR technical reports; and once again, **FHN** is strongly encouraged to focus efforts on improving encounter data submission.

**Harmony**'s encounter data submission was higher than **FHN** for every measure except *Lead Screening in Children*. **Harmony** had two measures with more than 90.0 percent encounter data completeness; only five measures had less than a 60.0 percent data completeness level. **Harmony** should continue to reinforce efforts to improve submission of encounter data to maintain this level of encounter data submission.

### Summary of Findings and Recommendations

The following is a brief summary of the findings and recommendations regarding the performance measures in this report:

- ◆ **FHN** had seven measures with rates that exceeded the 2010 HEDIS Medicaid 50th percentiles: one measure in the Child and Adolescent Care category, two in Preventive Screening for Women, and four in the Chronic Conditions/Disease Management category. In addition, **FHN** had 31 of the 33 trended measures improve since HEDIS 2008, with 18 of those measures improving by more than 10.0 percentage points. Compared to the 50th percentiles, **FHN** performed the lowest on measures related to maternity care and access to care.
- ◆ **Harmony** reported three measures with rates at or above the Medicaid 2010 HEDIS 50th percentiles: *Lead Screening in Children*, *Well-Child Visits (3–6 Years)*, and *Cervical Cancer Screening*. In addition, 32 of the 33 trended measures improved since HEDIS 2008 or the baseline rate; and 15 measures improved by more than 10.0 percentage points. Compared to the 50th percentiles, **Harmony** generally performed the lowest on maternity-related measures, diabetes care measures, and access measures.
- ◆ Due to **Meridian**'s low population size, **Meridian** did not have more than 30 eligible members for many of the HEDIS measures for HEDIS 2011; and trending rates across years was not possible. In accordance with NCQA requirements, the rates for these measures are not applicable (NA). However, all of **Meridian**'s reported rates for HEDIS 2011 were above the 50th percentiles.
- ◆ The low rates for *Children's Access to Primary Care Practitioners* and *Adults' Access to Preventive/ Ambulatory Care* services indicate that both **FHN** and **Harmony** need to improve access to care. The rates continued to improve but still remain low and well below the national 50th percentiles. This finding was mentioned in the past two annual reports, and the recommendation remains the same: both **FHN** and **Harmony** should examine their network provider coverage along with potential access-to-care barriers and evaluate internal policies regarding member and provider education. The MCOs and the State should also consider conducting a PIP around these measures.
- ◆ The rates for **FHN** and **Harmony** for measures in the preventive screenings for women category improved over last year but remain fairly low. **FHN** showed good improvement over last year for *Breast Cancer Screening*, *Cervical Cancer Screening*, and *Chlamydia Screening in Women*; however, these rates remained about the same as last year for **Harmony**.

- ◆ **FHN** and **Harmony** continue to report rates well below the 10th percentile for the maternity-related measures. In 2007, the MCOs began a PIP that includes these maternity-related measures. This year, **FHN** reported improved rates for *Frequency of Ongoing Prenatal Care*, *Timeliness of Prenatal Care*, and *Postpartum Care*. In contrast, the rates for **Harmony** remained about the same as reported last year. The MCOs should begin evaluating the effectiveness of their interventions for these PIPs, which may lead to improvement in their HEDIS rates.
- ◆ As also mentioned in the annual report for the past few years, both **FHN** and **Harmony** continue to struggle to improve on the *Diabetes Care—Eye Exam* measure. Both **FHN** and **Harmony** need to conduct an analysis to determine the reason the rate continues to be so low for this measure. The MCOs and the State should also consider conducting a PIP around this measure.
- ◆ The two measures related to mental health continue to represent an area of strength for **FHN**, with the 7-day rate exceeding the 90th percentile and the 30-day rate exceeding the 75th percentile. However, both rates for **Harmony** fell below the 50th percentile.
- ◆ Overall, the results show that **FHN** does not receive all of its encounter data. Twelve measures had less than a 50.0 percent encounter data completeness rate. Six of the 18 HEDIS measures had more than a 50.0 percent encounter data completeness rate, but none of the measures had a data completion rate at or above 90.0 percent. **FHN** continues to demonstrate difficulty in obtaining complete encounter data for childhood immunizations and lab-related measures for diabetes care. Encounter data for maternity-related care was also quite low. **FHN** should concentrate efforts on obtaining more complete encounter data from providers.
- ◆ The rates indicate **Harmony** has reasonably good encounter data completeness. Two measures had more than a 90.0 percent data completion rate, two were above 80.0 percent, seven were above 70.0 percent, and one measure was above 60.0 percent. However, five of the measures had less than 50.0 percent data completion rate. **Harmony** continues to demonstrate some difficulty in obtaining complete encounter data for lead screening, prenatal care, and some lab-related measures for diabetes care—especially those that require actual lab results. **Harmony** should concentrate efforts toward obtaining complete lab data.

### Validation of Performance Improvement Projects

#### Objectives

As part of its quality assessment and performance improvement program, HFS requires each MCO to conduct PIPs in accordance with 42 CFR 438.240. The purpose of a PIP is to achieve through ongoing measurements and intervention significant improvements in clinical and nonclinical areas of care that are sustained over time. This structured method of assessing and improving MCO processes can have a favorable effect on health outcomes and member satisfaction. Additionally, as one of the mandatory EQR activities under the BBA, the State is required to validate the PIPs conducted by its contracted MCOs and prepaid inpatient health plans (PIHPs). HFS contracted with HSAG to meet this validation requirement.

The primary objective of PIP validation was to determine each health plan's compliance with requirements set forth in 42 CFR 438.240(b)(1), including:

- ◆ Measuring performance using objective quality indicators.
- ◆ Implementation of systematic interventions to achieve improvement in quality.
- ◆ Evaluation of the effectiveness of the interventions.
- ◆ Planning and initiation of activities for increasing or sustaining improvement.

#### Conducting the Review

For such projects to achieve real improvements in care and member satisfaction, as well as confidence in the reported improvements, PIPs must be designed, conducted, and reported using sound methodology and must be completed in a reasonable time period.

#### Technical Methods of Data Collection and Analysis

The methodology used to validate PIPs was based on CMS guidelines as outlined in the CMS publication, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, Final Protocol, Version 1.0, May 1, 2002 (CMS PIP Protocol). Using this protocol, HSAG, in collaboration with HFS, developed the PIP Summary Form, which each MCO completed and submitted to HSAG for review and evaluation. The PIP Summary

Form standardized the process for submitting information regarding PIPs and ensured that the projects addressed all CMS PIP Protocol requirements.

HSAG, with HFS's input and approval, developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG reviewed each of the PIPs for the following 10 CMS PIP Protocol activities:

- ◆ Activity I. Appropriate Study Topic
- ◆ Activity II. Clearly Defined, Answerable Study Question
- ◆ Activity III. Clearly Defined Study Indicator(s)
- ◆ Activity IV. Correctly Identified Study Population
- ◆ Activity V. Valid Sampling Techniques (if Sampling Was Used)
- ◆ Activity VI. Accurate/Complete Data Collection
- ◆ Activity VII. Appropriate Improvement Strategies
- ◆ Activity VIII. Sufficient Data Analysis and Interpretation
- ◆ Activity IX. Real Improvement Achieved
- ◆ Activity X. Sustained Improvement Achieved

HSAG calculated the percentage score of evaluation elements met for each MCO by dividing the total elements *Met* by the total elements *Met*, *Partially Met*, and *Not Met*. Any evaluation element that received a *Not Applicable* or *Not Assessed* designation was not included in the overall score. While all elements are important in assessing a PIP, HSAG designated some elements as critical to producing valid and reliable results and for demonstrating high confidence in the PIP findings. These critical elements must be *Met* for the PIP to be in compliance. The percentage score of critical elements *Met* was calculated by dividing the total *Met* critical elements by the total critical elements *Met*, *Partially Met*, and *Not Met*. A *Partially Met* validation status indicates low confidence in the reported PIP results.



Table 7.1—PIP Validation Results

PIP Study Stage	Activity	Percentage of Applicable Elements		
		Met	Partially Met	Not Met
Design	I. Appropriate Study Topic	100% (54/54)	0% (0/54)	0% (0/54)
	II. Clearly Defined, Answerable Study Question(s)	100% (18/18)	0% (0/18)	0% (0/18)
	III. Clearly Defined Study Indicator(s)	100% (57/57)	0% (0/57)	0% (0/57)
	IV. Correctly Identified Study Population	100% (27/27)	0% (0/27)	0% (0/27)
<b>Design Total</b>		100% (156/156)	0% (0/156)	0% (0/156)
Implementation	V. Valid Sampling Techniques (if sampling was used)	100% (30/30)	0% (0/30)	0% (0/30)
	VI. Accurate/Complete Data Collection	96% (87/91)	3% (3/91)	1% (1/91)
	VII. Appropriate Improvement Strategies	100% (22/22)	0% (0/22)	0% (0/22)
<b>Implementation Total</b>		97% (139/143)	2% (3/143)	1% (1/143)
Outcomes	VIII. Sufficient Data Analysis and Interpretation	82% (47/57)	18% (10/57)	0% (0/57)
	IX. Real Improvement Achieved†	38% (6/16)	63% (10/16)	0% (0/16)
	X. Sustained Improvement Achieved	0% (0/4)	50% (2/4)	50% (2/4)
<b>Outcomes Total†</b>		69% (53/77)	29% (22/77)	3% (2/77)
<b>Overall PIP Results†</b>		93% (348/376)	7% (25/376)	1% (3/376)

† The sum of the *Met*, *Partially Met*, and *Not Met* scores in each activity, stage, or overall may not equal 100 percent due to rounding.

Table 7.2 shows the current evaluation scoring for the PIPs. The table presents each MCO, the PIPs for which each MCO is responsible, and the current validation status of each PIP.

Table 7.2—Percent of All Elements Met

PIP Topics	FHN	Harmony	Meridian
<i>EPSTD Screening</i>	86%	90%	100%
<i>Perinatal Care and Depression Screening</i>	92%	86%	94%
<i>Improving Ambulatory Follow-Up and PCP Communication</i>	94%	98%	100%

The validation scores of **FHN**, **Harmony**, and **Meridian**, demonstrate strong performance in the design and implementation phases for all three MCOs, indicating that each PIP was designed and implemented appropriately to measure outcomes and improvement.

During SFY 2010–2011, HSAG conducted a validation and analysis of the *EPSDT Screening*, *Perinatal Care and Depression Screening*, and *Improving Ambulatory Follow-Up and PCP Communication* PIPs to evaluate the MCOs’ performance on the PIP indicators. The following is a result of that analysis.

### EPSDT Screening PIP

#### Background

HFS required each MCO to participate in a mandatory statewide PIP focused on improving performance related to EPSDT screenings and visits, including the content of care for children younger than 3 years of age. EPSDT is designed to detect and treat health problems early through three methods: (1) regular medical, dental, vision, and hearing screening and blood lead testing; (2) immunizations; and (3) education. EPSDT provides a comprehensive child health program to help ensure that health problems are identified, diagnosed, and treated early, before they become more complex and treatment becomes more costly. The goals of the *EPSDT Screening* PIP were to:

- ◆ Provide baseline results of EPSDT screening indicators for targeting interventions and improving rates.
- ◆ Improve the quantity and quality of EPSDT examinations through a collaborative process.
- ◆ Enhance the MCOs’ knowledge and expertise in conducting PIPs while meeting both State and CMS requirements for PIPs.

Table 7.3 provides a list of the *EPSDT Screening* PIP study indicators validated for FY 2010–2011.

**Table 7.3—EPSDT Screening PIP Study Indicators**

Indicator	Description of Indicator
1	Total number of members with a health history documented on every EPSDT visit
2	Total number of members with a nutritional assessment performed on every EPSDT visit
3	Total number of members with a developmental screening documented on every EPSDT visit (Subjective and Objective)
4	Total number of members with anticipatory guidance documented on every EPSDT visit
5	Total number of members with a physical exam performed on every EPSDT visit
6	Total number of members with growth measurement documentation on every EPSDT visit
7	Total number of members with a hearing screening documented on every EPSDT visit
8	Total number of members with a vision screening documented on every EPSDT visit
9	Total number of members with a hematocrit or hemoglobin performed
10	Total number of members with other referrals documented

**Table 7.4—SFY 2011 Performance Improvement Project Outcomes for the EPDST Screening PIPs (N=3)**

MCO	Total Number of Study Indicators	Comparison to Study Indicator Results From Prior Measurement Period					Sustained Improvement <sup>1</sup>
		Declined	Statistically Significant Decline	Improved	Statistically Significant Improvement	Not Assessed	
Family Health Network, Inc.	10	2	0	1	7	0	1
Harmony Health Plan of Illinois, Inc.	10	0	0	1	9	0	4
Meridian Health Plan, Inc.	10	0	0	0	0	10	‡
<b>Overall Totals</b>	<b>30</b>	<b>2</b>	<b>0</b>	<b>2</b>	<b>16</b>	<b>10</b>	<b>5</b>

<sup>1</sup> The number of study indicators that demonstrated sustained improvement.

‡ The PIP(s) did not progress to this phase during the review period and could not be assessed for sustained improvement.

## Results

Overall, for the most recent measurement period, **FHN** has shown statistically significant improvement for seven of the 10 indicators. Rates ranged from 20.4 percent for members with a documented nutritional assessment to 58.3 percent for members with hematocrit or hemoglobin performed. However, two indicators declined from Remeasurement 1 to Remeasurement 2—health history and other referrals. **FHN** achieved sustained improvement for one of the 10 indicators—other referrals—despite the decline for the most recent measurement period.

**Harmony** outperformed **FHN** with nine of the 10 indicators demonstrating statistically significant improvement. The lowest reported rate was 1.7 percent for members with a hematocrit or hemoglobin performed. Conversely, the highest rate, 45.3 percent, was reported for members with a nutritional assessment performed. **Harmony** achieved sustained improvement for four of the ten indicators—developmental screening, anticipatory guidance, physical exam, and hematocrit or hemoglobin.

**Meridian** reported baseline rates only and could not be assessed for improvement or sustained improvement. Rates ranged from zero percent for hematocrit or hemoglobin to 80 percent for nutritional assessment, physical exam, and growth measurement.

Across all indicators for the two PIPs assessed for improvement and sustained improvement, 80 percent demonstrated statistically significant improvement. Furthermore, one fourth of the study indicators demonstrated sustained improvement.

## Barriers/Interventions

The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The MCO's choice of interventions, the combination of intervention types, and the sequence of implementing the interventions are essential to the performance improvement project's overall success.

For the *EPSDT Screening* PIP, all three MCOs identified that lack of provider documentation was a key barrier. In an attempt to overcome this barrier, the MCOs implemented a collaborative intervention of developing a standardized form to be used by the providers. This standardized form was distributed to the providers at the Pay for Quality (PFQ) meeting in September 2009. The MCOs conducted provider education and staff training on the use of the standardized form. In addition to this collaborative intervention, the individual MCOs implemented plan-specific member and systemwide interventions based on barriers identified through analysis. These interventions include but are not limited to the following:

- ◆ Member and provider newsletters
- ◆ An MCO representative one-on-one visit with provider offices
- ◆ Noncompliance lists mailed or faxed to providers quarterly
- ◆ Telephonic reminders
- ◆ Community outreach events
- ◆ Immunization and needed services reminder cards to members

## *Perinatal Care and Depression Screening PIP*

### Background

HFS identified improving birth outcomes as one of its health care priorities. The risks from untreated major depression during pregnancy may include decreased prenatal care, decreased nutritional quality, increased use of addictive substances, and increased risk of becoming a victim of violence. Improving participation in prenatal and postpartum care, as well as ensuring that perinatal depression screening occurs, are key components of HFS' program.

The PIPs were based on the *Timeliness of Prenatal Care* and *Postpartum Care* HEDIS measures to identify the eligible population and to improve rates for these two measures. In addition to the HEDIS measures, the State and the MCOs chose to determine the percentage of women who were enrolled in an Illinois Medicaid MCO and were screened for depression during the prenatal and/or postpartum period. The primary purpose of this collaborative PIP was to determine if MCO interventions have helped to improve the rates for the perinatal HEDIS measures, along with depression screening for these women. A secondary goal was to determine potential

opportunities to improve the rate of objective depression screening, along with appropriate treatment when depression is identified through screening and assessment. The study indicators for this PIP are as follows:

**Table 7.5—Perinatal Care and Depression Screening PIP Study Indicators**

Indicator	Description of Indicator
1	Timeliness of Prenatal Care (HEDIS Specifications)
2	Postpartum Care (HEDIS Specifications)
3a	Frequency of Ongoing Prenatal Care < 21%
3b	Frequency of Ongoing Prenatal Care 81%+
4	Women Who Were Screened for Depression During the Pregnancy and Prior to delivery
4a	Women Who Were Screened for Depression Within 56 days After Delivery
4b	Women Who Were Screened for Depression During the Pregnancy and Prior to Delivery or Within 56 days After Delivery
5	Women Who Had Treatment Within 7 Days for a Positive Depression Screen
6	Women Who Had a Referral Within 7 Days for a Positive Depression Screen
7	Women Who Had Follow-Up Within 7 Days for a Positive Depression Screen
8	Women Who Had Treatment Within 14 Days for a Positive Depression Screen
9	Women Who Had a Referral Within 14 Days for a Positive Depression Screen
10	Women Who Had Treatment Within 30 Days for a Positive Depression Screen
11	Women Who Had a Referral Within 30 Days for a Positive Depression Screen
12	Women Who Had Follow-Up Within 30 Days for a Positive Depression Screen

**Table 7.6—SFY 2011 Performance Improvement Project Outcomes for the Perinatal Care and Depression Screening PIPs (N=3)**

MCO	Total Number of Study Indicators	Comparison to Study Indicator Results From Prior Measurement Period					Sustained Improvement <sup>1</sup>
		Declined	Statistically Significant Decline	Improved	Statistically Significant Improvement	Not Assessed	
Family Health Network, Inc.	13 <sup>¥</sup>	3	2	3	4	1*	6
Harmony Health Plan of Illinois, Inc.	15	0	1	6	6	2*	7
Meridian Health Plan, Inc.	15	0	0	0	0	15	‡
<b>Overall Totals</b>	<b>43</b>	<b>3</b>	<b>3</b>	<b>9</b>	<b>10</b>	<b>18</b>	<b>13</b>

<sup>1</sup> The number of study indicators that demonstrated sustained improvement.

‡ The PIP(s) did not progress to this phase during the review period and could not be assessed for sustained improvement.

\* The rates did not change between the prior measurement period and the current measurement period.

¥ The plan did not report Study Indicators 8 and 9.

## Results

Overall, for the most recent measurement period **FHN** has shown statistically significant improvement for four of the 13 indicators. Rates ranged from zero percent for treatment and referral within 30 day following a positive screen for depression to 49.2 percent for members with timely prenatal care. However, five indicators declined in the most recent measurement period with two (referral and follow-up within 7 days of a positive screen for depression) of the five demonstrating a statistically significant decline. **FHN** achieved sustained improvement for six of the 13 indicators (Study Indicators 2, 3a, 3b, 4a, 4b, and 5).

**Harmony** outperformed **FHN** with six of the 15 indicators demonstrating statistically significant improvement. The lowest reported rate was 22.0 percent for two indicators, members with a treatment within 7 days and within 14 days of a positive screen for depression. Conversely, for two indicators the highest rate was 69.0 percent, members with a treatment and follow-up within 7 days and 30 days of a positive screen for depression. **Harmony** achieved sustained improvement for seven of the 15 indicators (Study Indicators 2, 3a, 4a, 7, 9, 11, and 12).

**Meridian** reported baseline rates only and could not be assessed for improvement or sustained improvement. Rates ranged from zero percent for treatment within 7, 14, or 30 days for women with a positive screen for depression to 100 percent for women screened for depression during the pregnancy and prior to delivery and 56 days after delivery.

Across all indicators for the two PIPs assessed for improvement and sustained improvement, 35.7 percent demonstrated statistically significant improvement. Furthermore, 46.4 percent of the study indicators demonstrated sustained improvement.

## Barriers/Interventions

The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The MCO's choice of interventions, the combination of intervention types, and the sequence of implementing the interventions are essential to the performance improvement project's overall success.

For the *Perinatal Care and Depression Screening* PIP, **FHN**'s medical director and vice president of medical management met to discuss results of the causal/barrier analysis and intervention.

Based on the barriers identified and discussed, the MCO implemented interventions that include contacting primary care providers (PCPs) and obstetrics/gynecology (OB/GYN) providers for updated demographic information on pregnant members, increasing the postpartum incentive to \$25 for completion of postpartum visits within the appropriate time frame, providing free baby

photo coupons to members who complete a postpartum visit within the appropriate time frame and complete a depression screening, and hiring a prenatal case manager.

**Harmony** implemented its Outreach through Harmony Hugs Program that includes outreach letters, home visits, and community meetings. In addition, the MCO initiated a HEDIS Postpartum Discharge process that was able to schedule appointments for 15 additional members between August and December 2011, and an OB Prenatal Reward program that provided strollers to members who completed the appropriate pre- and postnatal appointments. **Harmony** also implemented a workgroup that aggressively seeks out providers and physicians that provide obstetric services to increase access to care for members both prenatally and postpartum.

**Meridian** implemented an incentive program for members who received the appropriate prenatal and postpartum care visits according to HEDIS guidelines. Additionally, the MCO initiated the use of a standardized prenatal and postpartum depression screening tool to assist practitioners in the performance of objective perinatal depression screening. The plan established a process whereby all prenatal high-risk and prenatal and postpartum depression results are faxed to the OB practitioner and PCP for review and assessment. **Meridian** also established an outbound telephonic HEDIS reminder system to remind members to schedule their prenatal and postpartum visits, facilitate appointment scheduling, and arrange needed transportation.

## ***Improving Ambulatory Follow-Up and PCP Communication PIP***

### **Background**

In SFY 2008–2009, HFS required that each MCO participate in a statewide PIP on improving ambulatory follow-up and PCP communication. This is a two-part collaborative study between the State, EQRO, and MCOs that began in 2009. The study was developed based on the HEDIS 2010 Technical Specifications for the *Follow-up After Hospitalization for Mental Illness* measure. Appropriate follow-up care reduces the risk of repeat hospitalization and identifies those in need of further hospitalization before the member reaches the point of crisis. Communication and coordination of care between medical and behavioral health providers is a best practice principle essential to ensure consumer safety and optimal clinical outcomes. The goals of this PIP are to improve follow-up treatment after a mental illness and reduce or eliminate the barriers to effective communications between medical and behavioral health care providers. The *Improving Ambulatory Follow-up and PCP Communication* PIP had four study indicators that are outlined in Table 7.7.

**Table 7.7—Improving Ambulatory Follow-Up and PCP Communication PIP Study Indicators**

Indicator	Description of Indicator
1	Total Number of Discharges from an Acute Care Facility for Members Who Had an Outpatient or Intermediate Mental Health Visit on the Date of Discharge up to 7 Days after Hospital
2	Total Number of Discharges from an Acute Care Facility for Members Who Had an Outpatient or Intermediate Mental Health Visit on the Date of Discharge up to 30 Days after Hospital
3	Total Number of Inpatient Treatment Records and MCO Care Management Records Having Communication With the Members Primary Care Physician (PCP) or Primary Medical Provider
4*	Total Number of MCO Care Management Electronic Records Having Documented Communication With The Members Primary Care Physician (PCP) or Primary Medical Provider

\* Only Harmony Health Plan measured Study Indicator 4 for internal tracking purposes. The other two MCOs did not measure this study indicator.

**Table 7.8—SFY 2011 Performance Improvement Project Outcomes for the Improving Ambulatory Follow-Up and PCP Communication PIPs (N=3)**

MCO	Total Number of Study Indicators	Comparison to Study Indicator Results From Prior Measurement Period					Sustained Improvement <sup>1</sup>
		Declined	Statistically Significant Decline	Improved	Statistically Significant Improvement	Not Assessed	
Family Health Network, Inc.	3	0	0	0	0	3	‡
Harmony Health Plan of Illinois, Inc.	4	0	0	0	0	4	‡
Meridian Health Plan, Inc.	3	0	0	0	0	3	‡
<b>Overall Totals</b>	<b>10</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>10</b>	<b>0</b>

<sup>1</sup> The number of study indicators that demonstrated sustained improvement.  
 ‡ The PIP(s) did not progress to this phase during the review period and could not be assessed for sustained improvement.

**Results**

**FHN** reported baseline rates and could not be assessed for improvement or sustained improvement. Rates ranged from 3.6 percent for members with records documenting coordination of care to 72.3 percent for members having a follow-up visit within 30 days of discharge for a mental health inpatient admission.

**Harmony** reported baseline rates and could not be assessed for improvement or sustained improvement. Rates ranged from 49.2 percent for members having a follow-up visit within 7 days



of discharge for a mental health inpatient admission to 100 percent for members with records documenting coordination of care.

**Meridian** reported baseline rates and could not be assessed for improvement or sustained improvement. Rates ranged from 33.3 percent for members having a follow-up visit within 7 days of discharge for a mental health inpatient admission and for members with records documenting coordination of care to 100 percent for members having a follow-up visit within 30 days of discharge for a mental health inpatient admission. Rates for **Meridian** should be interpreted with caution as the denominators were composed of less than 10 discharges.

### Barriers/Interventions

The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The MCO's choice of interventions, the combination of intervention types, and the sequence of implementing the interventions are essential to the performance improvement project's overall success.

For the *Improving Ambulatory Follow-up and PCP Communication* PIP, a collaborative meeting occurred between the State, EQRO, and MCOs to discuss barriers. Based on the outcomes of this meeting, the MCOs implemented the following interventions:

- ◆ Member outreach calls within two business days of discharge from an inpatient facility to confirm the plan
- ◆ Provider outreach call after an appointment within seven calendar days to confirm that follow-up occurred
- ◆ If unable to confirm follow-up within seven days, a minimum of two additional outreach calls to the member are made to continue efforts to link the member with timely follow-up within 30 days
- ◆ If unable to reach the member after a minimum of three telephone contacts, an outreach letter is sent to the member informing the member of the importance of continued care and available services

In addition to these collaborative efforts, the MCOs implemented plan-specific interventions such as providing transportation, educating inpatient facility staff on the importance of coordinating care with other providers, and creating provider and member educational newsletters.

## Overall Recommendations

- ◆ The MCOs should build upon the existing momentum for study indicators with improving rates and implement new and/or enhanced quality improvement interventions for these PIPs.
- ◆ Implement a method to study the efficacy of the interventions to determine which interventions are most successful and which ones have not produced the desired effect.
- ◆ Identify study outcome barriers specific to the interventions already implemented. Barriers should be identified through analyses and then prioritized, based on the MCO's resources. Targeted interventions should be implemented to reduce and overcome the effects of the barriers.
- ◆ Conduct a “drill-down” type of analysis before and after the implementation of any intervention to determine if any subgroup within the population has a disproportionately lower rate that negatively affected the overall rate. The MCO's should target interventions to the identified subgroups with the lowest study indicator rates, allowing the implementation of more precise, concentrated interventions.
- ◆ Perform interim evaluations of the results in addition to the formal annual evaluation. Conducting interim measurements and evaluating the results could assist the MCO in identifying and eliminating barriers that impede improvement. The MCO should determine if the interventions are producing the desired effect, or if current interventions should be modified or new ones implemented to improve results based on the interim evaluation results.

The CAHPS surveys ask members to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. **FHN** and **Harmony** were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf. **FHN**'s and **Harmony**'s results were forwarded to HSAG for analysis.

Due to its size, **Meridian** was allowed to create and administer its own consumer satisfaction survey. The survey questions asked patients to report on their experiences with **Meridian** and addressed health care topics, such as patient wait time, doctor communication, office staff, smoking cessation, and rating of doctor and were based on the Adult CAHPS survey questions. As such, **Meridian**'s Member Satisfaction Survey was not congruent with the CAHPS surveys and the technical methods of data collection and analysis differed. A description of these technical methods is included with **Meridian**'s survey results later in this section of the report.

### **Objectives**

The overarching objective of the CAHPS surveys and **Meridian**'s Member Satisfaction Survey was to effectively and efficiently obtain information on members' levels of satisfaction with their health care experiences. **Meridian**'s survey results are included later in this section of the report following those of **FHN** and **Harmony**.

## **CAHPS Survey**

### **Technical Methods of Data Collection and Analysis**

For **FHN** and **Harmony**, the adult Medicaid and child Medicaid populations were surveyed. The Myers Group administered the CAHPS surveys on behalf of **FHN** and **Harmony**.

The technical method of data collection was through administration of the CAHPS 4.0H Adult Medicaid Survey to the adult population and the CAHPS 4.0H Child Medicaid Survey to the child population. Both plans used a mixed methodology for data collection, which included both a mail and telephone phase for data collection. The surveys could be completed in English or Spanish.

The survey questions were categorized into nine measures of satisfaction. These measures included four global ratings and five composite scores. The global ratings reflected members' overall satisfaction with their personal doctor, specialist, health plan, and all health care. The

composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). When a minimum of 100 responses for a measure was not achieved, the result of the measure was “Not Applicable” (NA).

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage was referred to as a question summary rate (or top-box response).

For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of the following two categories: (1) “Never,” “Sometimes,” “Usually,” and “Always,” or (2) “Definitely No,” “Somewhat No,” “Somewhat Yes,” and “Definitely Yes.” A positive or top-box response for the composites was defined as a response of “Always” or “Definitely Yes.” The percentage of top-box responses was referred to as a global proportion for the composite scores.

For **FHN**’s and **Harmony**’s plan-specific findings, a substantial increase is noted when a measure’s rates increased by more than 5 percentage points from 2010 to 2011. A substantial decrease is noted when a measure’s rate decreased by more than 5 percentage points from 2010 to 2011.

## Plan-Specific Findings

### Family Health Network

#### Adult Medicaid

The Myers Group collected 193 valid surveys from the eligible **FHN** adult Medicaid population from January through May 2011, yielding a response rate of 14.6 percent. The overall NCQA target number of valid surveys is 411. **FHN**'s 2010 and 2011 adult Medicaid CAHPS top-box percentages are presented in Table 8.1, along with NCQA's 2011 CAHPS top-box national averages.

**Table 8.1—FHN Adult Medicaid CAHPS Results**

	2010 Top-Box Percentages	2011 Top-Box Percentages	2011 NCQA CAHPS National Averages
<b>Composite Measures</b>			
<i>Getting Needed Care</i>	NA	NA	50.4%
<i>Getting Care Quickly</i>	55.9%	NA	56.4%
<i>How Well Doctors Communicate</i>	73.6%	70.5%	69.0%
<i>Customer Service</i>	NA	NA	59.3%
<i>Shared Decision Making</i>	NA	NA	59.5%
<b>Global Ratings</b>			
<i>Rating of All Health Care</i>	45.6%	38.8%	48.6%
<i>Rating of Personal Doctor</i>	56.1%	52.9%	61.3%
<i>Rating of Specialist Seen Most Often</i>	NA	NA	61.3%
<i>Rating of Health Plan</i>	46.3%	43.5%	54.6%
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as NA.			

For 2011, **FHN** reported valid CAHPS survey results for four of the nine CAHPS measures. A comparison of **FHN**'s 2010 results to its 2011 results revealed that **FHN**'s rates decreased for all four reportable measures: *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. The decrease in rate was substantial for *Rating of All Health Care*. However, **FHN** scored above the 2011 NCQA CAHPS top-box national average on one measure, *How Well Doctors Communicate*.

### Child Medicaid

The Myers Group collected 245 valid surveys from the eligible **FHN** child Medicaid population from January through May 2011, yielding a response rate of 15.4 percent. The overall NCQA target number of valid surveys is 411. **FHN**'s 2010 and 2011 child Medicaid CAHPS top-box percentages are presented in Table 8.2, along with NCQA's 2011 CAHPS top-box national averages.

**Table 8.2—FHN Child Medicaid CAHPS Results**

	2010 Top-Box Percentages	2011 Top-Box Percentages	2011 NCQA CAHPS National Averages
<b>Composite Measures</b>			
<i>Getting Needed Care</i>	NA	NA	56.4%
<i>Getting Care Quickly</i>	59.6%	58.7%	71.5%
<i>How Well Doctors Communicate</i>	71.8%	71.5%	75.2%
<i>Customer Service</i>	NA	NA	61.1%
<i>Shared Decision Making</i>	NA	NA	66.8%
<b>Global Ratings</b>			
<i>Rating of All Health Care</i>	59.9%	59.4%	62.5%
<i>Rating of Personal Doctor</i>	70.0%	67.2%	70.6%
<i>Rating of Specialist Seen Most Often</i>	NA	NA	68.0%
<i>Rating of Health Plan</i>	61.8%	54.1%	66.1%
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as NA.			

For 2011, **FHN** reported valid CAHPS survey results for five of the nine CAHPS measures. A comparison of **FHN**'s 2010 results to its 2011 results revealed that **FHN**'s rate decreased for all five reportable measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. The decrease in rate was substantial for *Rating of Health Plan*. In addition, **FHN** did not score above the 2011 NCQA CAHPS top-box national average on any of these measures.

## Harmony Health Plan

### Adult Medicaid

The Myers Group collected 436 valid surveys from the eligible **Harmony** adult Medicaid population from January through May 2011, yielding a response rate of 16.6 percent. The overall NCQA target number of valid surveys is 411. **Harmony**'s 2010 and 2011 adult Medicaid CAHPS top-box percentages are presented in Table 8.3, along with NCQA's 2011 CAHPS top-box national averages.

**Table 8.3—Harmony Adult Medicaid CAHPS Results**

	2010 Top-Box Percentages	2011 Top-Box Percentages	2011 NCQA CAHPS National Averages
<b>Composite Measures</b>			
<i>Getting Needed Care</i>	32.5%	37.1%	50.4%
<i>Getting Care Quickly</i>	51.8%	56.0%	56.4%
<i>How Well Doctors Communicate</i>	70.9%	74.2%	69.0%
<i>Customer Service</i>	57.1%	NA	59.3%
<i>Shared Decision Making</i>	60.6%	70.2%	59.5%
<b>Global Ratings</b>			
<i>Rating of All Health Care</i>	36.5%	43.8%	48.6%
<i>Rating of Personal Doctor</i>	52.2%	60.6%	61.3%
<i>Rating of Specialist Seen Most Often</i>	NA	NA	61.3%
<i>Rating of Health Plan</i>	36.4%	40.9%	54.6%
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as NA.			

For 2011, **Harmony** reported valid CAHPS survey results for seven of the nine CAHPS measures. A comparison of **Harmony**'s 2010 results to its 2011 results showed an increase in rates for all seven reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. The increase in rates was substantial for *Shared Decision Making*, *Rating of All Health Care*, and *Rating of Personal Doctor*. In addition, **Harmony** scored above the 2011 NCQA CAHPS top-box national averages on two measures: *How Well Doctors Communicate* and *Shared Decision Making*.

### Child Medicaid

The Myers Group collected 465 valid surveys from the eligible **Harmony** child Medicaid population from January through May 2011, yielding a response rate of 16.5 percent. The overall NCQA target number of valid surveys is 411. **Harmony's** 2010 and 2011 child Medicaid CAHPS top-box percentages are presented in Table 8.4, along with NCQA's 2011 CAHPS top-box national averages.

**Table 8.4—Harmony Child Medicaid CAHPS Results**

	2010 Top-Box Percentages	2011 Top-Box Percentages	2011 NCQA CAHPS National Averages
<b>Composite Measures</b>			
<i>Getting Needed Care</i>	40.8%	NA	56.4%
<i>Getting Care Quickly</i>	65.8%	61.3%	71.5%
<i>How Well Doctors Communicate</i>	70.0%	71.1%	75.2%
<i>Customer Service</i>	56.6%	NA	61.1%
<i>Shared Decision Making</i>	63.0%	61.4%	66.8%
<b>Global Ratings</b>			
<i>Rating of All Health Care</i>	47.5%	49.4%	62.5%
<i>Rating of Personal Doctor</i>	59.2%	64.3%	70.6%
<i>Rating of Specialist Seen Most Often</i>	NA	NA	68.0%
<i>Rating of Health Plan</i>	50.0%	53.4%	66.1%
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as NA.			

For 2011, **Harmony** reported valid CAHPS survey results for six of the nine CAHPS measures. A comparison of **Harmony's** 2010 results to its 2011 results showed an increase in rates for four measures: *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. The increase in rate was substantial for *Rating of Personal Doctor*. **Harmony's** rates decreased from 2010 to 2011 for two measures: *Getting Care Quickly* and *Shared Decision Making*; however, these decreases were not substantial. **Harmony** did not score above the 2011 NCQA CAHPS top-box national averages on any of the measures.



## Meridian Member Satisfaction Survey

### *Technical Methods of Data Collection and Analysis*

For Meridian, adult and child members were selected for the Member Satisfaction Survey. The survey consisted of a random sample of 519 adult and child members combined, who were from the eligible population. The eligible population criteria, at the time the sample was selected, was as follows: (a) continuously enrolled with **Meridian** for a six-month period beginning in January 2010, (b) currently eligible with **Meridian** without any pending termination notifications, and (c) had one or more visits with a **Meridian** primary care physician during 2010.

The technical method of data collection was through the administration of **Meridian**'s Member Satisfaction Survey to adult and child members. The survey was conducted telephonically. The results were captured and analyzed by **Meridian**. Of the 519 members selected for survey administration, 216 members completed a survey yielding a 42 percent response rate.

The percentage of members who chose a positive response was calculated for each survey question. For Question 1 and Questions 3 through 6, a positive response was defined as a response of "Usually or Always." For Question 2, a positive response was defined as a response of "Never." For Question 7 (not including the percentage of identified smokers), a positive response was defined as a response of "Yes." For Questions 8 and 9, the percentage of members who chose a satisfaction rating of "8, 9, or 10" on a scale of 0 to 10 (with 0 being the worst and 10 being the best) was defined as a positive response.

These questions were not sufficiently congruent with the CAHPS 4.0H Adult and Child Medicaid Surveys' questions to juxtapose **Meridian**'s results with NCQA CAHPS national averages. Furthermore, **Meridian**'s results did not include sufficient members to disaggregate the results to adult versus child members.

## Meridian Health Plan Survey Results

Table 8.5 presents **Meridian's** 2009 and 2010 results (i.e., percentage of positive responses) for each survey question from its Member Satisfaction Survey.

**Table 8.5—Meridian Member Satisfaction Survey Results**

Member Satisfaction Survey Question	2009 Results	2010 Results
1. Respondents stating they are always or usually able to get in to see the doctor as soon as needed	91%	85%
2. Respondents stating they never had to wait more than 30 minutes to see their doctor	63%	68%
3. Respondents stating their doctor always or usually listens to them and explains things in a way they can understand	90%	93%
4. Respondents stating the office staff is usually or always courteous and helpful to them	92%	93%
5. Respondents stating their doctor always or usually shows respect for what they have to say	92%	96%
6. Respondents stating their doctor always or usually spends enough time with them	87%	95%
7. Respondents identified as smokers (14 and 21 respondents in 2009 and 2010, respectively)	19%	12%
a. The identified smokers stating their doctor recommended they quit smoking	93%	71%
b. The identified smokers stating their doctor discussed medications to help them quit	57%	38%
c. The identified smokers stating their doctor discussed strategies other than medication to help them quit	50%	24%
8. Respondents stating they would rate their doctor as an 8, 9, or 10 on a scale of 0-10 with 10 being the best	85%	87%
9. Respondents stating they would rate <b>Meridian</b> as an 8, 9, or 10 on a scale of 0-10 with 10 being the best	93%	96%

A comparison of **Meridian's** 2009 results to its 2010 results (not including the percentage of identified smokers) reveal that **Meridian** improved on seven of the 11 measures. These measures include:

- ◆ Doctor's office wait time.
- ◆ Doctors who listen and explain things in an understandable way.
- ◆ Courteous and helpful office staff.
- ◆ Doctors who show respect for what patients say.
- ◆ Doctors who spend enough time with patients.
- ◆ Rating of doctor.
- ◆ Rating of **Meridian**.

Overall, **Meridian** showed the most improvement in the area of patients who reported their doctor always or usually spends enough time with them—from 87 percent in 2009 to 95 percent in 2010. While **Meridian** improved in the area of office wait time from 63 percent in 2009 to 68 percent in 2010, approximately one in three respondents reported having waited more than 30 minutes to see their doctor. As such, **Meridian** should explore ways to improve physician office wait time.

**Meridian** showed a decrease in rates from 2009 to 2010 on the following four measures.

- ◆ Getting in to see a doctor as soon as needed.
- ◆ Identified smokers who say their doctor recommended they quit smoking.
- ◆ Identified smokers who say their doctor discussed smoking cessation medications.
- ◆ Identified smokers who say their doctor discussed strategies other than medications to quit smoking.

While **Meridian**'s rates decreased for all smoking cessation measures from 2009 to 2010, extreme caution should be exercised when evaluating **Meridian**'s performance on these measures given the small number of respondents. A comparison of **Meridian**'s 2009 results to its 2010 results also reveal a decrease in the rate of members who reported they are always or usually able to get in to see the doctor as soon as needed—from 91 percent in 2009 to 85 percent in 2010. As such, **Meridian** should explore methods for improving in these areas.

## Plan Comparisons

Due to its small size, **Meridian** was allowed to conduct its own survey. Due to differences in survey instruments, **Meridian**'s results are not directly comparable with those of **FHN** and **Harmony**. For this reason, **Meridian**'s results are not displayed in this section of the report.

### Adult Medicaid

Table 8.6 presents the 2011 adult Medicaid CAHPS results for **FHN** and **Harmony**, as well as the 2011 NCQA national averages.

**Table 8.6—2011 Adult Medicaid CAHPS Results**

	FHN	Harmony	2011 NCQA CAHPS National Averages
<b>Composite Measures</b>			
<i>Getting Needed Care</i>	NA	37.1%	50.4%
<i>Getting Care Quickly</i>	NA	56.0%	56.4%
<i>How Well Doctors Communicate</i>	70.5%	74.2%	69.0%
<i>Customer Service</i>	NA	NA	59.3%
<i>Shared Decision Making</i>	NA	70.2%	59.5%
<b>Global Ratings</b>			
<i>Rating of All Health Care</i>	38.8%	43.8%	48.6%
<i>Rating of Personal Doctor</i>	52.9%	60.6%	61.3%
<i>Rating of Specialist Seen Most Often</i>	NA	NA	61.3%
<i>Rating of Health Plan</i>	43.5%	40.9%	54.6%
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as NA.			

Both **FHN** and **Harmony** scored above the 2011 NCQA Adult CAHPS top-box national average for *How Well Doctors Communicate*. **Harmony** scored more than 10 percentage points above the national average for *Shared Decision Making*.

Both **FHN** and **Harmony** scored more than 10 percentage points below the national average for *Rating of Health Plan*. In addition, both **FHN** and **Harmony** scored below the national averages for *Rating of All Health Care* and *Rating of Personal Doctor*.

A comparison of **FHN**'s and **Harmony**'s results to one another show that **Harmony** outperformed **FHN** on three of the four comparable CAHPS measures: *How Well Doctors Communicate*, *Rating of All Health Care*, and *Rating of Personal Doctor*.

## Child Medicaid

Table 8.7 presents the 2011 child Medicaid CAHPS results for **FHN** and **Harmony**, as well as the 2011 NCQA national averages.

**Table 8.7—2011 Child Medicaid CAHPS Results**

	FHN	Harmony	2011 NCQA CAHPS National Averages
<b>Composite Measures</b>			
<i>Getting Needed Care</i>	NA	NA	56.4%
<i>Getting Care Quickly</i>	58.7%	61.3%	71.5%
<i>How Well Doctors Communicate</i>	71.5%	71.1%	75.2%
<i>Customer Service</i>	NA	NA	61.1%
<i>Shared Decision Making</i>	NA	61.4%	66.8%
<b>Global Ratings</b>			
<i>Rating of All Health Care</i>	59.4%	49.4%	62.5%
<i>Rating of Personal Doctor</i>	67.2%	64.3%	70.6%
<i>Rating of Specialist Seen Most Often</i>	NA	NA	68.0%
<i>Rating of Health Plan</i>	54.1%	53.4%	66.1%
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as NA.			

Neither **FHN** nor **Harmony** scored above the 2011 NCQA Child CAHPS top-box national averages on any of the measures. Both **FHN** and **Harmony** scored more than 10 percentage points below the national averages for *Getting Care Quickly* and *Rating of Health Plan*. **Harmony** also scored more than 10 percentage points below the national average for *Rating of All Health Care*.

A comparison of **FHN**'s and **Harmony**'s results to one another show that **FHN** outperformed **Harmony** on four of the five comparable CAHPS measures: *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*.

## Conclusions and Recommendations

The following provides a summary of the CAHPS survey findings for **FHN** and **Harmony**, as well as a summary of **Meridian**'s findings from the Member Satisfaction Survey.

Recommendations have been provided for all health plans based on survey findings. For **FHN** and **Harmony**, areas of improvement have been identified based on a comparison of the health plans' CAHPS survey results to NCQA national averages, as well as prior years' results, where applicable. For **Meridian**, areas for improvement have been identified based on a comparison to prior year's Member Satisfaction Survey results. **Meridian**'s recommendations for improvement are included following those of **FHN** and **Harmony**.

### CAHPS Survey

#### Family Health Network

Based on **FHN**'s 2011 adult and child Medicaid CAHPS results, **FHN** has several areas that can be improved. **FHN** should focus on those areas where rates were both below CAHPS national averages and decreased from 2010 to 2011.

For the adult Medicaid population, **FHN** should focus on improving performance in the areas of *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*.

For the child Medicaid population, **FHN** should focus on improving performance in the areas of *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*.

#### Harmony Health Plan

Based on **Harmony**'s 2011 adult and child Medicaid CAHPS results, **Harmony** shows areas for improvement.

For the adult Medicaid population, **Harmony**'s rates increased from 2010 to 2011 for all seven reported CAHPS measures. However, **Harmony** scored more than 10 percentage points below the adult CAHPS national average for *Getting Needed Care* and *Rating of Health Plan*. As such, **Harmony** should continue to focus on improving in these areas.

For the child Medicaid population, **Harmony** should focus on those areas where rates were below CAHPS national averages and decreased from 2010 to 2011. As such, **Harmony** should focus on improving performance in the areas of *Getting Care Quickly* and *Shared Decision Making*.

## CAHPS Recommendations

Based on **FHN**'s and **Harmony**'s CAHPS surveys results, the following are general recommendations based on the information found in the CAHPS literature. The recommendations are intended to address those areas where CAHPS measure performance was low and opportunities for improvement exist for both **FHN** and **Harmony**. Each health plan should evaluate these general recommendations in the context of its own operational and quality improvement (QI) activities.

### Rating of All Health Care

- ◆ Health plans should identify potential barriers for patients receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deemed necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office.
- ◆ To improve patients' health care experience, health plans should identify and eliminate patient challenges when receiving health care. This includes ensuring that patients receive adequate time with a physician so that questions and concerns may be appropriately addressed and providing patients with ample information that is understandable.
- ◆ Since both patients and families have the direct experience of an illness or health care system, their perspectives can provide significant insight when performing an evaluation of health care processes. Therefore, health plans should consider creating patient and family advisory councils composed of the patients and families who represent the population(s) they serve. The councils' roles can vary and responsibilities may include input into or involvement in: program development, implementation, and evaluation; marketing of health care services; and design of new materials or tools that support the provider-patient relationship.

### Rating of Personal Doctor

- ◆ Health plans should encourage physician-patient communication to improve patient satisfaction and outcomes. Health plans also can create specialized workshops focused on enhancing physicians' communication skills, relationship building, and the importance of physician-patient communication.
- ◆ Health plans should request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit. This will allow providers to identify if adequate time is being scheduled for each appointment type and if appropriate changes can be made to scheduling templates to ensure patients are receiving prompt, adequate care. Patient wait times for routine appointments should also be recorded and monitored to ensure that scheduling can be optimized to minimize these wait times.

## Rating of Health Plan

- ◆ It is important for health plans to view their organization as a collection of microsystems, (such as providers, administrators, and other staff that provide services to members) that provide the health plan's health care "products." The first step to this approach is to define a measurable collection of activities. Once the microsystems are identified, new processes that improve care should be tested and implemented. Effective processes can then be rolled out throughout the health plan.
- ◆ A secure online patient portal allows members easy access to a wide array of health plan and health care information and services that are particular to their needs and interests. To help increase members' satisfaction with their health plan, health plans should consider establishing an online patient portal or integrating online tools and services into their current Web-based systems that focus on patient-centered care.
- ◆ Implementation of organization-wide QI initiatives are most successful when health plan staff at every level are involved; therefore, creating an environment that promotes QI in all aspects of care can encourage organization-wide participation in QI efforts. Furthermore, by monitoring and reporting the progress of QI efforts internally, health plans can assess whether QI initiatives have been effective in improving the quality of care delivered to members.

## How Well Doctors Communicate

- ◆ Health plans can encourage patients to take a more active role in the management of their health care by providing them with the tools necessary to effectively communicate with their physicians. Furthermore, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their health care and/or treatment options.
- ◆ Often, health information is presented to patients in a manner that is too complex and technical, which can result in patient non-adherence and poor health outcomes. To address this issue, health plans should consider revising existing and creating new print materials that are easy-to-understand based on patients' needs and preferences. Furthermore, providing training for health care workers on how to use these materials with their patients and ask questions to gauge patient understanding can help improve patients' level of satisfaction with provider communication.

## Getting Care Quickly

- ◆ An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Open access scheduling has been shown to have the following benefits: (1) reduces delays in patient care, (2) increases continuity of care, and (3) decreases wait times and number of no-shows resulting in cost savings.
- ◆ A patient flow analysis can be conducted to determine if dissatisfaction with timely care may be partly due to bottlenecks and redundancies in administrative and clinical patient flow



processes (e.g., diagnostic tests). A patient flow analysis involves tracking a patient's experience throughout a visit or clinical process (i.e., the time it takes to complete various parts of the visit/service).

- ◆ Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients that may not require an appointment with a physician. Furthermore, an online patient portal can aid in the use of electronic communication and provide a safe, secure location where patients and providers can communicate.
- ◆ Health plans can establish a nurse advice help line to direct members to the most appropriate level of care for their health problem(s). Additionally, a 24-hour help line can improve members' perceptions of getting care quickly by providing quick, easy access to the resources and expertise of clinical staff.

### Getting Needed Care

- ◆ Enhancing provider directories will allow patients to effectively choose a physician that will meet their needs. Frequent production and automated updates of provider directories are essential to ensure that the most current information is available. The utility of the provider directory can be enhanced by highlighting/emphasizing those providers who are currently accepting new patients.
- ◆ Health plans should ensure that patients are receiving care from physicians who are most appropriate to treat their condition. Tracking patients to ascertain that they are receiving effective, necessary care from those appropriate health care providers is imperative to assessing quality of care.

### Shared Decision Making

- ◆ Implementing a shared decision making model requires physician recognition that patients have the ability to make choices that affect their health care. Therefore, one key to a successful shared decision making model is ensuring that physicians are properly trained. Training should focus on providing skills to facilitate the shared decision making process, ensuring that physicians understand the importance of taking each patient's values into consideration, understanding patients' preferences and needs, and improving communication skills.
- ◆ Physicians will be able to better encourage their patients to participate in shared decision making if the health plan provides physicians with literature that conveys the importance of the shared decision making model. Furthermore, health plans can provide members with pre-structured question lists to assist them in asking all the necessary questions so the appointment is as efficient and effective as possible.

## **Meridian Member Satisfaction Survey**

### **Meridian Health Plan**

A comparison of **Meridian's** 2009 results to 2010 results reveal that **Meridian** improved most in the area of patients who reported their doctor always or usually spends enough time with them. While **Meridian's** percentage rates improved in the area of office wait time from 2009 to 2010, approximately one in three respondents reported having waited more than 30 minutes to see their doctor.

**Meridian** should focus on improving in those areas where performance decreased from 2009 to 2010. For **Meridian**, rates decreased from 2009 to 2010 for all smoking cessation measures, which include doctors recommending patients quit smoking, as well as physician-patient discussions regarding smoking cessation medications and strategies other than medications to help patients quit smoking. However, extreme caution should be exercised when evaluating **Meridian's** performance in the area of smoking cessation given the small number of respondents to these survey questions. A comparison of **Meridian's** 2009 results to 2010 results also showed a decrease in the rate of patients who reported getting to see a doctor as soon as needed.

### **Meridian Member Satisfaction Survey Recommendations**

Based on **Meridian's** Member Satisfaction Survey results, the following are general recommendations. The recommendations are intended to address those areas where performance was low and opportunities for improvement exist. **Meridian** should evaluate these general recommendations in the context of its own operational and QI activities.

#### **Smoking Cessation**

Some strategies for improving discussion between physicians and patients regarding smoking cessation could include providing physicians with educational materials that they can use to become more informed about the smoking cessation programs **Meridian** offers and similar resources that are available to members. **Meridian** also could explore the option of creating similar smoking cessation educational materials for members.

#### **Office Wait Time**

To improve in the area of office wait time, **Meridian** could encourage physicians to monitor patient flow. **Meridian** could provide instructions and/or assistance to those physicians that are unfamiliar with this type of evaluation. Dissatisfaction with timely care is often a result of bottlenecks and redundancies in the physician office flow processes. One method that can be used to identify these problems is to conduct a patient flow analysis. A patient flow analysis involves tracking a patient's experience throughout a visit or clinical service (i.e., the time it takes to

complete various parts of the visit/service). Examples of steps that are tracked include wait time at check-in, time to complete check in, wait time in the waiting room, wait time in the exam room, and time with provider. This type of analysis can help physicians identify “problem” areas, including steps that can be eliminated or steps that can be performed more efficiently.

A patient flow analysis should include measuring the amount of time it takes to complete a scheduled visit for various appointment types. By creating a schedule template that accurately reflects patient flow, physicians can reduce patient dissatisfaction with prolonged wait times and office staff time spent explaining appointment delays.

### **Physician Appointments**

To improve in the area of patients getting a physician appointment as soon as needed, **Meridian** could encourage physicians to explore open access scheduling. An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open access scheduling model includes leaving part of a physician’s schedule open for same-day appointments. Open access scheduling has been shown to have the following benefits: (1) reduces delays in patient care, (2) increases continuity of care, and (3) decreases wait times and number of no-shows resulting in cost savings.

### Introduction

As set forth in 42 CFR 438.364(a)(5), this section includes an assessment of the degree to which each Managed Care Organization (MCO) has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

In this section, HSAG provides an assessment of how each MCO has addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. The following sources were used to conduct this assessment:

- ◆ The prior year's EQR technical report.
- ◆ An evaluation of each health plan's annual report against criteria outlined by HFS. (At the request of the State, HSAG performed this evaluation during SFY 2009–2010.)
- ◆ An Information Systems (IS) review for Harmony Health Plan (conducted by HSAG at the request of the State in SFY 2011).

All of HSAG's recommendations for SFY 2009–2010 are complied, by MCO, and by categories of care and activities in the tables below. Each recommendation is followed by the health plan's response (e.g., initiatives, program changes, or other actions taken by the health plan to address the EQRO's prior year's recommendation.)

## Family Health Network

### Child and Adolescent Care

**Previous Recommendation:** FHN has shown significant improvement for five of the eight measures in the *EPSDT Screening* PIP since the baseline reporting period. The three highest-scoring measures from the *EPSDT Screening* collaborative PIP baseline period—health history, nutritional assessment, and growth measurement—have declined. FHN may be focusing on improving the lower rates but not ensuring that providers still perform and document the components for the other measures. FHN should continue efforts toward improving the *EPSDT* screening rates.

#### FHN Response:

- ◆ Implemented an immunization incentive in July 2010 consisting of mailing a monthly coupon for one free package of Osco brand diapers to members with children under 3 years of age who are enrolled in the program and whose immunizations are up to date.
- ◆ Provided educational sessions for medical groups targeting documentation requirements, coding, *EPSDT* components, and use of standardized charting forms.
- ◆ Conducted extensive meetings with medical groups' executive and quality staffs to discuss documentation requirements, coding, *EPSDT* compliance, and the use of standardized charting forms or electronic medical records. Information from the sessions was reinforced by visits from FHN's quality specialist and medical director.
- ◆ Conducted a collaborative outreach with Project LAUNCH. The goals of the project were to ensure that children maintain their physical and emotional health by increasing parent knowledge, ensure that families are connected to all the services they need, and ensure that children enter school ready to learn. The collaborative group is working with community-based organizations and providers, both medical and non-medical, to achieve these goals. As Project LAUNCH is limited to certain zip codes/neighborhoods in Chicago, the MCOs see this collaborative effort as a pilot intervention for the *EPSDT* PIP. Should these collaborative strategies, once developed, be effective, then the potential exists to expand into other areas of Chicago.

### Access to Care

**Previous Recommendation:** Achieving further improvements in the performance on HEDIS measures should be a top priority. The low rates for *Children's Access to PCPs* and *Adults' Access to Preventive/ Ambulatory Health Services* indicate that FHN needs to continue to improve access to care.

#### FHN Response:

- ◆ Continued monthly member newsletters which included articles on preventive and chronic care as well as seasonal items.
- ◆ Continued Missing Service Reminders to members semi-annually (March and September).

## Access to Care

- ◆ Continued Missing Service Reminders to medical groups semi-annually (March and September). These reports have been in place since September 2009. FHN plans to discuss the usefulness of the report in its current format and implement changes as needed to ensure the report is used for outreach to members.
- ◆ Member services continued to update addresses and telephone numbers for each call received by the representatives. This is a highly effective initiative, but updates are made only on members that call. Updates cannot be made on members that do not call.
- ◆ FHN's network was expanded to include 622 PCPs, 152 women's health care providers (WHCPs), 1523 specialists, and 298 behavioral health providers. Also, FHN met or exceeded all GeoAccess requirements for provider access.

**Previous Recommendation:** Continue to strengthen the case management and care coordination program.

### FHN Response:

- ◆ Continued implementation of the case management/disease management functions of the McKesson CareEnhance Clinical Management Software (CCMS). Case/disease management design included comprehensive assessment; risk stratification; and care plan problems, interventions, and goals. The FHN Medical Management Department used CCMS to automate work flow and clinical decision support criteria. CCMS allowed for integration of utilization, care, and disease management information. The CareEnhance software was used to document, track, support, and monitor the case management processes including health risk assessments, care treatment plans, case manager contact logs, and scanned letter storage.
- ◆ Implemented the disease management portion of the software in February 2011.
- ◆ Expanded care management staffing resources to expand the ability to outreach and engage members and ensure members receive Health Risk Assessments and Care Management and Care Coordination services as appropriate
- ◆ Continued work on the backlog of health risk assessments for new members.
- ◆ Hired a perinatal case manager dedicated to perinatal case management to work with its contracted behavioral health provider to provide intensive case management programs for members with behavioral health conditions.
- ◆ Implemented a care management action plan to ensure that all members receive health risk assessments and referrals for case/disease management as appropriate. The system is fully functional and the processes fully implemented.

## Maternity-Related Care

### Previous Recommendations:

- ◆ Track and monitor pregnant beneficiaries through claims/encounter data, case management, or other available data. These women should be encouraged to have regular prenatal care appointments and a postpartum care visit.
- ◆ Continue case management strategies for pregnant enrollees. Work more closely with the Family Case Management Program to assure coordination of services.
- ◆ Consider having the case managers arrange for postpartum care appointments while women are in the hospital following delivery or follow up immediately after hospital discharge.
- ◆ Continue incentives for women completing the recommended number of visits prior to delivery and for women who receive their postpartum care visit.
- ◆ Continue to regularly conduct provider profiling (e.g., once per quarter) to determine the rates for the three HEDIS measures, by provider. This information should be given to the providers to help improve results.
- ◆ Continue to educate providers about the importance of depression screening for women before and after delivery. The MCOs should also educate their network providers on screening, assessment, treatment, or referral for further assessment and treatment, as needed. At a minimum, providers should specifically attempt to screen for depression during the initial visit and periodically during subsequent prenatal care visits, as well as during the postpartum care visit.

### FHN Response:

- ◆ Recruited and hired a perinatal case manager dedicated to perinatal case management who works with its contracted behavioral health provider to provide intensive case management programs for its members with behavioral health conditions.
- ◆ Conducted member education on the importance of depression screening when the maternity case manager contacted the pregnant members.
- ◆ Implemented a telephonic screening tool for use by the FHN maternity care manager to screen for depression.
- ◆ Implemented same-day follow-up by the behavioral health vendor (PsycHealth) for positive screenings.
- ◆ Partnered with the CMS program "Text4baby." This free program sends text messages to pregnant women and to parents of newborns up to one year of age. The texts are educational and informative and are timed to the stage of the pregnancy or the age of the infant.
- ◆ Increased the postpartum incentive. Members are required to complete a timely postpartum visit and a depression screening to be eligible for the incentive.
- ◆ Implemented a new provider incentive for early notification of pregnant members. An

## Maternity-Related Care

incentive of \$25 is paid to PCPs and OBs the first time they notify FHN of a pregnant member. Information was included in the provider newsletter.

- ◆ Continued provider education efforts around the importance of perinatal depression screening and appropriate referral process.
- ◆ Completion of the Edinburgh Depression Screen for pregnant women increased from 7.8 percent in 2007 to 46 percent in 2010 due to combined efforts of case management activities at FHN and at PscHealth.

## Preventive Screening for Women

**Previous Recommendation:** The rates for the measures in the preventive screenings for women category improved over the prior year's results with the rate for chlamydia screening exceeding the 50th percentile; however, FHN should continue its focused quality improvement efforts to continue to improve the rates for the preventive screening measures.

### FHN Response:

- ◆ Continued member education via member handbook and member newsletter articles.
- ◆ Continued semi-annual notification to members of missing preventive services.
- ◆ Continued quarterly notification of members missing services to medical groups.
- ◆ Continued provider education on preventive care guidelines, appropriate coding, importance of encounter/claims data submission via group sessions, one-on-one sessions, and through the provider newsletter. Increased emphasis on encounter data submission.
- ◆ Continued with mammography incentive of a \$25 Payless Shoe Source gift card. Reminder letters to all women over 40 were mailed annually during October.
- ◆ Continued partnership with Weight Watchers. Members over age 18 who meet Weight Watchers requirements can enroll in the program. These enrollees are given information on the locations of Weight Watchers group meetings. FHN sends the participants coupons to cover the fee for the weekly meetings.

## Chronic Conditions/Disease Management

### Previous Recommendation:

The chronic conditions/disease management category has produced mixed results, with some rates increasing and several measures declining. FHN demonstrated notable improvement with *Comprehensive Diabetes Care—HbA1c Testing, LDL-C Screening, and Monitoring of Diabetic Nephropathy*. However, FHN's performance declined for *Controlling High Blood Pressure (Combined Rate), Comprehensive Diabetes Care—Poor HbA1c Control, Blood Pressure <140/90 mm/Hg, and Blood Pressure <130/80 mm/Hg*.



## Chronic Conditions/Disease Management

### FHN Response:

- ◆ Implemented a comprehensive case/disease management program for asthmatic and diabetic members starting February 2011. Process includes identification of potential members via multiple sources (claims, member services calls, health risk surveys, provider referral, member referral, UM), completion of a comprehensive assessment, risk stratification, development of a collaborative care plan involving member/care giver and providers, sharing of the care plan with the member and involved providers, and follow-up to evaluate movement toward the goals on the care plan.
- ◆ Focused QI efforts on improving member education, primarily through telephonic outreach for members with diabetes and asthma identified with a care gap. The nurses screen the member for case management and stratify for additional disease management as needed. The nurses assist the member with scheduling an appointment with the provider via a three-way telephone call to obtain the screening and/or evaluate for medication needs.
- ◆ Recruited and hired a certified diabetes educator.
- ◆ Implemented the preventive health incentive programs. FHN reported that all programs were having a positive effect on member compliance with preventive health services and that statistical evaluation will not be available until next annual report.
- ◆ Implemented a collaborative with Sinai Urban Health Institute Healthy Home Healthy Child Asthma Program. Children stratified as a level 2 or 3 were encouraged to participate in the program. Statistical results will be available at the end of 2012.
- ◆ Implemented a collaborative program with Osco Drug Stores for asthma education. Level 2 asthmatics are referred to this program. Statistical results will be available at the end of 2012.
- ◆ Implemented the collaborative Helping Her Live Mammography Program.
- ◆ Continued to educate providers on case/disease management programs via provider newsletter.
- ◆ Continued to educate providers one-on-one about case/disease management as their members are enrolled in the program.
- ◆ Evaluated effectiveness/outcomes of the Osco Asthma Program and the Sinai Urban Health Institute Asthma Program.
- ◆ Developed a separate report for identification of children with special health care needs.
- ◆ Provided care management staff with educational information on health literacy and motivational interviewing/coaching.

## Behavioral Health

**Previous Recommendation:** The two measures related to mental health continue to represent an area of strength for FHN, with the 7-day rate now exceeding the 90th percentile and the 30-day rate exceeding the 75th percentile. Below is a description of the initiatives implemented by FHN and its behavioral health vendor.

### FHN Response:

FHN's behavioral health vendor, PsychHealth, worked with FHN to continue and/or implement the following QI initiatives:

- ◆ Continued the Home Intervention and Transitional Care Program targeted at improving mental health follow-up rates and decreasing readmissions rates.
- ◆ Continued the Intensive Case Management Program designed to provide a much more intensive level of care coordination for members who have serious comorbid medical conditions, a history of non-compliance with behavioral health treatment recommendations, or chronic mental illness.
- ◆ Continued the discharge outreach program: every member discharged from the acute care setting is contacted to ensure knowledge of follow-up appointments with therapist, psychiatrist, and PCP.
- ◆ Implemented the Readmission Project: a new program with goals to connect members with the necessary services at the appropriate time and support treatment in the least restrictive setting.
- ◆ Continued the Aftercare Rewards Program: an incentive-based program to promote compliance and increase ambulatory follow-up rates.
- ◆ PsychHealth was awarded a URAC Best Practice Bronze Award for the Medical Follow-up After Acute Hospitalization Pilot Project. FHN members were participants in this pilot project.

## Consumer Satisfaction

**Previous Recommendation:** FHN's 2010 adult and child Medicaid CAHPS results indicated that quality improvement initiatives should focus on improving *Getting Needed Care* and *Ratings of All Health Care, Personal Doctor, Specialist Seen Most Often*, and *Health Plan* measure results.

### FHN Response:

- ◆ Conducted three quality assurance studies in the Member Services Department.
  - ✓ The first study, Customer Service Call Inspection, included a monthly survey of 30 member calls. The manager of the department randomly calls two members per representative within 72 hours of their call and also listens to three additional live calls per member services representative each month.
  - ✓ The second quality assurance study reviewed the accuracy of data entry for the enrollment applications into the FHN computer application system that is matched with the State

## Consumer Satisfaction

enrollment file upon enrollment of a member.

- ✓ The third quality audit measured the after-hours access to physicians and evaluated the messages on their answering machines or given by their answering services to ensure patients receive adequate instructions to receive care in off hours. Four calls were made per week in the late night hours. One in twenty calls resulted in a corrective action procedure for the physician office.

## Encounter Data

**Previous Recommendation:** The percentage of the rate that was captured using administrative encounter data was substantially lower for FHN. FHN's encounter data completeness was over 80.0 percent for *Well-Child Visits (3–6 Years)*, and *Adolescent Well-Care Visits*. However, eight measures had encounter data completeness rates of less than 60.0 percent. These results indicate that FHN continues to have difficulty obtaining complete encounter data. This concern was mentioned in the prior EQR technical report, and FHN is strongly encouraged to focus efforts on improving encounter data submission.

### FHN Response:

- ◆ Continued to work with its providers to improve encounter data submission. FHN will be increasing its work with providers throughout the remainder of 2011 and all of 2012.
- ◆ Increased the emphasis on encounter data submission to all physician providers and medical groups. FHN Information Systems (IS) department continued to work with IS departments of the medical groups to ensure all encounter information is being submitted to FHN. Additional IS staff was added to increase the emphasis and monitoring of encounter data from the medical groups. The medical groups are stressing the importance of encounter submission with their providers. FHN continued to work closely with the groups to try to determine why the “administrative data only” measures decreased this HEDIS cycle.
- ◆ Expanded the QA Pilot Project from 2009 to all Medical Groups and renamed it “2011 Pay for Quality Program.” The program has two components. Payment will take place in 2012 for dates of service in 2011. Part A of the program is reimbursement for electronic submission of encounter data for the eight HEDIS measures in the State's pay for quality withhold program. Part B of the program is payment for the State's eight pay for quality measures with payment following the State's payment methodology for reimbursement of the withhold and payment of the bonus incentive to FHN.
- ◆ Offered educational sessions to each medical provider group. Targeted educational information included: documentation requirements, coding, EPSDT components, encounter data submission, and use of standardized charting forms emphasizing thorough and complete documentation.
- ◆ FHN began implementation of McKesson's QNXI software to assist with the collection of encounter data and reporting to the medical groups.

## Annual Report Evaluation

### Previous Recommendations:

- ◆ Include the implementation of the case management and disease management programs into the 2010 work plan. FHN must develop a detailed timeline for the implementation of the case management and disease management programs.
  - ✓ FHN must include a discussion of how members were identified and screened for case management services prior to implementation of the Case Management (CM) software. The CM evaluation should also include progress and barriers to implementation of the CM program and strategies to address those barriers.
  - ✓ FHN must include a discussion of how members were identified and screened for Disease Management (DM) services prior to implementation of the software. The DM program evaluation should also include progress made along with barriers to implementation of the DM program and strategies to address those barriers.
- ◆ Include a discussion of methods used to manage members with chronic conditions, including barriers, interventions, and strategies to address those barriers in its subsequent annual reports.
- ◆ Strengthen the annual evaluation by addressing the member, provider, and internal barriers identified by developing targeted interventions to address the barriers. In addition, FHN should continue to conduct an evaluation of the effectiveness of the interventions and continue to refine intervention strategies to care for its members.
- ◆ Include in subsequent annual reports its evaluation of the Children with Special Health Care Needs (CSHCN) program, including services, barriers, and strategies to improve the care and management of the CSHCN population.
- ◆ Include an overall evaluation of the UM program, including a review of under- and overutilization information from the provider groups that are contracted with FHN to conduct UM activities. In addition, evaluate the initiatives employed to decrease out-of-network utilization and determine if the initiatives will be continued.
- ◆ Include identified barriers to the effectiveness of the health education program and the implementation of specific quality improvement initiatives to address the barriers identified.
- ◆ Include strategies/initiatives to address member dissatisfaction.
- ◆ Include strategies/initiatives designed to address member dissatisfaction with services from its provider network. The provider services staff should be included in the quality improvement initiatives.
- ◆ Expand the QI work plan to include information concerning the CM/DM system implementation; chronic care initiatives; health education; provider services activities; patient safety goals; fraud, waste and abuse; and privacy and security. FHN must include all QI activities in the annual work plan.

### FHN Response:

- ◆ Enhanced the annual report evaluation process and reporting to include the above recommendations.

## Harmony

### Child and Adolescent Care

#### Previous Recommendation:

- ◆ Harmony showed improvement for one measure (i.e., nutritional assessment) out of the eight EPSDT Screening Collaborative PIP measures. The rates for developmental screening, anticipatory guidance, and physical exam declined fewer than 4 percentage points. The other four measures demonstrated statistically significant declines in the rates. Harmony should continue efforts toward improving the EPSDT screening rates.

#### Harmony Response:

- ◆ Enhanced maternity discharge planning calls with the component of assisting with the scheduling of newborn well-care visit for well-child visits 0–15 months.
- ◆ Distributed newborn packets which included the recommended well-child visit schedule imprinted on a magnet which additionally listed the recommended immunization and lab test schedule. Also included an importance of immunization themed coloring book with crayons, a “wheel” that lists recommended immunization schedules by age, and the importance of well-child visits.
- ◆ Distributed preventive care booklets to new members which listed the recommended well-child visits and immunization schedule and highlighted the importance of preventive services.
- ◆ Continued a reward program of a \$50 gift card that can be used at one of several retail stores for completion of recommended well child visits in the first 15 months of life (6+ visits). (In 2011, 1,838 member incentive program letters were mailed; and an initial 20 gifts cards were issued in June 2011).
- ◆ Implemented the HEDIS Inbound Care Gap program on August 22, 2011. This intervention involves members who call inbound to the Customer Service Department and are identified as having a well-child visit or childhood immunization HEDIS Care Gap. Customer service representatives educate the member on the importance of scheduling and receiving preventive care services and offer to assist them in scheduling their doctor appointment via a three-way telephone call to the member’s physician office. If an appointment is scheduled or if members state that they already have an appointment scheduled for a future date, they are included on a daily report to a vendor who will make automated reminder telephone calls reminding members of their upcoming appointment with their physician.
- ◆ Continued participation in the MCO’s collaboration with Project LAUNCH, which is a five-year initiative funded by federal SAMSHA in partnership with the Greater Westside All Our Kids Network and the Illinois Children’s Mental Health Partnership, to ensure the healthy development of all young children from birth through age eight within a specific demographic area of Chicago. In the two largest zip codes of the Project LAUNCH target (60623 and

## Child and Adolescent Care

60624), Harmony Health Plan has approximately 4,000 children eight years of age alone. Identified were apparent synergies with the MCO's goals to increase EPSDT/Well-Child services and the Project LAUNCH goals relating to maintaining the child's physical and emotional health, connecting families to the services they need, and integrating the mental health services into other early childhood systems. (For well-child visits 0-15 months and 3-6 years of age only).

- ◆ Implemented QI nurse outreach visits to discuss the components and recommended schedule of EPSDT visits to medical groups and providers (currently nine visits completed in 2011).
- ◆ Continued provider representative outreach visits to medical groups and providers.
- ◆ Continued communication and education of providers regarding the capture of missed opportunities for the PCP to perform an EPSDT/ well-child visit when a hard-to-reach member presents for a sick visit.

## Access to Care

**Previous Recommendation:** Achieving further improvements in the Harmony's performance on HEDIS measures should be a top priority. The low rates for *Children's Access to PCPs and Adults' Access to Preventive/ Ambulatory Health Services* and the maternity-related measures indicate that Harmony needs to continue to improve access to care.

### Harmony Response:

- ◆ Began implementation of the HEDIS Inbound Care Gap program. This intervention will involve members who call inbound to the Customer Service Department and are identified as having a preventive service HEDIS care gap. Customer service representatives educate the member on the importance of scheduling and receiving preventive care services and offer to assist them in scheduling their doctor appointment via a three-way telephone call to the member's physician office. If an appointment is scheduled or if the members state they already have an appointment scheduled for a future date, they are included on a daily report to a vendor who will make automated reminder telephone calls reminding members of their upcoming appointment with their physician.
- ◆ Continued the QI nurse outreach visits to medical groups and providers.
- ◆ Distributed provider newsletter articles related to HEDIS specifications for preventive services and disease management along with the appropriate coding sheet.
- ◆ Continued to fax or mail noncompliant lists along with the coding sheets to providers.

**Previous Recommendation:** Continue to strengthen the case management and care coordination program.

### Harmony Response:

During the contract year, there were several process improvements in the Case Management program. Major process improvement activities include:

- ◆ Implemented a telephonic Transitional Care Management hospital-to-home program focusing

## Access to Care

on members with complex discharge needs with the goal of decreasing hospital inpatient re-admissions.

- ◆ Refined the referral process for 24-hour Nurse Advice Line cases which require follow-up by Case Management.
- ◆ Improved process for the identification of members for Case Management through Case and Disease Management Claims/Encounters Algorithm.
- ◆ Modified the Case Management database fields to standardize case management documentation requirements.
- ◆ Revised the process for assessing children and youth for special health care needs.
- ◆ Increased focus of patient self-management education and skills building through motivational interviewing techniques.

Harmony reported that the number of cases identified and referred to Case Management almost doubled from contract year 2010 (317 members) to contract year 2011 (632 members). Based on systems data, 36.7 percent of these referrals were identified through Harmony's Case and Disease Management Claims/Encounter Algorithm which identifies members based on severity, utilization, and costs. The second highest referral source (13.7 percent) was Harmony's Utilization Management Department and consists primarily of acute inpatient members transitioning from home who require extensive coordination of medical needs. Harmony continues to identify methods to increase the number of members referred to Case Management with a goal of managing 2 percent of Medicaid members over a 12-month period.

## Maternity-Related Care

### Previous Recommendation:

- ◆ For the *Perinatal Care and Depression Screening* PIP, the percentage of women who had a depression screen both before delivery and within 56 days after delivery has more than doubled (from 6.5 percent to 14.6 percent) but still presents an opportunity for improvement.
- ◆ Track and monitor pregnant beneficiaries through claims/encounter data, case management, or other available data. These women should be encouraged to have regular prenatal care appointments and a postpartum care visit.
- ◆ Continue case management strategies for pregnant enrollees. The MCOs should work more closely with the Family Case Management Program to ensure coordination of services.
- ◆ Consider having the case managers arrange for postpartum care appointments while women are in the hospital following delivery or follow up immediately after hospital discharge.
- ◆ Continue incentives for women completing the recommended number of visits prior to delivery and for women who receive their postpartum care visit.
- ◆ Continue to regularly conduct provider profiling (e.g., once per quarter) to determine the rates for the three HEDIS measures, by provider. This information should be given to the

## Maternity-Related Care

providers to help improve results.

- ◆ Continue to educate providers about the importance of depression screening for women before and after delivery. The MCOs should also educate their network providers on screening, assessment, treatment, or referral for further assessment and treatment, as needed. At a minimum, providers should specifically attempt to screen for depression during the initial visit and periodically during subsequent prenatal care visits, as well as during the postpartum care visit.

### Harmony Response:

- ◆ Initiated the Revise Harmony Hugs program in January 2011 since there appears to be a possible correlation between participation in the Harmony Hugs Program and compliance with recommended OB care.
- ◆ Implemented initial Hugs enrollment call for all pregnant Harmony members to educate pregnant members on the benefits of the Hugs program, services provided, and the incentives provided. The members were given the option of opting out of the Hugs program. Members were enrolled according to low, medium, and high risk groups.
- ◆ Referred high-risk cases for Centering and Doula programs to focus on pregnant members who fall into the age group and/or zip codes with the highest rates of noncompliance.
- ◆ Continued distribution of the maternity booklets which provide prenatal, postpartum, and newborn care education to all known pregnant members whether they are in the Harmony Hugs program or not.
- ◆ Continued the OB Prenatal Reward Program which provided strollers to members for completion of the requirements for the OB Prenatal Reward Program. During the reporting period the program was revised to remove the postpartum visit as a requirement; and the members were given a choice of a stroller or a “pack and play” upon completion of prenatal visits.
- ◆ Continued QI nurse visits to provider offices to educate about practice guidelines for prenatal care, PDSI and appropriate coding of encounters.
- ◆ Implemented a process that the QI nurse worked with Harmony Hugs staff to identify OB providers, discuss practice guidelines for prenatal and postpartum care, and educate provider offices and IPAs on appropriate coding for visits.
- ◆ Continued the Executive Level Face to Face HEDIS Focused Provider meetings. (Three Executive Level Face to Face HEDIS Focused Provider meetings have occurred in 2011).
- ◆ Distributed provider newsletter articles related to HEDIS specifications for timeliness of prenatal care and appropriate coding.
- ◆ Continued the provider incentive program which provides a monetary bonus for each compliant first prenatal visit, as confirmed by submission of a notification form. Focus on



### Maternity-Related Care

outreach to those IPAs with lowest numbers of provider notifications.

- ◆ Continued provider representative visits to educate the providers on the HEDIS measures and correct coding of encounters.
- ◆ Continued to fax or mail noncompliant member lists along with the coding sheets to providers.

### Preventive Screening for Women

**Previous Recommendation:** The rates for the measures in the preventive screenings for women category improved over last year but are below the 10th percentile. Harmony continued to show improvement with *Cervical Cancer Screening*, but the other rates remained about the same as last year. Harmony should continue quality improvement efforts to improve the breast cancer and chlamydia preventive screening measures.

#### Harmony Response:

- ◆ Continued to send periodicity letters for breast cancer.
- ◆ Continued to send periodicity letters for cervical cancer have been sent to members.
- ◆ Continued centralized telephonic outreach regarding the importance of scheduling a Pap smear. (In 2011, 5,951 have been made.)
- ◆ Continued to send new member packets to members.
- ◆ Continued the HEDIS Targeted Outreach Letter initiative. This mailing provides members with education on breast cancer screening and a list of provider offices where they could go and receive the screening in their county. The goal of this outreach is to improve compliance with preventive health measures and a corresponding improvement in HEDIS rates.
- ◆ Implemented the HEDIS Inbound Care Gap program on August 22, 2011. This intervention will involve members who call inbound to the Customer Service Department and are identified as having a preventive service HEDIS care gap. Customer service representatives educate the member on the importance of scheduling and receiving preventive care services and offer to assist them in scheduling their doctor appointment via a three-way telephone call to the member's physician office. If an appointment is scheduled or if members state they already have an appointment scheduled for a future date, they are included on a daily report to a vendor who will make automated reminder telephone calls reminding the member of their upcoming appointment with their physician.
- ◆ Implemented QI nurse outreach visits.
- ◆ Continued provider representative outreach visits.

## Chronic Conditions/Disease Management

**Previous Recommendation:** Harmony has shown little to no real improvement for the *Comprehensive Diabetes Care—Eye Exam* measure. Harmony needs to conduct an analysis to determine why this particular measure is so low. Harmony should consider conducting a PIP around this measure.

### Harmony Response:

- ◆ Completed an analysis of the eye exam measure results and identified non-compliance by unique zip code and provider group.
- ◆ Conducted a targeted medical record review.
- ◆ Implemented the Education/Screening Program (ESP). The purpose of the HEDIS ESP is to contact members identified by Harmony who have a care gap as defined by the HEDIS measures *Use of Appropriate Medications for People with Asthma* and *Comprehensive Diabetes Care*. HEDIS Disease Management (DM) nurses contact members identified with a care gap and provide education regarding the care gap and disease process. The nurses screen the member for case management and identify if additional disease management is needed. The nurse assists the member with scheduling an appointment with the provider via a three-way telephone call to obtain the screening and/or evaluate for medication needs. The goal of the HEDIS ESP is to improve compliance with screenings and a corresponding improvement in HEDIS rates.
- ◆ Continued centralized telephonic outreach regarding the importance of scheduling appointment for diabetes follow-up.
- ◆ Continued to send new member packets to members.
- ◆ Continued to send periodicity letters to members.
- ◆ Continued partnership with the Sinai Urban Health Institute for asthma initiative called Healthy Home, Healthy Child: the Westside Children's Asthma Partnership (HHHC). This partnership will be enhanced by the health plan sending out letters to eligible members.
- ◆ Continued the QI nurse outreach visits to medical groups and providers.
- ◆ Distributed noncompliant member lists quarterly to providers.
- ◆ Continued the provider representative outreach visits to medical groups and providers.
- ◆ Continued the executive level face-to-face HEDIS provider meetings.
- ◆ Continued the Pay-For-Quality Program. The Program is in the process of being revised for HEDIS 2012.

**Disease Management**—Harmony reported 6,873 members were enrolled in the program during the 1st and 2nd quarter of 2011. Initiatives undertaken during the reporting year included:

- ◆ Further stratify members that need a higher level of intervention within the Disease Management department. A higher level of focus will be made with these members to get them to participate in this program.

## Chronic Conditions/Disease Management

- ◆ Facilitate communication with the provider and member. Communication will be initiated by the nurse to the provider for follow up with the member.
- ◆ Staff Education: Continue to provide staff with tools needed to develop disease management skills and qualify for Chronic Care Professional (CCP) examination.
- ◆ Implement a telephone queue for increased member attention and ability to monitor all calls for quality purposes.
- ◆ Continued to improve reporting for Disease Management activities and outcomes.
- ◆ Conducted bi-annual calls to members when they are no longer working with a nurse, to make sure there are no further identified needs.

## Behavioral Health

**Previous Recommendation:** In the measures related to mental health, the 7-day rate for Harmony was above the 50th percentile but only 1.3 percentage points higher than the HEDIS 2007 rate. The 30-day rate showed little improvement and remains below the initial baseline rate.

### Harmony Response:

- ◆ Targeted outreach calls were made to the facility in which a member has been admitted for inpatient treatment. These calls were to reinforce the need for an outpatient appointment to be scheduled within seven (7) days of discharge, and offer assistance in locating providers. These calls were conducted by Harmony's behavioral health vendor, Magellan.
- ◆ Distributed a letter to members following discharge from hospital with the purpose of educating them on the importance of the continuum of treatment and the need to attend any and all outpatient appointments upon discharge; it also gives information on what to expect from an outpatient provider and how to prepare for the appointment.
- ◆ Followed up following discharge from an inpatient admission through an outreach call to the member to confirm the discharge plan. The outpatient provider is also called within seven (7) days after the appointment was scheduled to confirm if the appointment was kept.

## Consumer Satisfaction

**Previous Recommendation:** Harmony's 2010 adult and child Medicaid CAHPS results indicated that quality improvement initiatives should focus on improving *Getting Needed Care*, and *Ratings of All Health Care, Personal Doctor, Specialist Seen Most Often*, and *Health Plan* measure results. Harmony should continue to implement strategies to continually improve patient satisfaction.

**Harmony Response:** In response to the consumer satisfaction recommendations, Harmony implemented the following quality initiatives aimed at improving member satisfaction with health care services:

- ◆ Continued to use the Customer Service Quality Improvement Work Group to address issues identified by monitoring call trends, complaints, grievances, enrollment process, disenrollment

## Consumer Satisfaction

issues, and member satisfaction trends by establishing interventions to improve customer satisfaction.

- ◆ Launched the Quality Governance Program to drive improved quality and accountability for all call center sites.
- ◆ Continued to improve tools to measure customer satisfaction and first-call resolution. Prospective new customer satisfaction vendors will be identified and evaluated through the RFP process in an effort to enhance the satisfaction survey process overall through better analysis and results reporting.
- ◆ Expanded and fine-tuned the online help area by conversion of WellCare Link documentation to knowledge management solution provider.
- ◆ Enhanced tools and training to assist with complex call types such as out-of-service area.
- ◆ Enhanced grievance-specific training to all sites.
- ◆ Continued monitoring of access and availability reports to resolve deficiencies and work with providers to increase their hours of availability.

## Encounter Data

**Previous Recommendations:** Harmony's encounter data submission has improved, especially for the measures related to early well-child care (i.e., *Childhood Immunizations*, *Lead Screening in Children*, and *Well-Child Visits in the First 15 Months of Life*), maternity care, and diabetes care. Harmony should continue to reinforce efforts to improve submission of encounter data to maintain this level of encounter data submission.

### Harmony Response:

- ◆ Continued encounter data tracking by medical group, date of submission, and date of service for all direct submitters.
- ◆ Continued identification of data issues by medical group, by type of measure. Solved for root cause with each medical group, focusing by volume.
- ◆ Continued to provide noncompliant lists and report cards by PCP and medical group on an ongoing basis.
- ◆ Evaluated low encounter submitters and looked at contract interventions, including elimination of capitation to improve encounter submissions.

## Annual Report Evaluation

### Previous Recommendations:

- ◆ Include a summary of the work plan's goals and objectives met during the year. In addition, include a summary of the goals and objectives that were not met during the current annual evaluation period. The annual report should also identify how performance will be monitored and improved for those measures not meeting the performance goals in subsequent years.
- ◆ Include race or ethnicity information in the annual evaluation to determine if there are disparities in the delivery of health care services. Harmony should work with the State to identify ways to collect race and ethnicity information on its membership. In addition, Harmony must consider methods to electronically collect and report the race and ethnicity information for its membership. Harmony should also include a discussion on how the plan intends to address health care disparities in the 2010 annual evaluation.
- ◆ Include a barrier analysis and identify strategies for improvement when conducting its evaluation of members with chronic conditions.
- ◆ Include quality improvement strategies and initiatives for pregnant members younger than 21 years of age. Harmony should perform a barrier analysis for pregnant members 15–20 years of age, develop interventions, and design strategies and initiatives to target pregnant members under the age of 21.
- ◆ Include a barrier analysis for neonatal deaths, birth outcomes, and length of hospitalization for the mother and infant to determine interventions the plan could undertake to reduce neonatal deaths, improve birth outcomes, and remain within targets for C-section deliveries, vaginal deliveries and length of hospitalization after delivery.
- ◆ Continue to address barriers encountered during identification of members with CSHCN. Harmony should include a discussion of how the plan will address the barriers and the effectiveness of initiatives implemented in subsequent annual reports.
- ◆ Continue to monitor the progress of the PIPs and include the results of the medical record abstractions, barriers, and planned interventions for the collaborative PIPs in the next annual QAP evaluation. Subsequent annual reports should continue to provide an evaluation of the remeasurement results of the collaborative PIPs.
- ◆ Conduct a barrier analysis and identify specific strategies/initiatives to improve member satisfaction with services. Subsequent annual reports should include the results of the barrier analysis and discussion of interventions/strategies to improve member satisfaction.
- ◆ Expand the QI work plan to include information concerning provider services; patient safety; fraud, waste and abuse; privacy and security; and delegation oversight.

### Harmony Response:

- ◆ Enhanced the annual report evaluation process and reporting to include the above recommendations.

## Information Systems Review

**Previous Recommendation:** Harmony made changes to its claims/encounter processing system to better obtain encounter data and improve encounter data completeness and accuracy. These changes have improved some areas, but created additional, significant issues for Harmony, including:

- ◆ Future system upgrades or conversions should be thoroughly mapped and tested, and HFS should, at a minimum, be notified in advance of potential changes that could impact compliance with any contractual obligations.
- ◆ Enhance the data rejection tracking methodology.
- ◆ Implement a process to begin tracking and trending encounter data by NPI for providers that submit through clearinghouses and ultimately for direct submitters. By implementing this step, Harmony would be able to identify on a monthly basis which providers are under-submitting encounters. Harmony should continue to establish a benchmark based on historical encounter data submissions and identify providers that do not meet this benchmark on a monthly basis.
- ◆ Educate providers who use a clearinghouse about the appropriate steps to take if an encounter is rejected. Harmony should ensure that providers work with their clearinghouse to obtain the reason for a rejection and identify how to resubmit the data. Harmony should then be able to track providers that submit encounter data through a clearinghouse.
- ◆ Implement a process so that data from flat-file submissions (reported as 14 percent of overall claims/encounters) and the Pseudo-Claims database could be included for encounter data reporting. Harmony must provide a timeline and corrective action plan as to when it expects to have the encounter data issues resolved for flat-file submissions. Harmony should also be able to provide to HFS the breakout of what percentage each of these data sources contributes to Harmony's overall, self-reported rate.
- ◆ Develop a robust method for tracking encounter rejection reports (including the reason) from HFS. HSAG recommends that Harmony enhance the current tracking mechanism to identify all rejection types by HFS and how long it takes for the plan to ultimately correct the issue and resubmit the encounter until accepted by HFS. Harmony should use these internal statistics as a guide to identify the most common types of errors and how they are ultimately resolved. HSAG recommends that Harmony share these results with HFS on a monthly basis to identify rejections and their corresponding resolution.

### Harmony Response:

- ◆ Implemented quarterly reporting by the Encounter Data team that tracks submission of encounter data, by date of submission and date of service, from each IPA who submits directly, as compared to the target number of encounters per IPA dependent on their contract type and the types of encounters submitted directly. The team works closely with the IPAs to identify and intervene when submissions are not received or when the data are not timely received.
- ◆ Implemented efforts to move providers from the "flat-file" to clearinghouses. Since the format of the flat-file is not subject to the SNP edits, some of the encounter fall out during

## Information Systems Review

processing that would otherwise be captured at the front end and returned to the submitter for resubmission, decreasing encounter completeness.

- ◆ Re-contracted with Harmony's largest medical group to be capitated only for PCP services, instead of PCPs, specialists, and most outpatient services.
- ◆ Implemented discussions with the largest contracted medical group to obtain encounter data direct from its associated hospital-based lab.
- ◆ Continued working with HFS on encounter data rejections.

## Meridian

### Child and Adolescent Care

**Previous Recommendation:** Due to Meridian's low population, Meridian did not have more than 30 eligible members for any of the reported HEDIS measures. In accordance with NCQA, the rates for these measures are not applicable (NA). Therefore, Meridian's rates were not presented for this year. Meridian is expected to have a larger population in SFY 2012 and should be able to report for some measures.

**Meridian Response:** N/A

### Access to Care

**Previous Recommendation:** Due to Meridian's low population, Meridian did not have more than 30 eligible members for any of the reported HEDIS measures. In accordance with NCQA, the rates for these measures are not applicable (NA). Therefore, Meridian's rates were not presented for this year. Meridian is expected to have a larger population in SFY 2012 and should be able to report for some measures.

**Meridian Response:** N/A

**Previous Recommendation:** Continue to strengthen the case management and care coordination program.

#### Meridian Response:

- ◆ Developed new Complex Case Management Screens within the MHP Managed Care System (MCS). Data currently stored within the MCS was used to auto-populate some of these fields to create efficiencies.
- ◆ Hired a new nurse case manager.
- ◆ Developed and implemented a member outreach program to reduce the inappropriate utilization of urgent and emergency care services for routine and primary care needs. The program included the use of an ER assessment tool for members after ER utilization, coordination of care, connecting them with a PCP, and CM when indicated, for members with high-volume ER utilization.
- ◆ Implemented new trigger alerts from the member HRAs for both DM and CM follow-up.
- ◆ Developed a Family Case Management grid as an internal desk job aid to ensure appropriate referrals for pregnant women and families.
- ◆ Updated the format and mailed Disease Management newsletters to members identified as eligible for the program.

**Previous Recommendation:** Due to Meridian's low population, Meridian did not have more than 30 eligible members for any of the reported HEDIS measures. In accordance with NCQA, the rates for these measures are not applicable (NA). Therefore, Meridian's rates were not



**Access to Care**

presented for this year. Meridian is expected to have a larger population in SFY 2012 and should be able to report for some measures.

**Meridian Response:** N/A

**Maternity-Related Care**

**Previous Recommendation:** Due to Meridian's low population, Meridian did not have more than 30 eligible members for any of the reported HEDIS measures. In accordance with NCQA, the rates for these measures are not applicable (NA). Therefore, Meridian's rates were not presented for this year. Meridian is expected to have a larger population in SFY 2012 and should be able to report for some measures.

**Meridian Response:** N/A

**Preventive Screening for Women**

**Previous Recommendation:** Due to Meridian's low population, Meridian did not have more than 30 eligible members for any of the reported HEDIS measures. In accordance with NCQA, the rates for these measures are not applicable (NA). Therefore, Meridian's rates were not presented for this year. Meridian is expected to have a larger population in SFY 2012 and should be able to report for some measures.

**Meridian Response:** N/A

**Chronic Conditions/Disease Management**

**Previous Recommendation:** Due to Meridian's low population, Meridian did not have more than 30 eligible members for any of the reported HEDIS measures. In accordance with NCQA, the rates for these measures are not applicable (NA). Therefore, Meridian's rates were not presented for this year. Meridian is expected to have a larger population in SFY 2012 and should be able to report for some measures.

**Meridian Response:** N/A

**Behavioral Health**

**Previous Recommendation:** Due to Meridian's low population, Meridian did not have more than 30 eligible members for any of the reported HEDIS measures. In accordance with NCQA, the rates for these measures are not applicable (NA). Therefore, Meridian's rates were not presented for this year. Meridian is expected to have a larger population in SFY 2012 and should be able to report for some measures.

**Meridian Response:** N/A

## Consumer Satisfaction

**Previous Recommendation:** Meridian's non-CAHPS survey results indicated satisfaction in 6 of the 11 measures. Opportunities for improvement were seen for providers discussing medications to help the member to quit smoking as well as offering strategies other than medications for smokers to quit, beyond the doctor's recommendation to do so. In addition, Meridian HFS beneficiaries expressed some dissatisfaction with office wait times. Meridian should implement initiatives to improve HFS beneficiaries' dissatisfaction with office wait times and to educate providers regarding smoking cessation programs.

### Meridian Response:

- ◆ Due to its size, Meridian was allowed to create and administer its own consumer satisfaction survey. The survey questions asked patients to report on their experiences with Meridian and addressed health care topics, such as patient wait time, doctor communication, office staff, smoking cessation, and rating of doctor.
- ◆ In 2010, improving customer service also became a corporate objective. MHP uses three data sources as indicators for member satisfaction. The three metrics are:
  - ✓ Telephone Service Rates
  - ✓ Patient Experience Surveys (proxy for CAHPS)
  - ✓ Member Grievance and Appeals
- ◆ Member Services goals included achieving a telephone servicing factor of 98 percent (percentage of calls answered within 30 seconds or less), live person transfers when appropriate, and improving the rating of customer service as reported in the annual Patient Experience Survey.
- ◆ Network Development Specialists (NDS) will focus on increasing availability and access throughout the provider network.
- ◆ Distribution of enhancing patient satisfaction flyer to all provider offices.
- ◆ Educate members on what to expect at an office visit and how to be prepared.
- ◆ Monitor access to care complaints in the new vs. existing counties for possible trends and issues.
- ◆ Replace the Patient Experience Survey with formal CAHPS surveys once membership is sufficient for required reporting.

## Annual Report Evaluation

### Previous Recommendation:

- ◆ As Meridian continues to grow its enrollment, future annual reports should include a more detailed discussion of the CM program, barriers, interventions, strategies, and initiatives. Meridian should also include a discussion of enhancements to the CM software program.
- ◆ Include a discussion on how CSHCNs are identified, barriers to improvement, services

### Annual Report Evaluation

provided, and quality improvement strategies in subsequent annual reports.

- ◆ Include a discussion of the remeasurement results, barriers, and interventions for the EPSDT PIP.
- ◆ Include a discussion of provider service activities, patient safety, and delegation oversight.
- ◆ Include health education and provider service activities in the annual QI work plan.

#### Meridian Response:

- ◆ Enhanced the annual report evaluation process and reporting to include the above recommendations.

### Technical Assistance to HFS and MCOs

HSAG has provided a variety of technical assistance to HFS that has led to quality outcomes. This includes technical assistance in the following areas: PIPs, grievance and appeals process, care management programs, performance tracking tools, children’s special health care needs, the Pay-for-Performance (P4P) program, MCO compliance and readiness reviews, identification and selection of program-specific performance measures, developing and implementing new Medicaid programs, and much more. HSAG has worked with HFS and the MCOs to develop models of stakeholder collaboration for quality improvement projects, essential for identifying and implementing sustainable activities that lead to improved preventive and developmental services. The Illinois collaborative PIPs have improved EPSDT screening services for children; improved perinatal care, post-partum care and depression screening for women; and improved communication between behavioral health and medical providers for participants with behavioral health conditions.

HSAG understands the importance of providing ongoing and specific technical assistance to each MCO, as needed, and provides consultation, expertise, suggestions, and advice to assist with decision-making and strategic planning. HSAG works in partnership and collaboration with the State and MCOs to ensure that it delivers effective technical support that facilitates the delivery of quality health services to Illinois Medicaid members. As requested by HFS, HSAG has continued to provide technical guidance to the MCOs to assist them in conducting the mandatory EQR activities—particularly, to establish scientifically sound PIPs and develop effective corrective action plans (CAPs). HSAG, at the request of HFS, provided technical assistance training to the MCOs in conducting root cause analyses and implementing meaningful interventions to address the findings outlined in the MCOs’ annual program evaluations and the results of PIPs and performance measures.

Specific examples of technical assistance topics conducted in SFY 2010–2011 are listed below.

#### **Conducting PIPs**

- ◆ Selecting PIP Topics
- ◆ Development of Study Question(s)
- ◆ Selection of Study Indicator(s)

- ◆ Selection of Study Population
- ◆ Sampling Methods
- ◆ Data Collection/Analyses
- ◆ Assessment of Quality Improvement Strategies
- ◆ Sustained Improvement

### ***Performance Measures***

- ◆ Provided Consultation on Identification and Selection of ABD Performance Measures
- ◆ Provided HEDIS and HEDIS-like Measure Recommendations
- ◆ Provided Consultation on Selection of P4P Measures for the ICP Program

### ***Participation in Monthly and Quarterly Managed Care Quarterly Meetings***

HSAG meets regularly with HFS throughout the term of its EQRO contract in order to partner effectively and efficiently with the State. Currently, both the executive director and the project manager assist and attend HFS' on-site quarterly meetings with the MCOs as well as the monthly teleconference meetings. The purpose of these meetings is to review all current and upcoming EQR activities, discuss any barriers or progress, design solutions or a course of action, and review the goals of the quality strategy. The meetings include discussion of compliance with the State's quality strategy, ongoing monitoring of performance of the VMCO and ICP programs, program changes or additions, and future initiatives. In addition, the on-site quarterly meetings serve as a forum for review of the MCOs' progress in managing their quality assessment and performance improvement programs, as well as provide time for technical assistance and training sessions provided by HSAG.

For both monthly and quarterly meetings, HSAG is responsible for consulting with HFS in selecting meeting content, preparing the agenda and any necessary meeting materials, forwarding materials to participants in advance of the meeting, and facilitating the meeting. Meeting materials may include slide handouts, worksheets, PowerPoint presentations, or technical demonstrations. Subject matter experts, including clinical and analytical staff as required, are involved in the development of meeting content; and appropriate staff will provide the instruction and/or facilitation, as appropriate. Following each meeting, HSAG prepares meeting minutes, and upon HFS' approval forwards them to all meeting participants. As part of this process, HSAG creates an action item list and then follows up with the MCOs and HFS to ensure timely completion of those items. HSAG provides status updates to HFS so it can track MCO progress on completing follow-up items.

## ***Development of Integrated Care Plan Performance Measures***

The Center for Health Care Strategies, Inc. (CHCS) outlines the following information about developing effective performance measures:

- ◆ The performance measures available to purchasers and providers today are unevenly distributed across the acute medical, behavioral health, and long-term care sectors. Quality measures for preventive and acute medical care and common chronic illnesses (e.g., asthma and diabetes) are fairly well developed, in contrast with performance measures related to behavioral health and long-term care. Many sources have documented the need for more comprehensive and holistic measures for people with disabilities and chronic illnesses, but this need is only addressed to a limited extent in current nationally recognized measurement sets such as HEDIS. The driving force in health plan performance measurement today is the NCQA's HEDIS measures, which are used to evaluate the performance of commercial, Medicaid, and Medicare managed care plans nationally.
- ◆ For the most part, the HEDIS measures focus on acute medical care, with an emphasis on preventive care screenings and care delivery processes for a few of the most common health conditions and chronic illnesses. While many of these measures are relevant to individuals in integrated care programs, the measures only address a portion of their acute and chronic health care conditions and needs. In addition, there is no comprehensive measurement set that addresses the complexity of health issues and support services common to those in long-term care settings (e.g., consumer transitions between health care settings, care coordination, etc.). As a result, many health plans and researchers specializing in the care of people with chronic illnesses believe that alternative quality measures are needed to accurately assess performance for plans and providers caring for frail elders and people with disabilities.<sup>10-1</sup>

To assist HFS in developing performance measures that would meet the unique demands of the Integrated Care Program, HSAG completed a literature review to determine if there were applicable measures currently being developed and identified existing measures that could be adapted for use. HSAG worked collaboratively with HFS and the ICPs to identify and develop performance measures specific to ICP members. Through this collaboration, 30 performance measures were identified; and data specifications were developed for each of the performance measures. The 30 ICP performance measures that were developed by HFS and the ICPs are a mix of HEDIS, HEDIS-like, and State-defined measures.

## ***Performance Tracking Tool (PTT)***

Modifications to the PTT were completed in SFY 2010–2011. The modifications included current benchmarks along with the new quality incentive measures and methodology, as well as performance measure goals for SFY 2011–2012.

<sup>10-1</sup> [http://www.chcs.org/usr\\_doc/ICP\\_Resource\\_Paper.pdf](http://www.chcs.org/usr_doc/ICP_Resource_Paper.pdf)

The PTT includes the following:

- ◆ A key timeline for reporting requirements.
- ◆ Compliance monitoring activities, including areas for targeted improvement for the MCOs.
- ◆ A simplified process for entering rates for the various activities (e.g., HEDIS, CAHPS, PIPs).
- ◆ Links to automatically trend, graph, determine HEDIS percentile rankings, determine next goals, and calculate incentive payment qualification.
- ◆ PIP summary tables to determine validation status and improvements on individual PIP quality indicators.
- ◆ A Chi-square and *p* value calculator to facilitate the MCOs' ability to determine if changes were statistically significant.

**FHN**, **Harmony**, and **Meridian** use the PTT for tracking and monitoring rates and activities, quality improvement efforts, and comparisons to benchmarks; setting and achieving goals; and internal and external reporting (e.g., the MCO's annual report to HFS).

HFS may use the PTT to enhance reporting to CMS and to the State legislature, as well as to enhance other interdepartmental reporting, and determine areas that need focused attention (e.g., HFS can use the PTT to develop collaborative PIPs).

### **Case Management and Care Coordination Programs**

To address the goals of improving care coordination for Illinois Medicaid beneficiaries and to align with the national priorities for improved care coordination, HFS, HSAG, and the VMCOs have focused their efforts to improve case management information systems and coordination of care for their enrollees. Case management was one area assessed during focused reviews conducted by HSAG in 2010–2011.

To monitor the case management and disease management programs within the VMCOs, HFS requires HSAG to conduct reviews of the programs and the VMCOs to submit monthly, quarterly, and annual reports. These reports describe the VMCOs' efforts to identify and intervene for enrollees with special health care needs, or with social circumstances or behavioral health issues that place the enrollee at risk for poor health outcomes.

Using an internal algorithm and systems to determine the conditions and risk levels of enrollees, VMCOs are required to identify at-risk enrollees; assign a stratification level such as high, moderate, or low; and report the risk stratification level for its enrollees. The risk stratification information reported by the VMCOs enables HFS to monitor risk levels of the MCOs' enrollees and subsequent trends and movement of the VMCOs' enrollees to higher or lower risk levels. In

addition, the VMCOs submit reports measuring the outreach efforts employed to locate and engage enrollees, including telephone calls, mailings, and home visits.

The focused review conducted by HSAG centered on assessing VMCO compliance with HFS case management contract requirements including methods for member identification and selection for case management services, activities of assessment, problem identification, care planning, care delivery, monitoring, evaluation of the care provided, and the health care team's ability to meet the desired outcomes and established goals for members receiving case management services.

During the on-site focused review and as follow-up to the review, HSAG provided ongoing technical assistance to the VMCOs to ensure that they had addressed all non-compliant areas. HSAG provided technical assistance in the development and implementation of corrective actions plans. Implementation of the CAPs were reviewed periodically for progress toward full compliance with updates provided to HFS. The corrective actions taken by the VMCOs was validated through document review and will continue to be evaluated through on-site review in subsequent years.

Case management and care coordination will continue to be an area of focus until HFS is assured that the MCOs' case management and care coordination programs increase access to health care services, improve outcomes of the care delivered, improve the overall quality of care, and reduce the cost of health care services to HFS beneficiaries.



Table A.1—Child and Adolescent Care and Adults’ Access to Preventive/Ambulatory Care Measures

HEDIS Measures	Meridian	FHN	Harmony	All MCOs	National Medicaid HEDIS 2010 Percentiles				
					10th	25th	50th	75th	90th
<b>Child and Adolescent Care</b>									
<i>Childhood Immunizations—Combo 2</i>	NA	75.7%	65.9%	70.9%	61.8%	68.8%	76.6%	81.6%	85.6%
<i>Childhood Immunizations—Combo 3</i>	NA	70.4%	61.6%	66.1%	56.0%	63.5%	71.0%	76.6%	82.0%
<i>Lead Screening in Children</i>	NA	81.9%	78.1%	80.1%	42.3%	57.6%	71.6%	81.0%	88.4%
<i>Well-Child Visits in the First 15 Months (0 Visits)*</i>	NA	3.5%	5.4%	4.4%	0.5%	0.7%	1.4%	2.9%	5.1%
<i>Well-Child Visits in the First 15 Months (6+ Visits)</i>	NA	53.8%	51.3%	52.6%	40.9%	52.2%	60.1%	69.7%	76.3%
<i>Well-Child Visits (3–6 Years)</i>	NA	67.4%	71.8%	69.5%	59.9%	65.9%	71.8%	77.3%	82.5%
<i>Adolescent Well-Care Visits</i>	NA	43.9%	38.9%	41.5%	34.4%	38.8%	46.8%	56.0%	63.2%
<i>Immunizations for Adolescents</i>	NA	40.5%	29.9%	35.3%	21.9%	31.2%	42.4%	53.9%	65.9%
<i>Children’s Access to PCPs (12–24 Months)</i>	100.0%	82.2%	86.5%	84.3%	90.6%	95.1%	96.8%	97.9%	98.5%
<i>Children’s Access to PCPs (25 months–6 Years)</i>	92.1%	69.9%	73.3%	72.4%	81.0%	87.1%	89.8%	92.2%	94.1%
<i>Children’s Access to PCPs (7 –11 Years)</i>	NA	51.1%	70.5%	66.3%	85.0%	87.7%	91.3%	93.4%	95.6%
<i>Adolescent’s Access to PCPs (12 –19 Years)</i>	NA	53.0%	71.4%	68.1%	80.6%	85.4%	88.9%	91.8%	93.7%
<b>Adults’ Access to Preventive/Ambulatory Care</b>									
<i>20–44 Years of Age</i>	90.5%	64.6%	69.3%	68.3%	67.4%	78.0%	82.9%	86.7%	88.5%
<i>45–64 Years of Age</i>	NA	67.4%	68.8%	68.5%	73.2%	83.2%	88.1%	90.1%	91.3%

\* Lower rates indicate better performance for this measure.

	National Medicaid HEDIS 2010 Percentile					
	<10	10–24	25–49	50–74	75–89	90–100
Color Code for Percentiles						

**Table A.2—Preventive Screening for Women and Maternity-Related Measures**

HEDIS Measures	Meridian	FHN	Harmony	All MCOs	National Medicaid HEDIS 2010 Percentiles				
					10th	25th	50th	75th	90th
<b>Preventive Screening for Women</b>									
<i>Breast Cancer Screening</i>	NA	47.7%	30.7%	33.8%	39.8%	46.2%	52.0%	59.6%	63.8%
<i>Cervical Cancer Screening</i>	NA	69.4%	69.8%	69.6%	50.4%	61.0%	67.8%	72.9%	78.9%
<i>Chlamydia Screening (16–20 Years of Age)</i>	NA	62.5%	46.1%	48.5%	43.8%	48.5%	53.0%	61.1%	66.4%
<i>Chlamydia Screening (21–24 Years of Age)</i>	NA	70.7%	57.2%	59.5%	49.5%	55.8%	62.4%	69.1%	73.4%
<i>Chlamydia Screening (Combined Rate)</i>	NA	66.3%	50.9%	53.3%	44.2%	50.6%	55.7%	63.7%	69.5%
<b>Maternity-Related Measures</b>									
<i>Frequency of Ongoing Prenatal Care (&lt;21% of Visits)*</i>	NA	18.2%	16.5%	17.4%	2.2%	3.4%	7.0%	13.9%	22.2%
<i>Frequency of Ongoing Prenatal Care (81–100% of Visits)</i>	NA	42.3%	39.9%	41.1%	31.5%	52.1%	64.2%	73.7%	82.2%
<i>Timeliness of Prenatal Care</i>	98.2%	62.4%	64.7%	63.5%	70.6%	80.3%	86.0%	90.0%	92.7%
<i>Postpartum Care</i>	85.5%	40.2%	48.7%	44.3%	53.0%	58.7%	65.5%	70.3%	74.4%

\* Lower rates indicate better performance for this measure.

	National Medicaid HEDIS 2010 Percentile					
	<10	10–24	25–49	50–74	75–89	90–100
Color Code for Percentiles						

Table A.3—Chronic Conditions/Disease Management Measures

HEDIS Measures	Meridian	FHN	Harmony	All MCOs	National Medicaid HEDIS 2010 Percentiles				
					10th	25th	50th	75th	90th
<b>Chronic Conditions/Disease Management</b>									
<i>Controlling High Blood Pressure</i>	NA	45.6%	42.6%	43.6%	41.9%	49.4%	57.1%	63.3%	67.2%
<i>Diabetes Care (HbA1C Testing)</i>	NA	79.2%	69.6%	72.6%	69.4%	76.0%	81.1%	86.4%	90.2%
<i>Diabetes Care (Poor HbA1c Control)*</i>	NA	69.9%	65.9%	67.2%	27.7%	33.8%	43.2%	53.4%	63.5%
<i>Diabetes Care (Good HbA1c Control)</i>	NA	31.7%	29.4%	30.1%	29.9%	38.7%	46.6%	54.2%	58.8%
<i>Diabetes Care (Eye Exam)</i>	NA	31.7%	18.2%	22.4%	32.1%	41.4%	54.0%	63.7%	70.1%
<i>Diabetes Care (LDL-C Screening)</i>	NA	68.9%	63.7%	65.3%	62.6%	69.3%	75.4%	80.1%	84.0%
<i>Diabetes Care (LDL-C Level &lt;100 mg/dL)</i>	NA	29.5%	17.5%	21.2%	19.5%	27.2%	33.6%	40.9%	45.5%
<i>Diabetes Care (Nephropathy Monitoring)</i>	NA	84.7%	67.4%	72.7%	65.7%	72.5%	77.7%	82.7%	86.2%
<i>Diabetes Care (BP &lt;140/90)</i>	NA	54.6%	49.6%	51.2%	43.8%	53.5%	61.6%	68.2%	73.4%
<i>Appropriate Medications for Asthma (Combined)</i>	NA	90.3%	86.0%	86.6%	84.6%	86.7%	88.6%	90.8%	92.8%
<i>Follow-up After Hospitalization for Mental Illness—7 Days</i>	NA	70.9%	42.7%	49.1%	18.2%	29.6%	43.5%	59.1%	64.3%
<i>Follow-up After Hospitalization for Mental Illness—30 Days</i>	NA	80.2%	56.1%	61.6%	31.8%	49.0%	62.6%	74.3%	83.6%
* Lower rates indicate better performance for this measure.									

	National Medicaid HEDIS 2010 Percentile					
	<10	10–24	25–49	50–74	75–89	90–100
Color Code for Percentiles						

HEDIS Measures	HEDIS Rates for Family Health Network				HEDIS Rates for Harmony Health Plan				HEDIS 2010 National Medicaid Percentiles				
	2008	2009	2010	2011	2008	2009	2010	2011	10th	25th	50th	75th	90th
<b>Child and Adolescent Care</b>													
<i>Childhood Immunizations—Combo 2</i>	68.9	72.0	75.5	75.7	53.8	62.5	67.4	65.9	61.8	68.8	76.6	81.6	85.6
<i>Childhood Immunizations—Combo 3</i>	53.0	65.8	69.7	70.4	42.8	51.6	60.6	61.6	56.0	63.5	71.0	76.6	82.0
<i>Lead Screening in Children</i>	70.4	69.5	82.2	81.9	65.9	69.8	74.7	78.1	42.3	57.6	71.6	81.0	88.4
<i>Well-Child Visits in the First 15 Months (0 Visits)*</i>	10.0	7.7	5.1	3.5	9.2	4.6	4.1	5.4	0.5	0.7	1.4	2.9	5.1
<i>Well-Child Visits in the First 15 Months (6+ Visits)</i>	29.0	43.5	48.4	53.8	21.7	40.4	45.7	51.3	40.9	52.2	60.1	69.7	76.3
<i>Well-Child Visits (3–6 Years)</i>	68.4	74.8	79.2	67.4	57.4	65.9	69.8	71.8	59.9	65.9	71.8	77.3	82.5
<i>Adolescent Well-Care Visits</i>	32.2	36.9	45.7	43.9	37.7	37.7	37.2	38.9	34.4	38.8	46.8	56.0	63.2
<i>Immunizations for Adolescents**</i>	NA**	NA**	18.2	40.5	NA**	NA**	23.4	29.9	21.9	31.2	42.4	53.9	65.9
<i>Children’s Access to PCPs (12 –24 Months)</i>	77.3	81.8	84.1	82.2	82.5	83.3	82.2	86.5	90.6	95.1	96.8	97.9	98.5
<i>Children’s Access to PCPs (25 months–6 Years)</i>	65.2	68.9	70.6	69.9	65.7	70.1	73.1	73.3	81.0	87.1	89.8	92.2	94.1
<i>Children’s Access to PCPs (7 –11 Years)</i>	52.4	49.5	47.8	51.1	60.7	61.6	69.3	70.5	85.0	87.7	91.3	93.4	95.6
<i>Adolescent’s Access to PCPs (12 –19 Years)</i>	48.4	49.9	46.7	53.0	58.7	60.8	68.6	71.4	80.6	85.4	88.9	91.8	93.7
<b>Adults’ Access to Preventive/Ambulatory Care</b>													
<i>20–44 Years of Age</i>	56.6	59.4	65.4	64.6	57.5	66.3	67.3	69.3	67.4	78.0	82.9	86.7	88.5
<i>45–64 Years of Age</i>	48.6	58.8	69.9	67.4	54.6	63.3	67.6	68.8	73.2	83.2	88.1	90.1	91.3
<b>Preventive Screening for Women</b>													
<i>Breast Cancer Screening</i>	27.8	33.9	44.9	47.7	35.5	32.5	31.5	30.7	39.8	46.2	52.0	59.6	63.8
<i>Cervical Cancer Screening</i>	68.0	55.4	63.9	69.4	59.1	62.0	69.3	69.8	50.4	61.0	67.8	72.9	78.9
<i>Chlamydia Screening (16–20 Years of Age)</i>	47.7	53.6	55.4	62.5	45.1	44.5	45.6	46.1	43.8	48.5	53.0	61.1	66.4
<i>Chlamydia Screening (21–24 Years of Age)</i>	47.7	53.8	57.5	70.7	53.3	54.8	56.2	57.2	49.5	55.8	62.4	69.1	73.4

HEDIS Measures	HEDIS Rates for Family Health Network				HEDIS Rates for Harmony Health Plan				HEDIS 2010 National Medicaid Percentiles				
	2008	2009	2010	2011	2008	2009	2010	2011	10th	25th	50th	75th	90th
<i>Chlamydia Screening (Combined Rate)</i>	47.7	53.7	56.4	66.3	49.3	48.8	49.9	50.9	44.2	50.6	55.7	63.7	69.5
<b>Maternity-Related Measures</b>													
<i>Frequency of Ongoing Prenatal Care (&lt;21% of Visits)*</i>	29.4	39.3	16.9	18.2	21.9	27.0	17.8	16.5	2.2	3.4	7.0	13.9	22.2
<i>Frequency of Ongoing Prenatal Care (81–100% of Visits)</i>	33.4	25.6	26.1	42.3	31.4	33.6	39.4	39.9	31.5	52.1	64.2	73.7	82.2
<i>Timeliness of Prenatal Care</i>	45.4	49.4	49.2	62.4	56.4	56.4	65.2	64.7	70.6	80.3	86.0	90.0	92.7
<i>Postpartum Care</i>	32.3	32.9	39.3	40.2	35.0	40.1	49.6	48.7	53.0	58.7	65.5	70.3	74.4
<b>Chronic Conditions/Disease Management</b>													
<i>Controlling High Blood Pressure</i>	45.3	54.6	27.0	45.6	34.3	39.7	43.3	42.6	41.9	49.4	57.1	63.3	67.2
<i>Diabetes Care (HbA1C Testing)</i>	68.5	66.9	77.6	79.2	57.7	68.1	67.0	69.6	69.4	76.0	81.1	86.4	90.2
<i>Diabetes Care (Poor HbA1c Control)*</i>	56.5	65.5	69.1	69.9	72.7	67.3	64.2	65.9	27.7	33.8	43.2	53.4	63.5
<i>Diabetes Care (Good HbA1c Control)</i>	12.0	27.0	30.9	31.7	15.6	24.6	28.8	29.4	29.9	38.7	46.6	54.2	58.8
<i>Diabetes Care (Eye Exam)</i>	22.8	24.3	25.0	31.7	9.0	13.3	15.0	18.2	32.1	41.4	54.0	63.7	70.1
<i>Diabetes Care (LDL-C Screening)</i>	56.5	60.8	69.1	68.9	52.3	58.0	58.2	63.7	62.6	69.3	75.4	80.1	84.0
<i>Diabetes Care (LDL-C Level &lt;100 mg/dL)</i>	15.2	19.6	27.0	29.5	12.4	17.7	18.6	17.5	19.5	27.2	33.6	40.9	45.5
<i>Diabetes Care (Nephropathy Monitoring)</i>	57.6	79.7	85.5	84.7	59.9	69.9	68.4	67.4	65.7	72.5	77.7	82.7	86.2
<i>Diabetes Care (BP &lt;140/90)</i>	51.1	45.3	40.8	54.6	45.0	54.0	51.3	49.6	43.8	53.5	61.6	68.2	73.4
<i>Appropriate Medications for Asthma (Combined)</i>	79.3	85.0	93.0	90.3	84.1	86.6	86.5	86.0	84.6	86.7	88.6	90.8	92.8
<i>Follow-up After Hospitalization for Mental Illness—7 Days</i>	56.4	64.2	66.9	70.9	20.0	43.2	49.2	42.7	18.2	29.6	43.5	59.1	64.3
<i>Follow-up After Hospitalization for Mental Illness—30 Days</i>	67.9	76.5	79.8	80.2	32.3	55.6	58.7	56.1	31.8	49.0	62.6	74.3	83.6

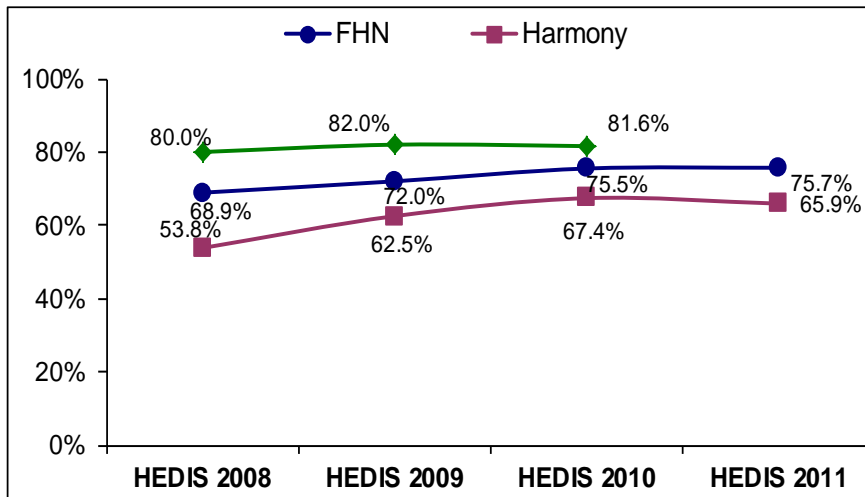
\* Lower rates indicate better performance for these measures.  
\*\* Immunizations for Adolescents was new for HEDIS 2010, and therefore, trending is based on two years.

Quality Performance Program Measures
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**Note:** Meridian Health Plan is not displayed in the table since they only have two years of HEDIS reporting and their eligible population is too small (<30 cases) for most of the measures.

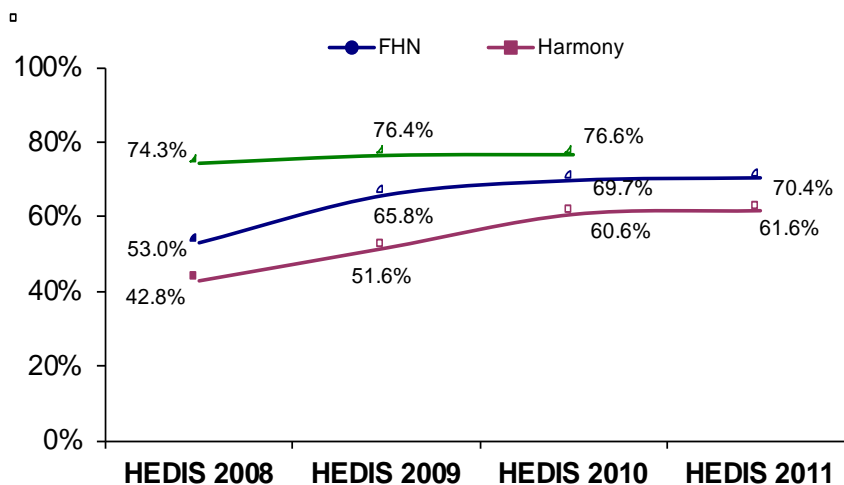
This appendix displays trended line graphs for the performance measures with at least two years of HEDIS reporting compared to the national Medicaid HEDIS 75th percentile for each reporting year. In several cases when lower performance is better, then the 25th percentile is used. The national Medicaid HEDIS percentiles for each year are provided beside each graph

**Figure C.1—Childhood Immunizations—Combination #2**



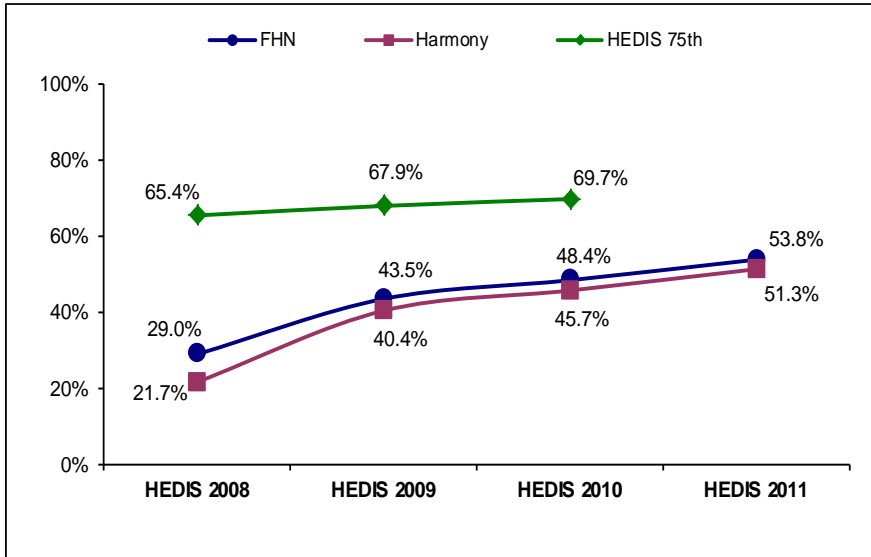
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	57.2	67.6	75.4	80.0	84.7
2009	56.4	68.5	77.9	82.0	85.4
2010	61.8	68.8	76.6	81.6	85.6

**Figure C.2—Childhood Immunizations—Combination #3**



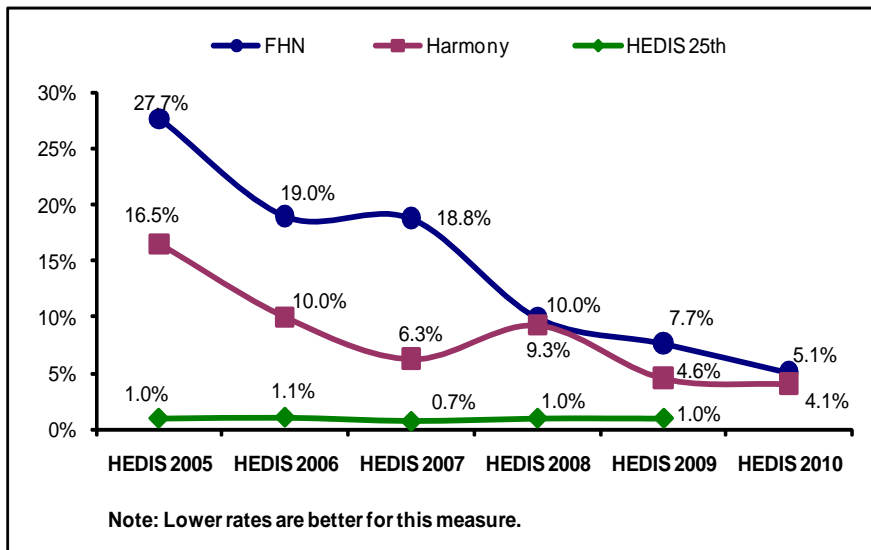
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	50.1	59.9	68.6	74.3	78.2
2009	50.9	62.4	71.8	76.4	80.6
2010	56.0	63.5	71.0	76.6	82.0

Figure C.3—Well-Child Visits in the First 15 Months of Life (6+ Visits)



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	29.0	44.5	57.5	65.4	73.7
2009	40.4	51.6	60.6	67.9	73.9
2010	40.9	52.2	60.1	69.7	76.3

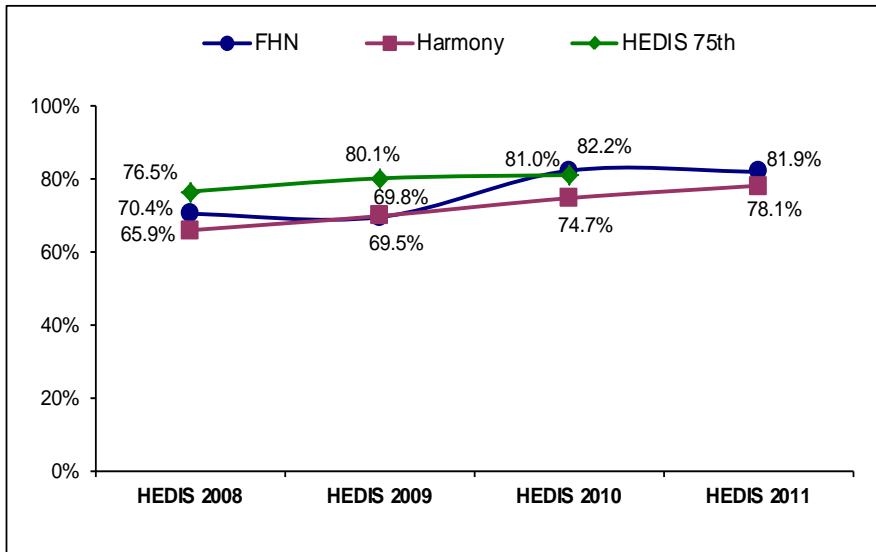
Figure C.4—Well-Child Visits in the First 15 Months of Life (No Visits)



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	0.6	1.0	1.9	3.1	6.8
2009	0.3	1.0	1.5	3.0	5.3
2010	0.5	0.7	1.4	2.9	5.1

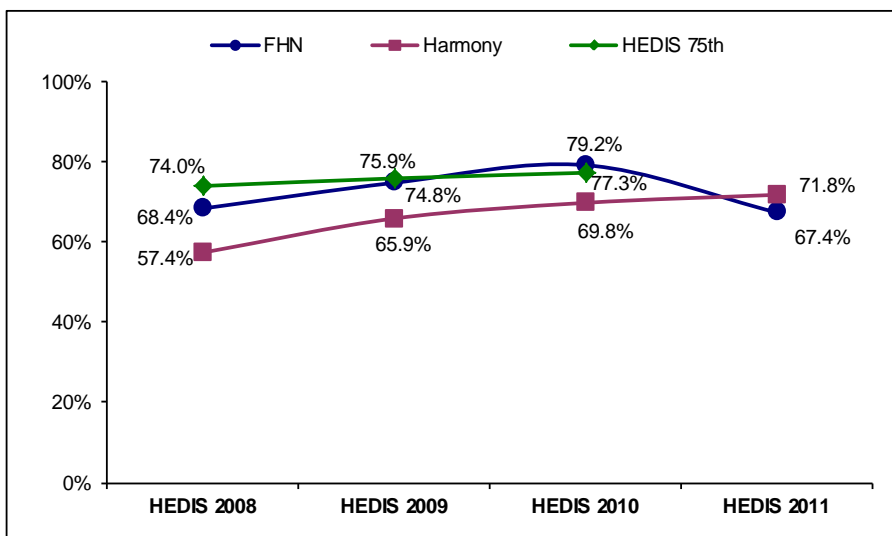
Note: Lower rates are better for this measure.

Figure C.5—Lead Screening in Children



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	32.3	49.3	65.9	76.5	84.0
2009	43.8	56.2	70.5	80.1	87.1
2010	42.3	57.6	71.6	81.0	88.4

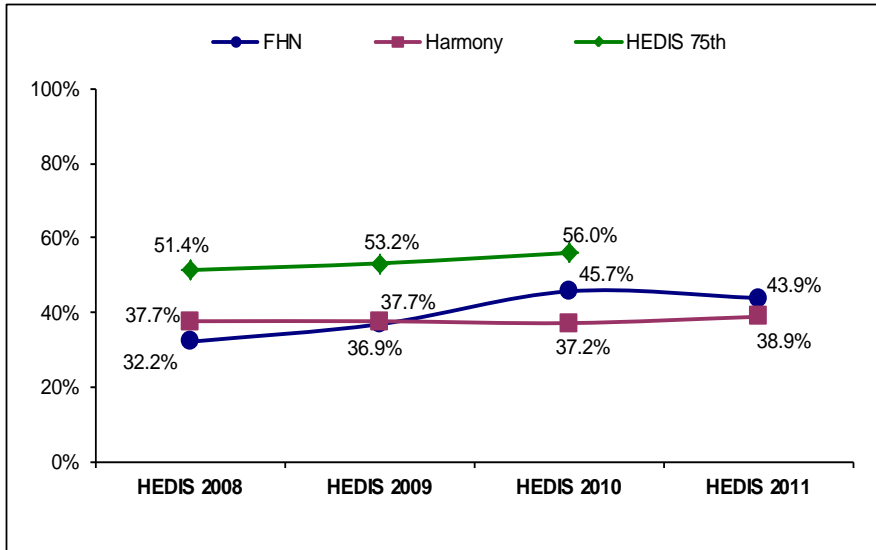
Figure C.6—Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	52.3	59.8	68.2	74.0	78.9
2009	57.5	64.0	70.4	75.9	80.3
2010	59.9	65.9	71.8	77.3	82.5

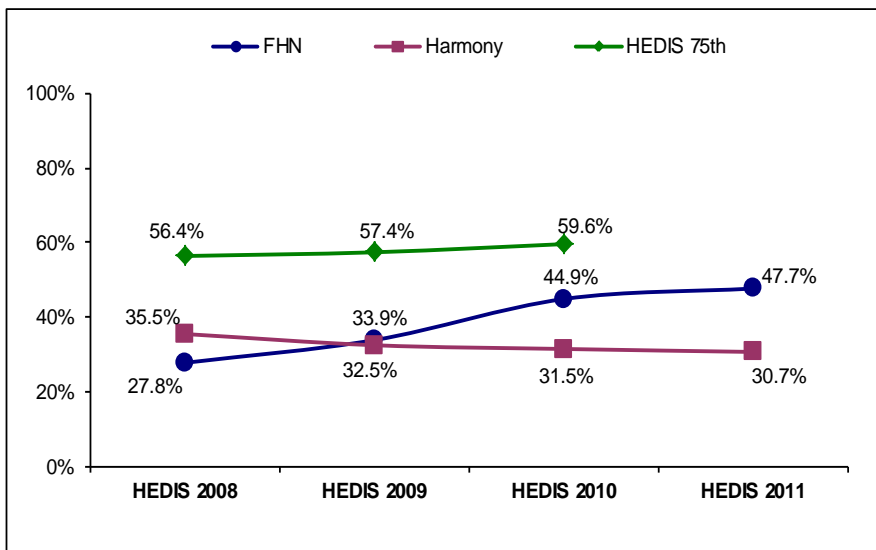


Figure C.7—Adolescent Well-Care Visits



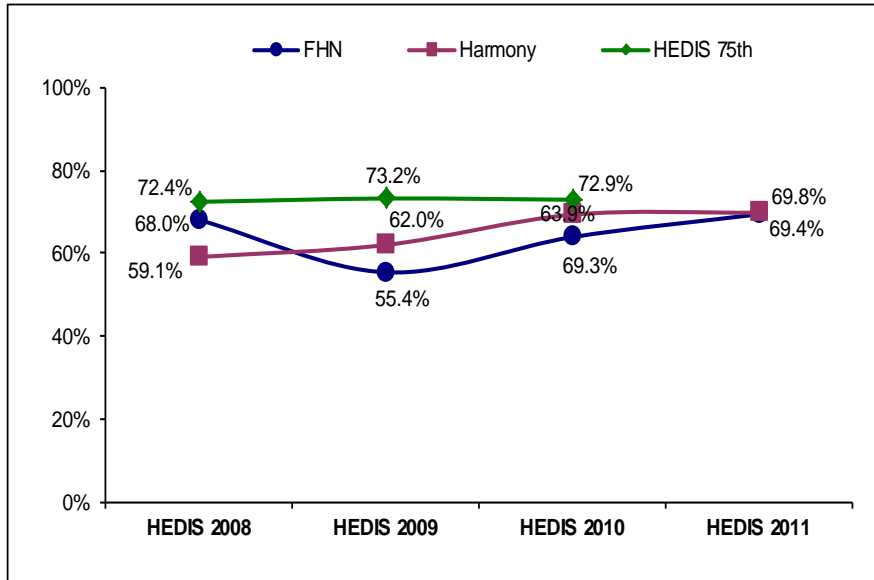
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	27.2	35.9	42.1	51.4	56.7
2009	32.8	37.9	45.1	53.2	59.4
2010	34.4	38.8	46.8	56.0	63.2

Figure C.8—Breast Cancer Screening



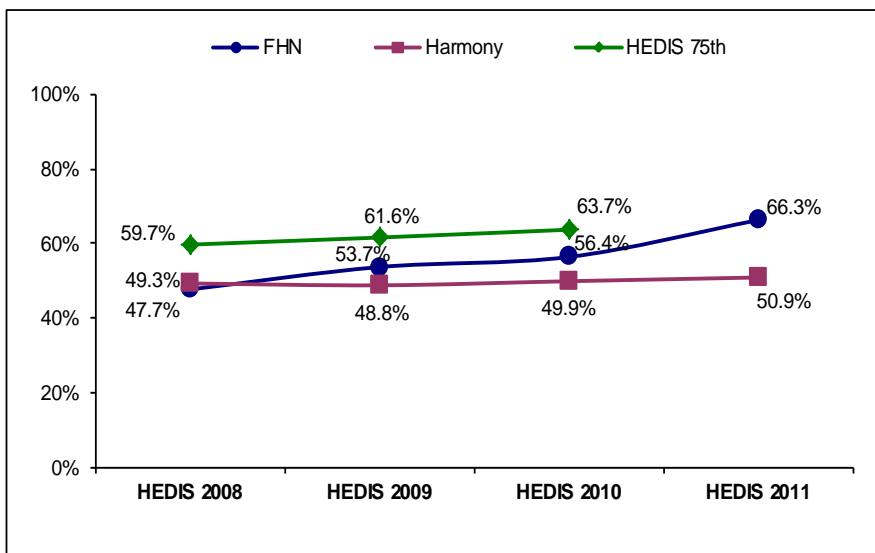
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	38.8	44.4	50.1	56.4	61.2
2009	38.6	45.0	50.5	57.4	63.0
2010	39.8	46.2	52.0	59.6	63.8

Figure C.9—Cervical Cancer Screening



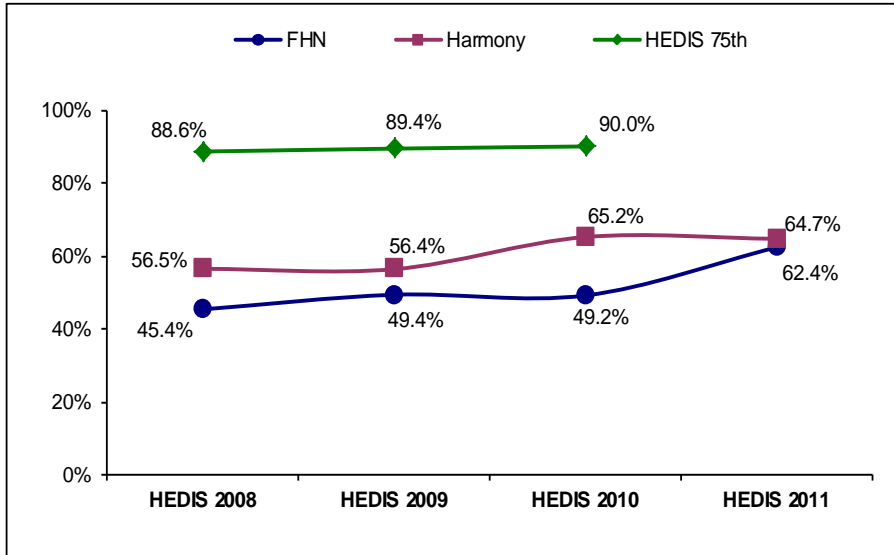
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	50.5	56.5	67.0	72.4	77.5
2009	52.1	60.9	67.6	73.2	79.5
2010	50.4	61.0	67.8	72.9	78.9

Figure C.10—Chlamydia Screening in Women



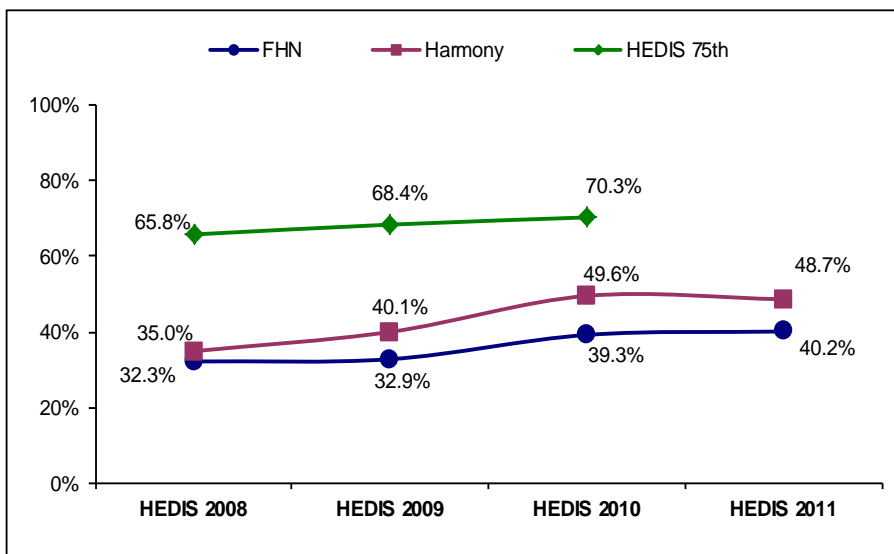
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	32.6	43.7	51.9	59.7	67.0
2009	43.4	48.7	54.8	61.6	68.6
2010	44.2	50.6	55.7	63.7	69.5

Figure C.11—Timeliness of Prenatal Care



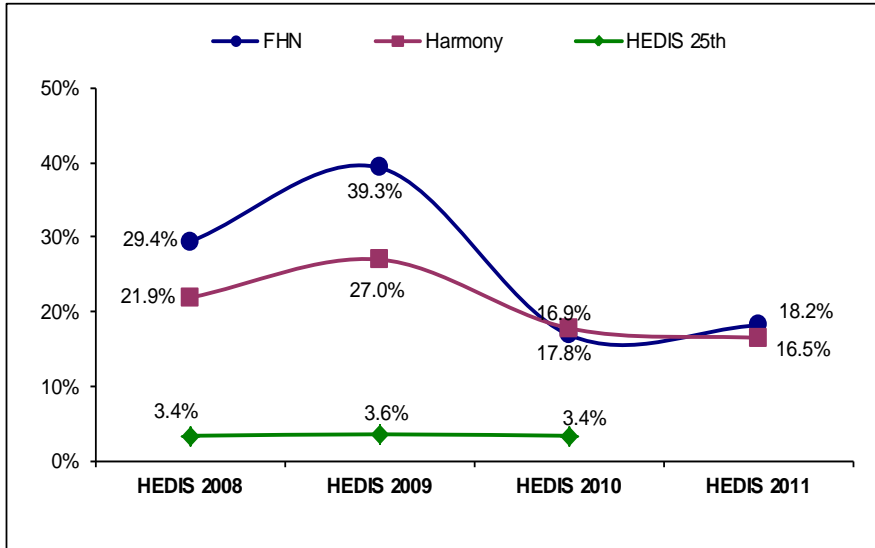
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	68.4	76.6	84.1	88.6	91.4
2009	67.9	78.5	85.6	89.4	92.2
2010	70.6	80.3	86.0	90.0	92.7

Figure C.12—Postpartum Care Visits



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	47.0	54.0	60.8	65.8	70.6
2009	50.3	57.9	63.9	68.4	72.7
2010	53.0	58.7	65.5	70.3	74.4

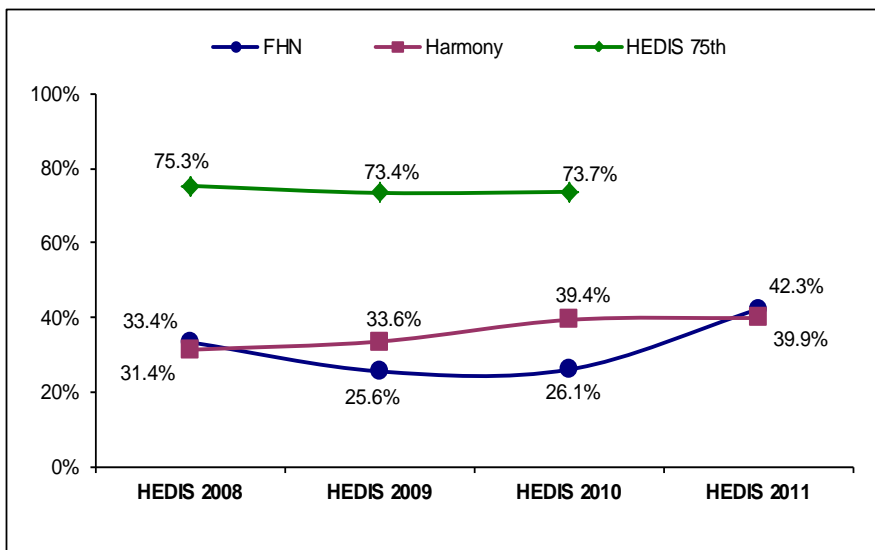
Figure C.13—Frequency of Ongoing Prenatal Care (<21% of Recommended Visits)



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	1.9	3.4	7.7	15.1	24.4
2009	2.3	3.6	8.3	15.6	27.3
2010	2.2	3.4	7.0	13.9	22.2

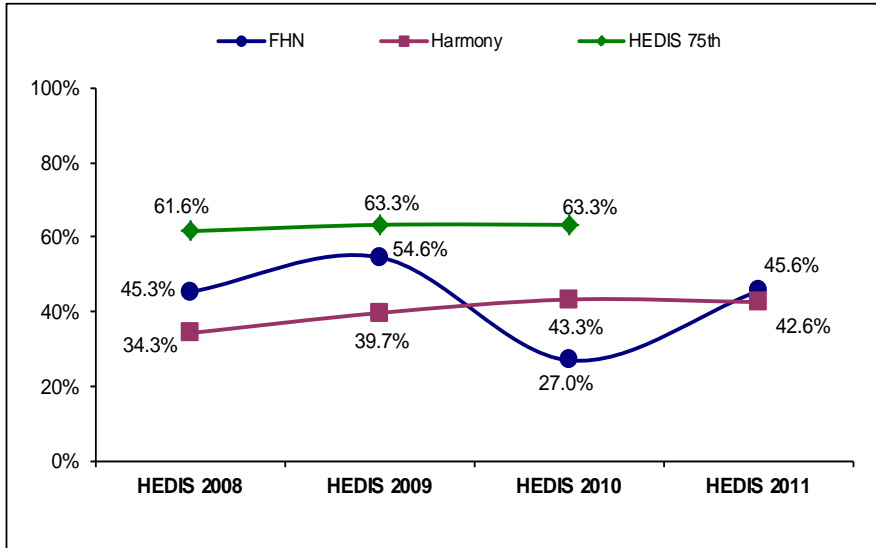
Note: Lower rates are better for this measure.

Figure C.14—Frequency of Ongoing Prenatal Care (81%–100% of Recommended Visits)



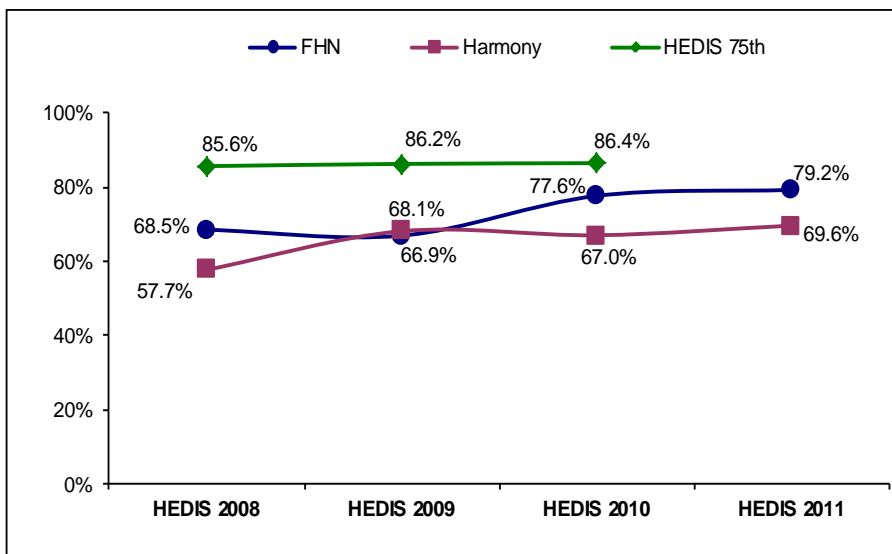
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	31.1	50.6	61.5	75.3	80.7
2009	28.9	46.8	62.8	73.4	81.0
2010	31.5	52.1	64.2	73.7	82.2

Figure C.15—Controlling High Blood Pressure



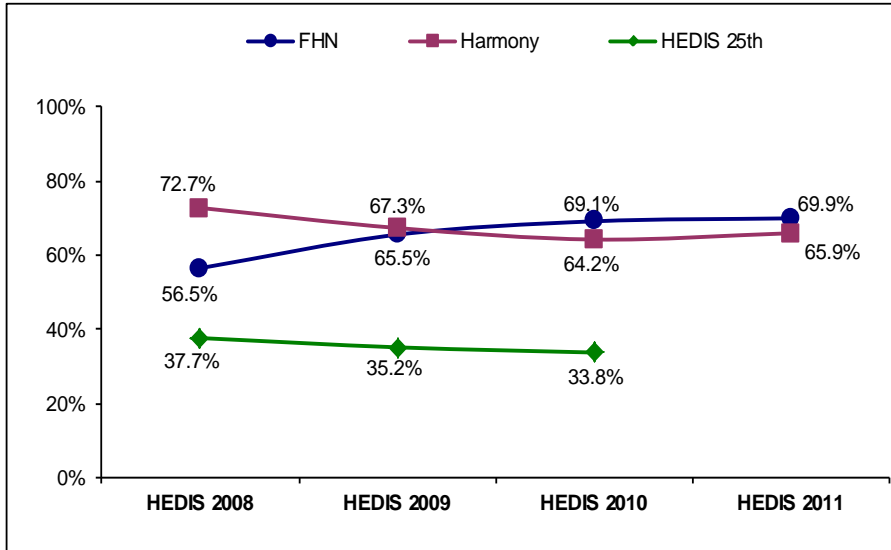
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	39.0	47.2	55.4	61.6	65.0
2009	40.6	51.4	58.0	63.3	66.6
2010	41.9	49.4	57.1	63.3	67.2

Figure C.16—Comprehensive Diabetes Care—HbA1c Testing



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	65.7	74.2	79.6	85.6	88.8
2009	69.8	76.5	80.7	86.2	89.3
2010	69.4	76.0	81.1	86.4	90.2

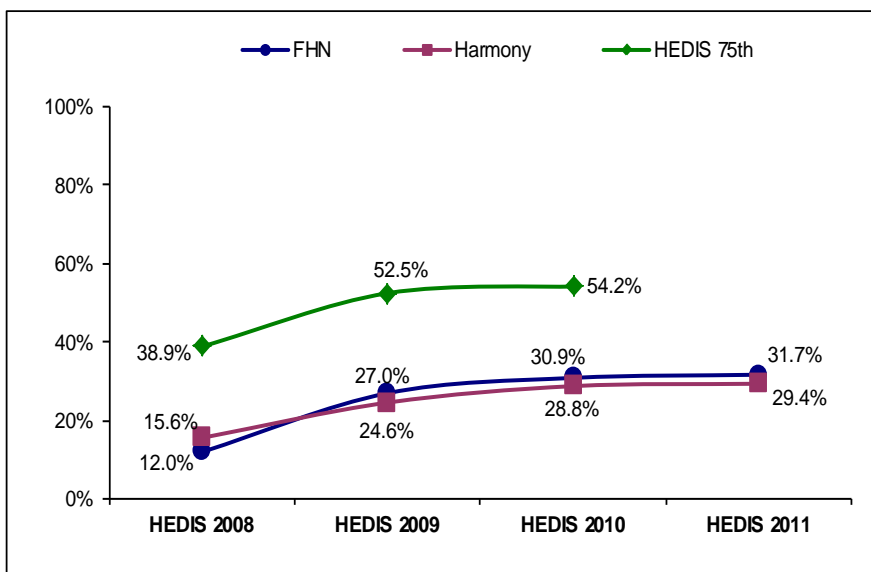
Figure C.17—Comprehensive Diabetes Care—Poor HbA1c Control



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	32.4	37.7	46.0	52.5	69.8
2009	29.2	35.2	42.6	50.6	61.0
2010	27.7	33.8	43.2	53.4	63.5

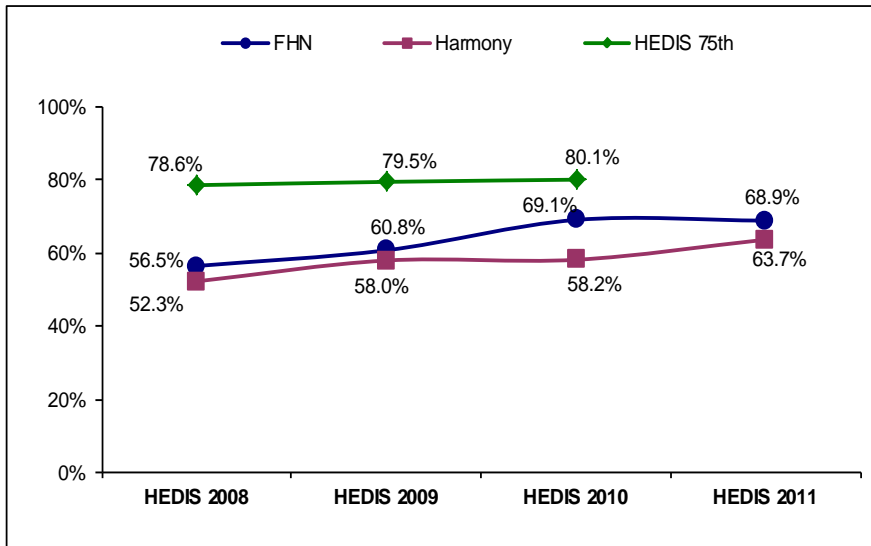
Note: Lower rates are better for this measure.

Figure C.18—Comprehensive Diabetes Care—Good HbA1c Control



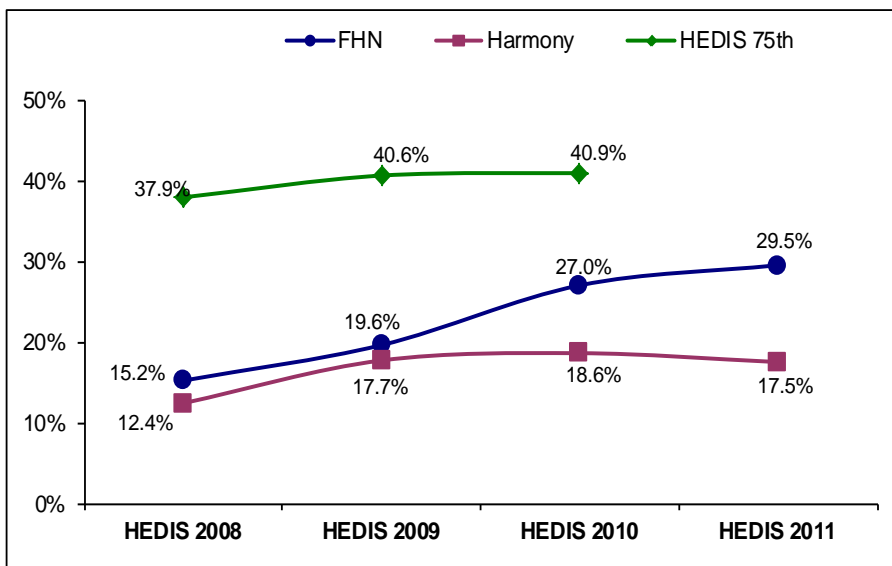
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	15.9	27.7	32.8	38.9	42.5
2009	27.8	37.5	45.6	52.5	60.1
2010	29.9	38.7	46.6	54.2	58.8

Figure C.19—Comprehensive Diabetes Care—LDL-C Screening



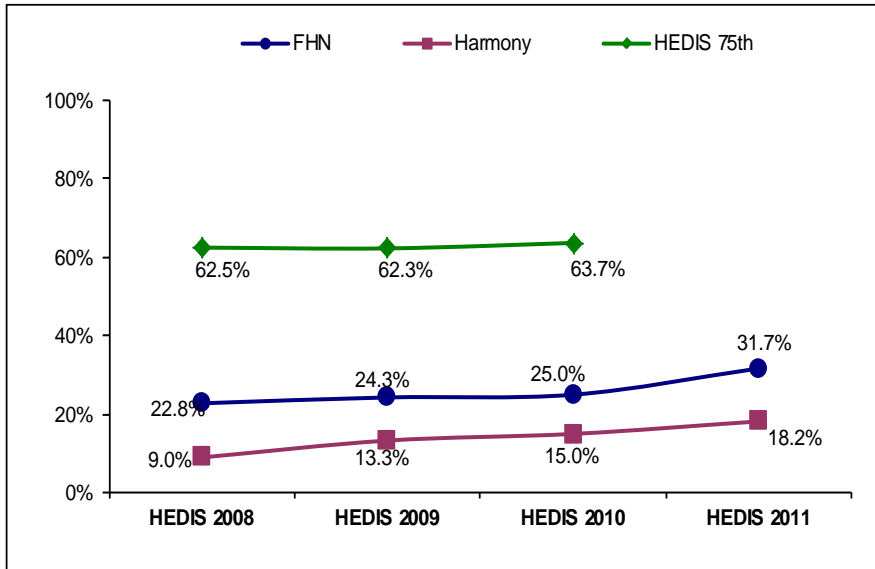
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	58.6	66.7	73.2	78.6	81.8
2009	62.7	71.5	76.1	79.5	82.5
2010	62.6	69.3	75.4	80.1	84.0

Figure C.20—Comprehensive Diabetes Care—LDL-C Level <100



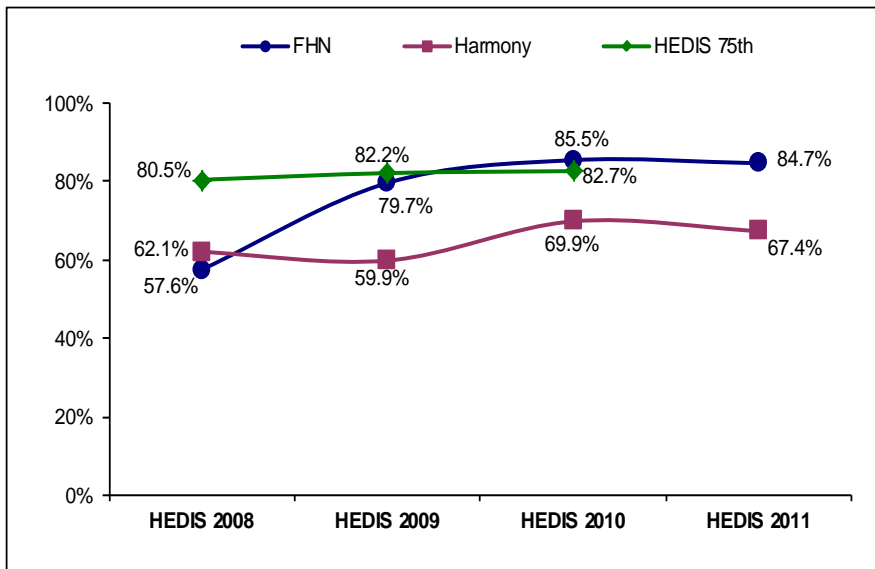
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	16.5	25.1	33.1	37.9	42.6
2009	21.3	27.2	35.1	40.6	44.7
2010	19.5	27.2	33.6	40.9	45.5

Figure C.21—Comprehensive Diabetes Care—Eye Exams



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	24.2	39.7	53.8	62.5	67.6
2009	33.3	44.4	55.4	62.3	70.8
2010	32.1	41.4	54.0	63.7	70.1

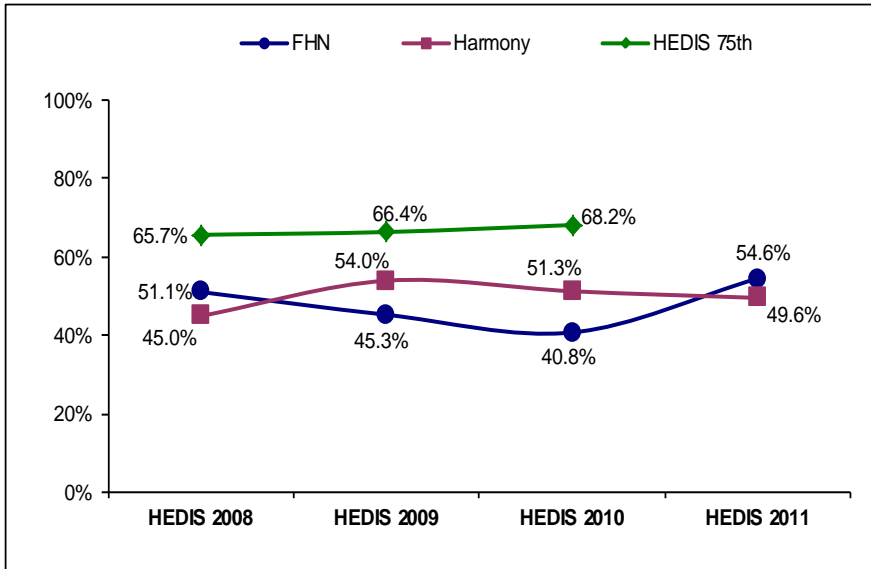
Figure C.22—Comprehensive Diabetes Care—Monitoring Nephropathy



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	59.7	67.9	76.1	80.5	85.4
2009	64.5	73.4	78.1	82.2	85.4
2010	65.7	72.5	77.7	82.7	86.2

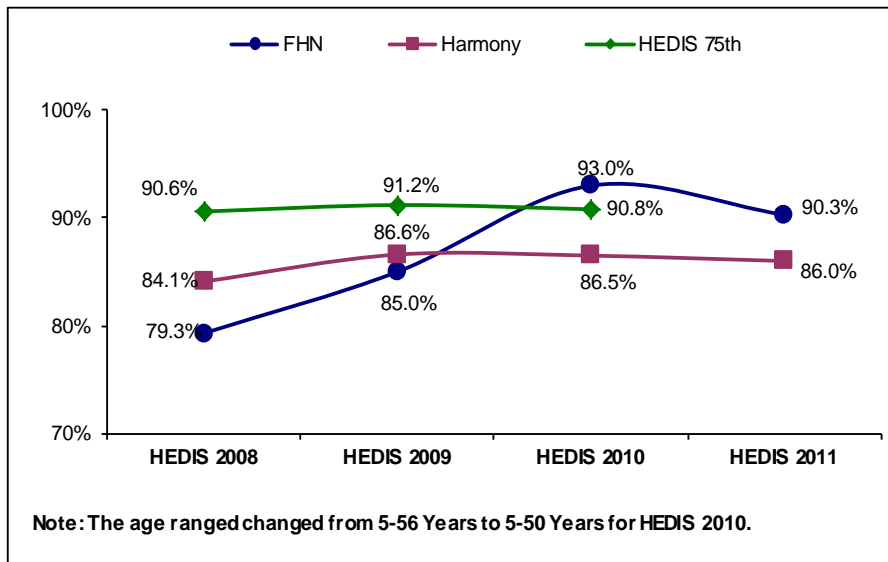


Figure C.23—Comprehensive Diabetes Care—Blood Pressure <140/90



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	37.0	49.6	58.2	65.7	71.3
2009	37.5	52.3	61.1	66.4	71.2
2010	43.8	53.5	61.6	68.2	73.4

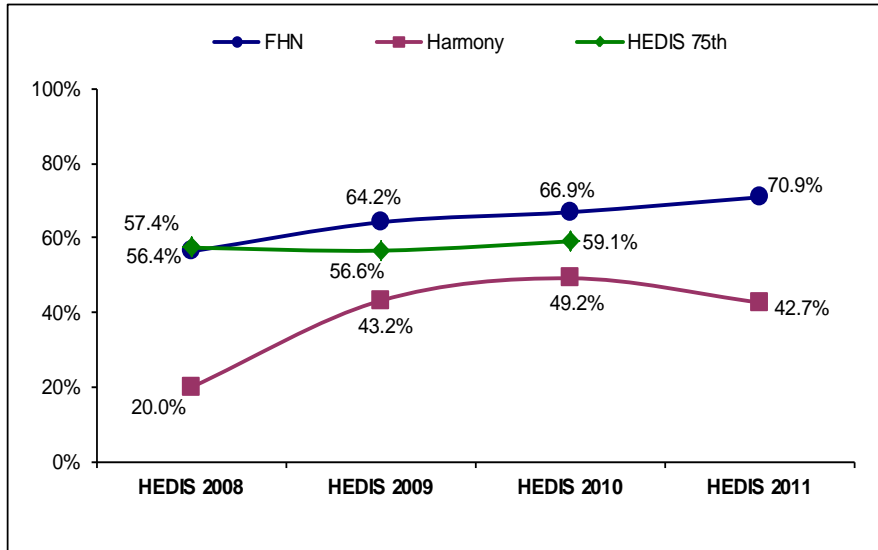
Figure C.24—Use of Appropriate Medications for People With Asthma (Combined Rate)



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	80.4	86.1	88.7	90.6	91.9
2009	84.1	86.6	89.2	91.2	92.1
2010	84.6	86.7	88.6	90.8	92.8

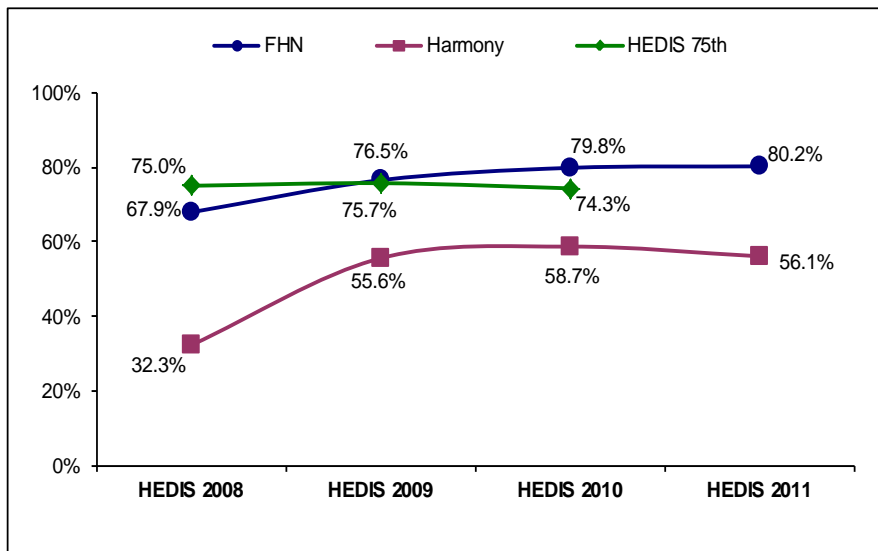
Note: Starting with HEDIS 2010, the age ranged changed from 5-56 Years to 5-50 Years.

Figure C.25—Follow-up After Hospitalization for Mental Illness (7–Day)



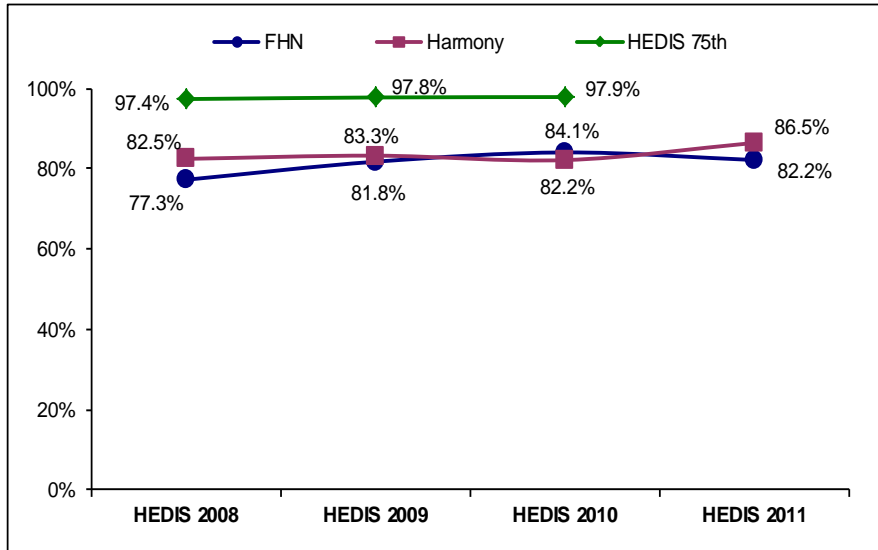
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	14.5	27.5	43.2	57.4	65.4
2009	15.5	31.6	44.5	56.6	64.2
2010	18.2	29.6	43.5	59.1	64.3

Figure C.26—Follow-up After Hospitalization for Mental Illness (30–Day)



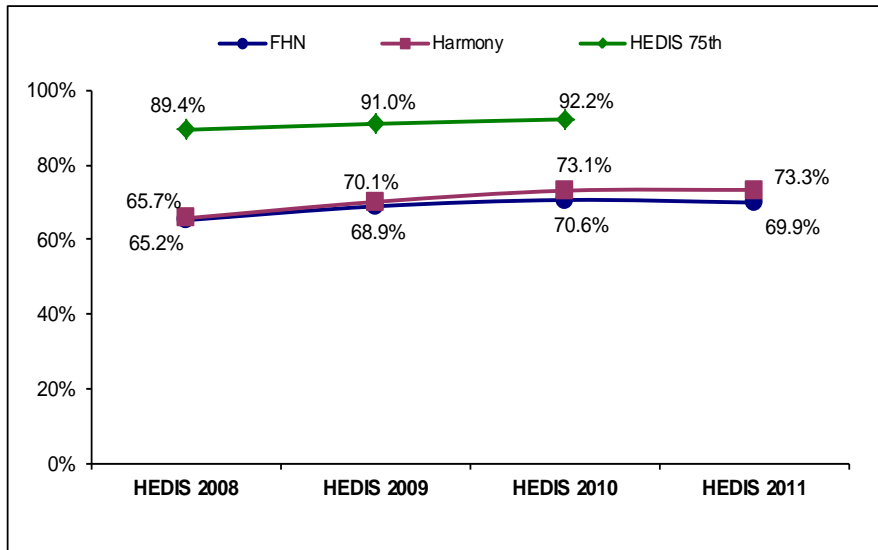
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	30.5	51.4	65.9	75.0	80.3
2009	37.3	49.6	64.3	75.7	81.2
2010	31.8	49.0	62.6	74.3	83.6

Figure C.27—Children’s Access to PCPs (12–24 Months)



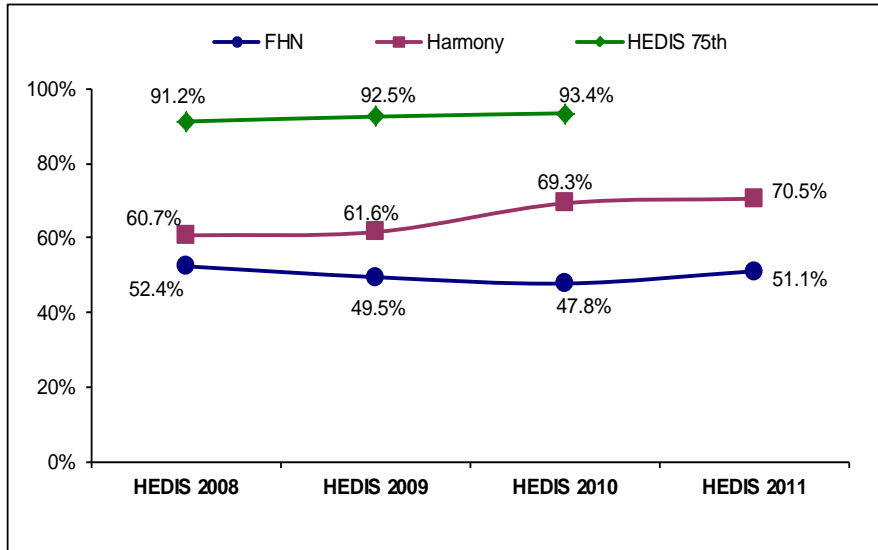
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	87.7	93.2	95.8	97.4	98.4
2009	90.2	93.9	96.3	97.8	98.4
2010	90.6	95.1	96.8	97.9	98.5

Figure C.28—Children’s Access to PCPs (25 Months to 6 Years)



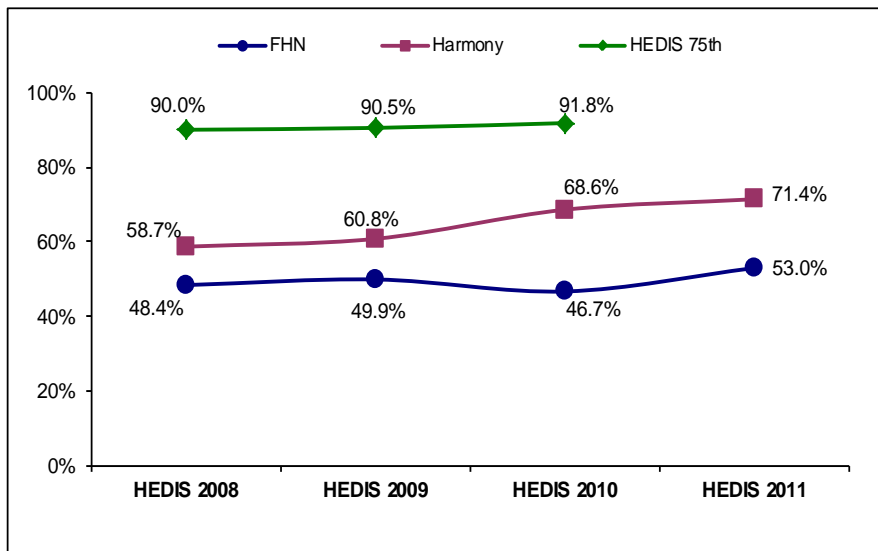
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	74.2	82.3	86.5	89.4	92.0
2009	78.6	85.4	88.3	91.0	92.6
2010	81.0	87.1	89.8	92.2	94.1

Figure C.29—Children’s Access to PCPs (7–11 Years)



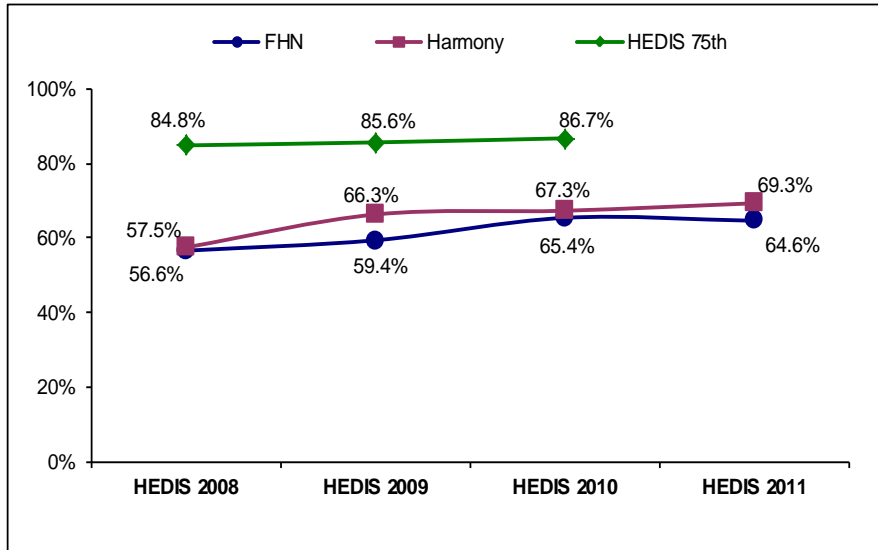
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	75.5	82.2	87.8	91.2	94.1
2009	79.9	84.9	89.0	92.5	94.6
2010	85.0	87.7	91.3	93.4	95.6

Figure C.30—Children’s Access to PCPs (12–19 Years)



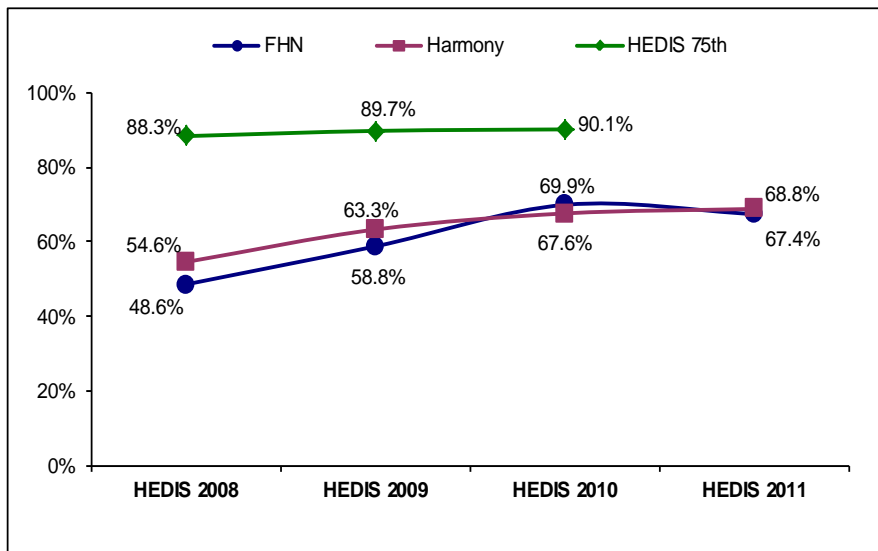
Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	70.6	78.1	84.5	90.0	91.9
2009	76.1	82.5	87.2	90.5	92.2
2010	80.6	85.4	88.9	91.8	93.7

Figure C.31—Adult's Access (20–44 Years)



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	60.7	71.6	79.6	84.8	87.6
2009	67.8	77.3	81.5	85.6	88.4
2010	67.4	78.0	82.9	86.7	88.5

Figure C.32—Adult's Access (45–64 Years)



Medicaid HEDIS Percentiles					
HEDIS	10th	25th	50th	75th	90th
2008	71.2	79.3	85.7	88.3	90.2
2009	78.7	83.9	87.5	89.7	91.1
2010	73.2	83.2	88.1	90.1	91.3

APPENDIX D. MEDICAID HEDIS 2010 MEANS AND PERCENTILES

Medicaid HEDIS 2010 Means and Percentiles						
	Mean	P10	P25	P50	P75	P90
Childhood Immunizations (Combo 2)	74.3	61.8	68.8	76.6	81.6	85.6
Childhood Immunizations (Combo 3)	69.4	56.0	63.5	71.0	76.6	82.0
Lead Screening in Children	66.4	42.3	57.6	71.6	81.0	88.4
Annual Dental Visit (Combined Rate)	45.7	28.1	38.0	49.2	54.8	64.1
Well-Child Visits in the First 15 Months of Life (0 Visits)*	2.3	0.5	0.7	1.4	2.9	5.1
Well-Child Visits in the First 15 Months of Life (6+ Visits)	59.4	40.9	52.2	60.1	69.7	76.3
Well-Child Visits (3–6 Years)	71.6	59.9	65.9	71.8	77.3	82.5
Adolescent Well-Care Visits	47.7	34.4	38.8	46.8	56.0	63.2
Immunizations for Adolescents (Combined Rate)	42.5	21.9	31.2	42.4	53.9	65.9
Children’s and Adolescents’ Access to PCPs (12–24 Months)	95.2	90.6	95.1	96.8	97.9	98.5
Children’s and Adolescents’ Access to PCPs (25 Months–6 Years)	88.3	81.0	87.1	89.8	92.2	94.1
Children’s and Adolescents’ Access to PCPs (7–11 Years)	90.3	85.0	87.7	91.3	93.4	95.6
Children’s and Adolescents’ Access to PCPs (12–19 Years)	87.9	80.6	85.4	88.9	91.8	93.7
Adult’s Access to Preventive/Ambulatory Care (20–44 Years)	80.5	67.4	78.0	82.9	86.7	88.5
Adult’s Access to Preventive/Ambulatory Care (45–64 Years)	85.3	73.2	83.2	88.1	90.1	91.3
Breast Cancer Screening	52.4	39.8	46.2	52.0	59.6	63.8
Cervical Cancer Screening	65.8	50.4	61.0	67.8	72.9	78.9
Chlamydia Screening in Women (16–20 years)	54.4	43.8	48.5	53.0	61.1	66.4
Chlamydia Screening in Women (21–24 Years)	61.6	49.5	55.8	62.4	69.1	73.4
Chlamydia Screening in Women (Combined)	56.7	44.2	50.6	55.7	63.7	69.5
Timeliness of Prenatal Care	83.4	70.6	80.3	86.0	90.0	92.7
Postpartum Care	64.1	53.0	58.7	65.5	70.3	74.4
Frequency of Ongoing Prenatal Care (<21%)*	10.3	2.2	3.4	7.0	13.9	22.2
Frequency of Ongoing Prenatal Care (81–100%)	61.6	31.5	52.1	64.2	73.7	82.2
Controlling High Blood Pressure (Combined Rate)	55.3	41.9	49.4	57.1	63.3	67.2
Comprehensive Diabetes Care (HbA1c Testing)	80.6	69.4	76.0	81.1	86.4	90.2
Comprehensive Diabetes Care (Poor HbA1c Control)*	44.9	27.7	33.8	43.2	53.4	63.5
Comprehensive Diabetes Care (HbA1c Control <8)	45.7	29.9	38.7	46.6	54.2	58.8
Comprehensive Diabetes Care (HbA1c Control <7)	33.9	20.0	27.4	35.5	39.5	44.5
Comprehensive Diabetes Care (Eye Exams)	52.7	32.1	41.4	54.0	63.7	70.1
Comprehensive Diabetes Care (LDL-C Screening)	74.2	62.6	69.3	75.4	80.1	84.0

Medicaid HEDIS 2010 Means and Percentiles						
	Mean	P10	P25	P50	P75	P90
<i>Comprehensive Diabetes Care (LDL-C Level &lt;100)</i>	33.5	19.5	27.2	33.6	40.9	45.5
<i>Comprehensive Diabetes Care (BP &lt;130/80)**</i>	32.2	21.4	27.1	32.5	36.7	44.3
<i>Comprehensive Diabetes Care (BP &lt;140/90)</i>	59.8	43.8	53.5	61.6	68.2	73.4
<i>Comprehensive Diabetes Care (Monitoring Nephropathy)</i>	76.9	65.7	72.5	77.7	82.7	86.2
<i>Use of Appropriate Medications for People With Asthma (5–11 Years)</i>	91.8	88.2	90.0	92.2	93.9	95.5
<i>Use of Appropriate Medications for People With Asthma (12–50 Years)</i>	86.0	79.9	83.8	86.3	89.1	90.7
<i>Use of Appropriate Medications for People With Asthma (Total)</i>	88.6	84.6	86.7	88.6	90.8	92.8
<i>Follow-up After Hospitalization for Mental Illness (7 Days)</i>	42.9	18.2	29.6	43.5	59.1	64.3
<i>Follow-up After Hospitalization for Mental Illness (30 Days)</i>	60.2	31.8	49.0	62.6	74.3	83.6
* A lower rate indicates better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile).						
** This measure changed to BP<140/80 for HEDIS 2011.						